

FINDINGS AND RECOMMENDATIONS

COURT DETAILS

Court State Coroner's Court of NSW
Case number 710/09

PROCEEDINGS

Inquest into the death of **James Llewellyn DRURY**
Also known as - (Veronica Maree BAXTER and Telisha DRURY)

Hearing dates 4 April 2011
Date of findings 4 April 2011
Place of findings State Coroner's Court, 44-46 Parramatta Rd, Glebe
Findings of His Honour Magistrate MacMahon, Deputy State Coroner

FINDINGS

James Llewellyn Drury (born 23 February 1975) died between 3.30pm 15 March 2009 and 6am 16 March 2009 at the Department of Corrective Services, Metropolitan Remand Centre, Silverwater. The cause of his death was asphyxiation, which occurred as a result of him hanging himself with the intention of ending his life.

RECOMMENDATIONS

To the Commissioner of Corrective Services:

That where the "Knock Up" facility is used by an inmate such use, and the corrective services officer response thereto, be recorded and such recordings thereof be retained for an appropriate period.

REPRESENTATION

Assisting the coroner Sergeant Ramage, Police Advocate
Representing the family Mr McLachlan
Other parties Mr Saidi for Corrective Services NSW
Mr Singh for Justice Health

REASONS FOR FINDINGS

This has been an inquest into the death of James Llewellyn Drury who was born on 23 February 1975. The deceased was of Aboriginal descent. He identified himself as trans gender and as such was known as Telisha Drury, Veronica Baxter and by a variety of other names. In this inquest and in these findings, the deceased has been referred to in the feminine and with the name Veronica. That appears to have been a name which the deceased identified with more often perhaps than other names and out of respect for that identification I propose to use it in these findings. The deceased, however, on the evidence available to me had not changed his birth name and as such the formal findings will reflect that formal position.

Veronica was a person who was engaged in the criminal milieu of society. She had been incarcerated on a number of occasions prior to 2009 for a variety of offences. The circumstances of those incarcerations and the offences are not relevant in these proceedings except to the extent that it is noted that some of those offences involved matters of violence.

On 10 March 2009, Veronica was arrested by police and charged with a number of serious drug offences. She appeared at the Central Local Court following her arrest and having appeared in court was remanded in custody and had to re-appear at court on 24 April 2009. She was initially transferred from Central Local Court to the Sydney Police Centre and specifically the section of that location which was under the control of the Department of Corrective Services. She remained there until 14 March 2009 when she was transferred to the MRRC at Silverwater.

On arrest and on her presentation at court and to the Department of Corrective Services she was dealt with under the name of Telisha Drury. At Silverwater she was placed in cell 65 of the Darcy Wing. She was awaiting classification at that time. She was placed one out that is she was placed in a cell by herself. She was last seen alive by Corrective Services Officer Freeman at about 3 o'clock on the afternoon of 15 March 2009 when she was locked in her cell for the night.

At about 6am the next morning, that is 16 March 2009 when her cell was opened by Corrective Services Officer Glenn Clarke, she was found to be deceased. The apparent cause of her death being hanging, she having been found within the cell hanging with bedding material used as a noose.

It is important to understand what the role of a coroner is in these circumstances. Section 81 of the Act specifies that a coroner conducting an inquest is to make certain findings if evidence is available. Those findings deal with the identity of a deceased person, the date and place of their death and the cause and manner thereof. In this case, there is little controversy as to Veronica's identity. The evidence is clear as to her birth name and her transgender identification and the various names that she identified with although none of those names were names that she had legally adopted.

The place of her death is also not controversial that being cell 65 of the Darcy Wing of the Metropolitan Remand Centre at Silverwater under the administration of the Department of Corrective Services. The time of her death is not exact. As I have already indicated she was last seen alive on the afternoon of 15 March and she was found deceased on the morning of 16 March. She clearly died between those two times.

The cause of her death is also of little controversy. Following her death, her body was transported to the Department of Forensic Medicine here at Glebe where an autopsy was conducted by Associate Professor DuFlou, the director of the centre. Associate Professor DuFlou had also attended the cell in which Veronica was found deceased and observed her body in situ. He identified in his report the direct cause of her death as being hanging. Importantly, he did not identify any other injuries which either could have resulted in her death or which would have suggested that she had been the subject of a violent attack or abuse prior to her death. There was nothing in his report and in his observations of her body that would suggest that the manner of her death was other than intentional self harm.

As I have indicated, Veronica was locked in cell 65 a little around about 3pm on 15 March and she was found deceased about 6am on 16 March. There was no evidence that her cell was opened between those two times and there is no evidence that any third party had any involvement in her death.

Having regard to the evidence available, I am satisfied that the manner of her death was intentional self harm and that her action was undertaken with the intention of ending her life.

