CORONERS ACT, 1975 AS AMENDED

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 10th day of May and 16th day of June, 2000, before Wayne Cromwell Chivell, a Coroner for the said State, concerning the death of Michael Andrew Curren.

I, the said Coroner, do find that Michael Andrew Curren, aged 38 years, late of Mobilong Prison, Murray Bridge, died at Mobilong Prison on the 10th day of June, 1998 as a result of neck compression due to hanging. I find that the circumstances of death were as follows:-

1. **Reason for inquest**

1.1 On 4 February 1985 Michael Andrew Curren was sentenced to life imprisonment for the crime of murder. A non-parole period of 22 years was fixed. On 3 April 1991, Mr. Curren escaped from Mobilong Prison, and was recaptured two days later. On 1 July 1992, further periods of imprisonment were imposed for the escape and for offences he committed while at large. The existing non-parole period was extended for a further period of five years, and was expected to expire on 11 June 2003.

1.2 Accordingly, on 10 June 1998 Mr. Curren was “detained in custody” pursuant to an Act or law of this State within the meaning of Section 12(1)(da) of the Coroners Act, and an inquest was therefore mandatory pursuant to Section 14(1a) of that Act.

2. **Background**

2.1 Michael Curren was considered a quiet prisoner who was isolative and studious. He had not received a visit in nearly five years and received little mail. The Education Coordinator at Mobilong Prison, Mr. M.T. Hancock, said:-

> "Michael was a student under my supervision and was studying university studies. Michael would attend the unit on most days, Monday to Friday. I found Michael to be an enthusiastic student who took pride in his work. I found him also to be quiet, and a loner within the prison.
>
> Michael never ever discussed any problems he may have had with any other inmates or staff in the prison. He never displayed any suicidal tendencies to me whilst under my supervision. In fact, I found him to be a very good student".
>
> (Exhibit C.6a) (see also the statement of Mr. R.D. Coupland, Exhibit C.9a).

2.2 Events of 5 June 1998

There is a suggestion that Mr. Curren was assaulted by another prisoner on 5 June 1998. Blood was noted on the footpath behind the visitors' centre, but the incident was not witnessed (see the Department for Correctional Services investigation report, Exhibit C.18a, p8).

2.3 Mr. Curren denied being assaulted, and alleged that he fell in the shower. He attended upon Dr. R.R. Martin on that day, and the doctor noted swelling, contusions and a laceration in the vicinity of the left eye. His wounds were cleaned, and he was given a tetanus immunisation.

2.4 On 10 June 1998 Dr. Martin saw Mr. Curren again and he was complaining of headaches, aches and pains, etc. Dr. Martin said:-

> "He was worried about onset of brain damage from his injury". (Exhibit C.5a)

Dr. Martin found a slight fever, his throat was inflamed and gave him Panadol and a sleeping tablet on the basis that he thought he had a viral illness.

2.5 Dr. Martin found no indication of a depressive illness during either of these visits.

2.6 In his consultation on 10 June, Dr. Martin also noted that Mr. Curren's facial swelling was settling, and there was some yellow bruising around the left eye. These signs were also noted by Dr. J.D. Gilbert during the post mortem examination, which I will discuss later.

2.7 Another prisoner, Thomas Byron, confirmed that Mr. Curren had been assaulted at around this time. He said:-

> "But when I spoke with him about it he didn't seem disturbed or depressed".
> (Exhibit C.11a, p3).

2.8 The incident was investigated by Correctional Officer Patrick Welby. In his statement, Mr. Welby said:-

> "I spoke with Curren in Murray Unit. He insisted that he had fallen in the shower. When I said that I had heard that there had been an assault and that he may have been the victim, he replied that he was not admitting any involvement, but that there was very often some truth in rumours heard in the prison. I asked him if he had any concerns for his safety and he replied that he had none. I asked him if he thought there may be any future related incidents and he replied that he did not. Curren also stated that he would not be leaving the unit for the next two weeks, other than to attend medication, because he was studying for his end of semester exams. He said that he would resume his normal activities and routine after this two week period. This was all Curren was prepared to say about the matter". (Exhibit C.21, p1-2).

2.9 The investigation into Mr. Curren's death by the Department for Correctional Services ("DCS") threw some further light on this matter. An allegation was made by one prisoner that Mr. Curren had told him that he had been involved in some type of dispute with other prisoners (see the statement of Peake, Exhibit C.12a), and there was another allegation that he had been threatened on the morning of his death by an Aboriginal prisoner (see Exhibit C.18a, p8).

