CORONERS ACT, 2003

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 22nd, 23rd, 24th, 25th and 28th days of August 2006 and the 25th day of September 2006, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the deaths of Tracy Jayne Foster and Neil James Brooks.

The said Court finds that Tracy Jayne Foster aged 43 years, late of 45 Macedonia Street, Osborne, South Australia died at Osborne, South Australia on or about the 5th or 6th day of December 2002 as a result of neck compression due to strangulation by ligature.

The said Court finds that Neil James Brooks aged 43 years, late of the Adelaide Remand Centre, Currie Street, Adelaide died at the Adelaide Remand Centre, South Australia on the 6th day of May 2003 as a result of suffocation by plastic bag.

The said Court finds that the circumstances of their deaths were as follows:

1. Introduction

1.1. Tracy Jayne Foster was 42 years of age at the time of her death on or about 5 December 2002 at her home address at Macedonia Street at Osborne. Dr John Gilbert attended the scene and conducted a post-mortem examination subsequently, reporting that the cause of Ms Foster's death was neck compression due to strangulation by ligature.

1.2. Ms Foster had been in a relationship with Neil Brooks for some time. It appeared that the relationship had broken up some three or four months prior to Ms Foster's death, but had recommenced within a reasonably short time of the break up.

1.3. When police attended at Macedonia Street, Osborne on 6 December 2002 they found a note on the dining room table with the words 'I'm very, very sorry' written on it, several notes apparently written by Ms Foster about her relationship with Mr Brooks, empty packets of Imovane and Panadeine Forte and a receipt from the Largs Bay Chemplus timed and dated 1421 hours, 5 December 2002 in the name of Neil Brooks. In the shed at the rear of the house they found two lengths of rope, which appeared to be identical to another piece of rope located in the dining room of the house, that piece of rope being approximately 90cm long and knotted at both ends. That rope appeared to be consistent with the ligature marks on Ms Foster's neck.

1.4. On the morning of 5 December 2002 Mr Brooks went to his parents house and left some of his possessions there, and in the evening of the same day he took a television and video to his children from a previous marriage and gave these to them. At some stage during the evening of Thursday, 5 December 2002 Mr Brooks contacted his sister Tracey and asked her to sell his car. It appears that Mr Brooks was in the Macedonia Street house around the time that Ms Foster was strangled. The evidence shows that Ms Foster had been out during the evening of 5 December 2002 and had returned home at around midnight. Ms Foster was found on the bed, fully clothed, at that address the following day after police attended. It appeared that Mr Brooks had taken an overdose of sleeping pills and Panadeine. However, he awoke the following morning (6 December 2002) and had cut both of his wrists in another attempt to kill himself. As a result of a visit to the Macedonia Street house on 6 December 2002 by his mother, sister and brother-in-law, police were called and discovered the body of Ms Foster.

1.5. Mr Brooks was taken to The Queen Elizabeth Hospital on 6 December 2002 where he was detained under the Mental Health Act. On Saturday, 7 December 2002 he was formally arrested and charged with the murder of Tracy Jayne Foster.

1.6. Mr Brooks was transferred from The Queen Elizabeth Hospital to Brentwood Ward at the Glenside Campus of the Royal Adelaide Hospital. He was seen on 9 December 2002 at approximately 11 o'clock in the morning by Dr John Clayer, Psychiatrist,

who ordered a further period of detention of 14 days. Unfortunately Dr Clayer was very ill at the time of the Inquest and was unable to give oral evidence. However, a record of an interview that was conducted with him, and a transcript of that interview was admitted in evidence in these proceedings as Exhibits C16z, C16aa, C16ab and C16ac. That detention order was revoked by Dr Norman James, Director of the Glenside Campus some two hours later. Dr James (also a Psychiatrist) having formed the view that a further period of detention was unnecessary and that Mr Brooks could be adequately attended to within the prison system at the Adelaide Remand Centre. He was transferred from the Glenside Campus to the Adelaide Remand Centre that same day.