Section 23 of the Coroner's Act is relevant to Veronica's death that requires that where a person dies in custody that an inquest be undertaken and that such an inquest be undertaken by either the State Coroner or one of the Deputy State Coroners. The public policy reason for that is that where a person's liberty has been taken away from them the organisations of state who have responsibility for their care have an obligation to ensure that that care is provided in an appropriate manner and one which does not contribute to a death. That is the general principle and applies to all persons who are in custody.

In Veronica's case, that general principle is amplified by two factors and those two factors are recognised as placing a person in custody such as Veronica at perhaps greater risk. Those two factors are her Aboriginality and her transgender identification. In those circumstances, it is recognised that in particular by the Royal Commission into Aboriginal Deaths in Custody that indigenous persons can be subject to greater difficulties whilst in custody and likewise although it has not been the subject of a Royal Commission, it is recognised by the department itself that a person who has a transgender identification has greater risks whilst in custody.

Finally, of relevance in these proceedings is s 82 of the Coroner's Act which grants the coroner a discretion to make recommendations if he or she considers it appropriate about any matter which arises out of the death of the deceased person with whom the inquest is dealing.

The purpose or the primary function of the inquest the matters being dealt with under s 81 being subject to little or no controversy has been to ensure that appropriate action was taken in respect of Veronica's appearance in custody to identify any risks of self harm and if such risks were identified to take appropriate action to overcome or mitigate such risks. Clearly, a person who is being brought into custody will suffer stressors and anxiety as a result of their change in circumstances. The prospect of a prison term, the loss of freedom which goes with that would be stressful and would ordinarily be stressful, however, some persons would react in a different way and may be tempted to take action which would result in their harm. It is mandatory on the Department of Corrective Services to seek to identify such persons and where identified to take action to mitigate those risks.

In this case, I am satisfied that the Department of Corrective Services and the New South Wales Police Service before them did take action to endeavour to identify such risks. When a person comes into police custody which Veronica did after she was arrested and brought to the police station to be charged, a custody management record is created and that custody management record shows that at the time of being brought into police custody which was at approximately 11am on 10 March 2009 Veronica was not agitated; not under the influence of drugs or alcohol; not exceedingly despondent; did not exhibit any signs of previous attempts at self injury; did not make any threat of self injury whilst in custody; did not appear to be mentally disturbed and did not make any complaints. Indeed, the observation was that she was co-operative.

In answer to specific questions, she denied that she had tried to take her life previously; that she had any serious mental medical or mental health problems and was receiving treatment. It was appropriately identified as being she was appropriately identified as being Aboriginal. On her transfer to Corrective Services' custody, Veronica underwent a similar screening. The records show among other things in response to a question, "Do you feel that there is hope for the future?", she said, "Yes"; "Since being arrested, have you had any thoughts about harming yourself or taking your own life or harming others?", she denied it; "Do you have any current plans for self harm or taking your own life?", she denied it and "Have you tried to take your own life or harm yourself in the past whether either as a juvenile or as an adult?", she denied it.

The corrective service officer undertook a visual assessment of self harm and like the police officer previously did not identify any suggestions that there would be self harm. The comments that were made were that Veronica was co-operative and again at a later time the interviewer's comments and observations that "She was calm and co-operative, nil suicidal ideation at present, transgender was identified" and "withdrawing from heroin" was also a comment made.

Veronica subsequently underwent on 11 March a further assessment by Sandra Laycock, a counsellor. Sandra Laycock in her report said, "I found Letisha(as said) able to converse with me and answer all questions put to her". She stated that she had no previous history of self harm or suicide and no current self harm or suicide ideation and she concluded, that is Sandra Laycock concluded, "I did not see or hear anything to suggest that she was having difficulties being incarcerated".

On arrival at the Metropolitan Remand Centre, Marilena Bortoli undertook a screening process in respect of Veronica. Her observation of her was undertaken on 14 March 2009 at about 7.45pm and took approximately half an hour. She was identified as being Aboriginal and given the opportunity of being screened by a person of an Aboriginal background. Veronica did not object to Ms Bortoli undertaking this screening. Ms Bortoli said that during the course of her interview Veronica was "smiling, happy and talking". She was co-operative and polite. She kept good eye contact at all times. During the conversation, she presented as a happy and smiling. She concluded, that is Ms Bortoli concluded that there were no indicia suggestive that Veronica was at risk of self harm.

The situation therefore from the perspective of the Department of Corrective Services on reception of Veronica into its custody I am satisfied was that Veronica did not display any indicia which made it likely or foreseeable that she would self harm. Of course, there is one thing that a person or a front that a person can place before officials which might not necessarily be the same before your peers. The officer-in-charge of the investigation undertook a significant number of interviews with fellow inmates. Contained in the brief are statements from some ten of those inmates.