2.10 Unfortunately, these matters have not been thoroughly investigated. Indeed, the person who made the allegation that Mr. Curren was threatened on 10 June 1998 has not even been interviewed by police (see Exhibit C.18a, p8). I will discuss the police investigation into this matter later in these findings. It should be stated, however, that even if it could be conclusively established that Mr. Curren was assaulted on 5 June 1998, it is not possible to conclude that this motivated him to take his own life.

3. <u>Events of 10 June 1998</u>

3.1 The investigation report of DCS (Exhibit C.18a) discloses that Correctional Officer Freeth was on duty in Murray Unit during the day shift, and observed nothing unusual in Mr. Curren's behaviour or attitude.

The social worker, Ms. Janette Padman, saw Mr. Curren during the afternoon regarding the annual review of his parole. It was reported:-

> "She considered that he was in good spirits and was looking forward to the Parole review". (Exhibit C.18a, p4).

3.2 Registered Nurse Williams saw Mr. Curren at approximately 8.00p.m. that night, when he went to ask for something to help him sleep. Mr. Williams reported to the investigation that:-

> "They chatted for about five minutes and Curren did not appear upset, depressed or any different than his usual quiet self". (Exhibit C.18a, p5).

3.3 Unfortunately, Freeth, Padman, and Williams were not interviewed for the purpose of the police investigation into this matter, so I must rely upon the hearsay account (which I have no reason to doubt) from DCS. Again, this is an unsatisfactory state of affairs which I will discuss later in these findings.

3.4 All prisoners in Murray Unit were locked in their cells at 8.10p.m. At 8.22p.m., Correctional Officers Massie and Sadler commenced a patrol of all accommodation units. In evidence, Mr. Sadler told me that he would have sighted Mr. Curren at about 8.30 or 8.35p.m. (T.14).

3.5 At about 10.30p.m., Officers Massie and Sadler commenced a further count of prisoners. At about 10.48p.m. Mr. Sadler noticed that the viewing glass to cell 12 in the North Wing, Murray Unit, was partially fogged up. Upon closer inspection he saw what he thought was the prisoner standing up, and then concluded that the prisoner was hanging. The cell was immediately unlocked. Mr. Sadler ran to the Officers' Station, broke the glass and obtained the "cut-down knife". Mr. Massie requested an ambulance over the radio.

3.6 Upon entering the cell, Mr. Sadler noted that Mr. Curren was hanging from the middle of the cell, he assumed from an air-conditioning vent, by a dark leather belt (T.15).

3.7 The two officers cut Mr. Curren down, and then commenced cardio-pulmonary resuscitation.

3.8 Ambulance Officer G.J. Rayson reported that a message was received at 10.46p.m., they arrived at the prison at 10.57p.m., and they arrived at the cell at about 11.00p.m. (Exhibit C.16a, p1). This is a commendably quick response time. Upon examining Mr. Curren, the ambulance officers noted that he appeared deceased. The pupils were fixed and dilated, the skin was mottled and there was no sign of life. A cardiac monitor indicated that Mr. Curren's heart was in asystole, which means that there was no heart activity. There were no respirations, and no other signs of life. Having regard to the fact that he had been collapsed for at least fifteen minutes, it was agreed that no further attempts to resuscitate him would be made (Exhibit C.16a, p2). At 11.50p.m., Dr. Nicholls attended the prison, and after examination, declared life extinct (see Exhibit C.2a).

4. **The police investigation**

4.1 The first police officers attended at 11.30p.m. on 10 June 1998, and Detective Sergeant B.P. Connell from Murray Bridge Criminal Investigation Branch arrived at about the same time. Mr. Connell noted that there was a plastic chair sitting on top of the wooden bunk bed, and a reading lamp on a desk was operating and pointing towards the ceiling. An exhaust fan positioned on the wall above the shower area had been covered with cardboard. There was an air-conditioning vent in the centre of the room. Its steel cover, comprising a number of small holes approximately one centimetre in diameter, had a section of red nylon rope threaded around several of the small holes forming a number of loops. Through those loops, a section of leather belt was tied. Detective Sergeant Connell concluded:-

> "From my investigations, it appeared that the deceased had caused his own death by hanging. The position of the bedding on the floor, the chair on the wooden bed bunk, one desk light on, one fluorescent light removed, heavy condensation within the room when the shower was operating, pieces of red nylon skipping rope on the chair and in a bucket in the corner of the room, piece of leather strap still attached to the nylon rope on the air-conditioning vent, and the same piece of leather strap still in position around the deceased neck, that the deceased had planned to take his own life. It may well be that he placed the chair on the bed bunk in which to stand to tie the red nylon cord into the vent. It also appears that he cut sections from the red nylon cord in which to shorten the distance from ceiling to floor.