The general observations made by each of those inmates was that although Veronica had some concerns about her incarceration and to one appeared to be angry about something there were no indicia that came to their attention which would suggest that she intended to harm herself. This was particularly relevant in the observations of Sheena Tanovich(?) who I will refer to as Sheena - Sheena was an inmate of the Darcy Wing who had known Veronica since 1994. Sheena was also a person of transgender orientation. Sheena in her statement said, "I didn't think that she would do what she did. She did not give me any reason to believe that she was that bad and to take her life". She spoke to Veronica on 15 March shortly before Veronica was locked into her cell.

Sheena concluded her statement by saying, "When I spoke with her she did not say anything to me that would cause me to be concerned. She told me nothing about her feelings apart from being anxious about her charges. If I knew she was going to kill herself I would have told the officers straight away to put her in a safe cell. I did not hear anything unusual through the night or the early hours of the morning of the 16th".

The evidence therefore is that not only in the way in which she approached the police and Corrective Services' officers, also in her dealings with her fellow inmates, Veronica did not give any indication of an intention to self harm. I am satisfied that on the evidence available there was no relevant evidence that would have suggested that Veronica was likely to end her life on the evening of 15 March or the morning of 16 March 2009.

There is one issue of concern as to the actions of the Department of Corrective Services in respect of the period between Veronica being locked up on 15 March and found deceased

on the 16th. Within each cell there is what is called a knock up facility. This is a manner in which inmates who need urgent assistance can communicate with prison officers whilst they are locked in their cells. It is obvious that there must be a need for an inmate to so communicate in the event of a problem occurring such as a medical problem. The evidence is that there was some use of the knock up facility by Veronica during the relevant period.

Unfortunately, the evidence that has been able to be obtained in preparation for this inquest has not been able to tell us what it was or why it was that Veronica used that facility because although the use has been identified, it has not been possible or able to identify the officers of the department who responded and not having been able to identify the officers who responded we do not know - there's no evidence available to let us know what it was that she used the facility for.

Now, of course, these knock up facilities can be used for proper purpose or abused. An inmate - and I am not speaking about Veronica on this occasion, an inmate could use it for the purpose of annoying prison officers or generally speaking for improper purposes. Mr Saidi in his submissions opined the possibility of inmates using it to order pizzas. Now, that is I suppose possible to try and order pizzas but the real use of such a facility is in case of emergencies. We don't know why Veronica used the knock up. It may well be that it was for an innocent purpose. It may well be that it was for an important purpose, we just don't know. It seems to me that that is an area in which there is relevant evidence which was not able to be provided to the inquest because readily available facilities should be able to identify uses of the knock up even if that is manual.

The department's principal investigator has recommended that the use of the knock up be recorded and that's an obvious solution to the problem. Had this been recorded on this occasion we would know whether or not Veronica made any indication that suggested that she had become suicidal. It may well be that she used it for an altogether different purpose and we wouldn't have been any the wiser, we just don't know.

It seems to me that the recommendation of the principal investigator that the use of the knock up facility by inmates be recorded is a proper and commendable one and because the system that was in place by the department did not ensure that relevant evidence was available to the inquest I propose to endorse that recommendation and make a recommendation in similar terms in accordance with s 82 of the Coroner's Act.

A second issue of concern in this matter, of course, is the fact that Veronica was able to use what was at hand to create the resources necessary to self harm. She used bedding material to create the ligature and use the bed that she was provided as part of that process. It is acknowledged and I acknowledge it that over the years the Department of Corrective Services have responded to numerous recommendations made by coroners that hanging points and the use of Corrective Services' furniture which can become available to be used as hanging points or in other ways used to self harm have been identified and considerable efforts have been taken to ensure that furniture is or cannot be used to self harm.

The furniture in question in this matter was furniture which was specifically designed to try and overcome those problems and the previous State Coroner had been involved in that process. Whilst acknowledging that the efforts have been made, it is clear that in this case there has been a flaw identified. The principal investigator's report has made suggestions and those suggestions are further developed in exhibit 4 before me that there be certain modifications of the relevant furniture. I would endorse that recommendation. The identification of the floor is not a criticism of the department because it is acknowledged that even with the best intentions there are situations which result in equipment being used not in the way that they should or it should. I recognise the actions which are being taken by the department and I commend them for that but I do not think it is necessary for me to make a recommendation in accordance with s 82 in respect of that issue.

It was acknowledged by Mr McLachlan who appears for the family of Ms Baxter that there were no matters which identified the possibility of her intentionally self harming but he has submitted and I should make a recommendation that in cases such as Ms Baxter, that is persons who have a transgender identification when they are brought in to custody and until such time as their classification assessment has been completed they should be placed in an observation cell. Mr Saidi appearing on behalf of the department submits that such a recommendation would not be appropriate.

In this and other inquests, I have become familiar with the environment of an observation cell. The design of such a cell is to ensure that every action of an inmate is able to be and indeed is observed. There is thus as such a total lack of privacy for the inmate. Inmates are men and women who deserve the same privacy that an ordinary member of society is entitled to and that privacy should be limited only when there is good reason to do so. Mr McLachlan has submitted that in this case the good reason is that the assessment or the classification of Veronica had not been completed and it may well have been that something more could have been discovered during the classification

process that would have identified a possibility of intentional self harm and had she been placed in an observation cell she would have been less able to take the action that I'm satisfied she did.

The approach that I have taken in previous inquests and the recommendations that I have made in this regard is that an inmate should be treated using the same principles that a person who is not in custody is treated, that is where a person has - that a person should not be placed in an observation cell unless they would be placed in a similar situation were they to be admitted to a hospital for mental health reasons. If a person is identified on admission to a hospital as being at risk of self harm, a variety of actions can be taken to ensure that the risk is mitigated. A similar principle, in my view, should be adopted by Department of Corrective Services and in previous inquests I have made that recommendation.

In this case, applying that principle to Veronica, there was nothing to suggest that she had mental health issues or was at risk of self harm. In those circumstances, it would seem to me inappropriate for the Department of Corrective Services to simply because she was transgender to place her in an observation cell with the consequent loss of her privacy. In those circumstances, I do not consider it appropriate to make the recommendation that has been sought.

One of the issues which must be identified and examined is the manner in which the department had responded to Veronica's transgender identification. The evidence before me is that at the time of Veronica's being brought into custody the Department of Corrective Services had a policy as to the management of transgender inmates and I am satisfied that there was substantial compliance with that policy. I also note the evidence before me that that policy is currently the subject of review, however, noting that, it appears to me appropriate not to make recommendations concerning that policy and I do not intend to contribute towards the review of that policy.

On the evidence available to me, as I have said, there was substantial compliance with the policy by the department in dealing with Veronica and there is nothing before me to suggest that any failure of the department in this regard in any way contributed to her death.

The loss of any person to suicide is a tragedy. It is a tragedy for, of course, the person who has died. They lose their life, they lose the opportunity of their future contributions to society and their future wellbeing. It is also a tragedy for those who they leave behind and society in general. It must be regretted but it also must be acknowledged that some persons in some circumstances form the view that suicide is the only way in which they can respond to the situations that they find themselves in. Clearly, Veronica reached that position.

On the evidence available to me, it would seem that either she reached that position and then in a relatively calculated way set about acting to end her life or did so on the spur of the moment having reached a point where she was unable to cope with the situation that she was in. I do not think that there was anything which the Department of Corrective Services could have reasonably done which would have prevented this tragedy occurring.

There is one issue which needs to be dealt with in conclusion and that is in the interviewing of a number of the fellow inmates one of them suggested that the prison officers acted too slowly in trying to protect or seek to revive her. The evidence does not support the suggestion that faster action would have made a difference. The evidence is that at the time the cell was opened, Veronica was deceased and had been for some time. That allegation appears to be not substantiated.

IN ACCORDANCE WITH S 81(1) OF THE CORONER'S ACT (2009) I FIND THAT JAMES LLEWELLYN DRURY BORN ON 23 FEBRUARY 1975 DIED BETWEEN 3.30PM ON 15 MARCH 2009 AND 6AM ON 16 MARCH 2009 AT THE DEPARTMENT OF CORRECTIVE SERVICES METROPOLITAN REMAND CENTRE, SILVERWATER. THE CAUSE OF HIS DEATH WAS ASPHYXIATION WHICH OCCURRED AS A RESULT OF HIM HANGING HIMSELF WITH THE INTENTION OF ENDING HIS LIFE.

I make the following recommendation in accordance with s 82 of the Coroner's Act (2009) to the Commissioner of Corrective Services that where a knock up facility is used by an inmate such use and the Corrective Services' officer response thereto be recorded and such recordings thereof be retained for an appropriate period. I express my condolences to the members of the family of Veronica.

SIGNATURE

Signature	
Name	Magistrate MacMahon
Capacity	Deputy State Coroner
Date	4 April 2011

ORDERS

I am satisfied that it is in the public interest that a report of the proceedings and the Findings be published and in accordance with Section 75(5) Coroners Act 2009 authorise such publication without restrictions.

SIGNATURE

Signature	
Name	Magistrate MacMahon
Capacity	Deputy State Coroner
Date	7 April 2011