This appears evident from the piece of red cord on the chair and the remainder in the bucket by the corner. ... As a result of my investigations, I found that there were no suspicious circumstances surrounding the death of Michael Andrew Curren and that he took his own life by hanging or strangulation". (Exhibit C.19a, p3-4).

4.2 I agree with Detective Sergeant Connell's conclusions in this matter.

4.3 Unfortunately, the investigation report in this matter was not received from Detective Sergeant Connell until 25 March 2000, some 21 months or so after Mr. Curren's death. Even when it was received, the investigation was woefully inadequate, and a number of further statements had to be taken prior to the hearing on 10 May 2000. Indeed, the vast majority of those statements were taken in the last few weeks before the inquest.

4.4 Unfortunately, as I have already observed, it has not been possible to fully investigate the circumstances surrounding the alleged assault of Mr. Curren on 5 June 1998, and whether it played a role in his decision to take his own life. It may be that no such conclusion could have been drawn even had that matter been fully investigated, but that is no consolation.

4.5 The comments I made in Carter (Inquest No.23/2000), in findings also delivered today, are equally apt in this case:-

"10.9 The performance of the police officers involved in the initial investigation of these events can be described, to use a mild expression, as disappointing. With nine years' experience since the delivery of the final report of the Royal Commission for Aboriginal Deaths in Custody, and the development of a detailed protocol between this office and the Commissioner of Police for the investigation of such deaths, the lack of investigational rigour displayed by those involved here is mystifying.

10.10 What is also mystifying is that the allegations made by Gray and Daniel Carter and Wells amounted to serious criminal behaviour, and yet even that did not seem to be enough to spur the investigators into action. Recommendation 35 of the Royal Commission into Aboriginal Deaths in Custody provides:-

> 'That Police Standing Orders or instructions provide specific directions as to the conduct of investigations into the circumstances of a death in custody. As a matter of guidance and without limiting the scope of such directions as may be determined, it is the view of the Commission that such directions should require, inter alia, that:-
>
> a. Investigations should be approached on the basis that the death may be a homicide. Suicide should never be presumed;'.

It is clearly apparent that such an approach was not adopted in this case.

10.11 ... The Commissioner of Police has statutory responsibility for the performance of his organisation. I draw these comments to his attention".

5. **<u>Other issues arising at the inquest</u>**

5.1 I agree with the submissions of all counsel who appeared at the inquest that the role played by officers Sadler and Massie in relation to the discovery of Mr. Curren's body, and the provision of first aid assistance to him were commendable.

5.2 Although the failure of Officer Massie to call a "Code Black" was technically a breach of Standard Operating Procedures, there were no medical or nursing staff present at Mobilong Prison during that evening to answer such a call in any event, so the breach had no effect on the outcome. It is necessary, however, to remind officers that it is safer to comply with Standard Operating Procedures in all circumstances, to avoid confusion.

5.3 <u>Hanging points</u>

In a number of previous inquests, I have drawn attention to the construction of cells, and in particular the provision of exposed piping in B Division at Yatala Labour Prison, and recommended that this be removed since it constitutes such an obvious hanging point (see <u>Wakely</u> 7/95, <u>Goldsmith</u> 6/96, <u>Bonney</u> 28/96). Mrs. Atkins, Counsel Assisting me, submitted that consideration should be given to changing the air-conditioning vents at Mobilong Prison to a collapsible type so that they would not support the weight of a prisoner. There may be serious security issues militating against such change. I draw the issue to the attention of the Chief Executive Officer, Department for Correctional Services, for consideration, without making a formal recommendation pursuant to Section 25(2) of the Coroners Act.

5.4 Having regard to the state of the evidence before me, I am unable to draw any further conclusions, or make any recommendations arising out of Mr. Curren's death.

Key Words: death in custody; hanging

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 16th day of June, 2000.

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Coroner