1.7. Mr Brooks remained in the Adelaide Remand Centre until 6 May 2003 when he was found deceased by correctional services officers in his cell when it was unlocked that morning. A post-mortem examination was conducted by Dr John Gilbert who gave as his cause of death suffocation by plastic bag.

2. Dr Norman James

2.1. Dr James gave evidence at the Inquest. He stated that Brentwood Ward at Glenside Campus is an intensive psychiatric care unit and is the only one of its kind in the State. It is intended for patients with serious psychiatric illnesses who are a danger to themselves or to the public and is a closed ward. All patients in Brentwood Ward are detained under the Mental Health Act, or are otherwise detained under the justice system. Dr James stated that no bed was available at James Nash House and that is why Mr Brooks was admitted to the Glenside Campus. The Brentwood occupancy is normally one hundred percent, as is the occupancy at James Nash House. Brentwood is used as an overflow for James Nash House on occasions numbering approximately once per month.

2.2. Dr James stated that because Brentwood is the only ward of its type in South Australia, it is absolutely essential that he and the staff of Glenside Campus do all possible to enable patients to go to less secure units in order to maintain the capacity of Brentwood to accept patients whose needs are more urgent.

2.3. Dr James stated that if no bed is available in Brentwood, the only alternative for the acutely mentally ill who are a danger to themselves or the public, is detention in the Royal Adelaide Hospital with guards and shackles on medical wards.

2.4. Dr James stated that he regarded the 10 day detention order imposed by Dr Clayer as a mark of ambivalence as to whether it was needed at all. Dr James explained that it is his practice and policy to impose 21 day detention orders because in the event that an extension of the order is required, under the Mental Health Act, two psychiatrists must confirm a subsequent period of detention. Dr James effectively stated that a practice of imposing a period of detention of less than 21 days has the potential to create unnecessary work. He regards it as more appropriate to impose a 21 day detention order which can be revoked at an earlier time than the expiry of the 21 days if that is necessary.

2.5. This subject only became relevant because one of Dr James' justifications for his revocation of the detention order which had been imposed by Dr Clayer was based on the asserted ambivalence of the latter in imposing a period of detention of less than the full 21 days. In my view, Dr James is quite wrong in this approach. The Mental Health Act contemplates that the period of detention ordered by a psychiatrist will be any period up to a maximum of 21 days. It contemplates that active consideration will be given to the period of detention that is required and, if a psychiatrist genuinely thinks that some period less than 21 days will be sufficient, the psychiatrist is duty bound to impose only that lesser period of detention. In any event, nothing turned upon this, because Mr Brooks' death did not take place for some 5 months following his brief stay in Glenside Campus.

2.6. Dr James determined that the appropriate course was to revoke the order of detention which had been imposed by Dr Clayer and to grant leave from the initial period of detention (the so-called '3 day order') which was applicable at that time and due to expire at midnight that day.

2.7. Mr Brooks it will be remembered had been arrested for a charge of murder on 7 December 2002. He had been brought before a bedside sitting of the Magistrate's Court and was remanded in custody at that time. Therefore, upon being released from mental health detention by Dr James, Mr Brooks remained under detention, but on this occasion, by force of the orders of the Magistrate's Court remanding him in custody.

2.8. Dr James stated that he had been informed by nursing staff of Brentwood Ward that Mr Brooks had been detained by Dr Clayer. Dr James decided to assess Mr Brooks

for himself. He had intended to speak to Dr Clayer before he examined Mr Brooks but as circumstances turned out was unable to do so. He did speak to Dr Clayer later in the day after he had seen Mr Brooks. He informed Dr Clayer about his examination and stated that he informed Dr Clayer of his decision to revoke the detention.

2.9. He stated that Mr Brooks had what he described as static issues and acute issues. The static issues included the fact that he had been born male and had fathered children but had then realised that he wanted to be female. Mr Brooks lived as a female for several years, underwent an orchidectomy operation (surgical castration) but then decided that he wanted to become a male again and in order to achieve that aim had been receiving testosterone injections every three weeks, treatment which would have to continue for, I assume, his life.

2.10. Dr James stated that the acute issues faced by Mr Brooks included the fact that he had been informed that he had murdered his girlfriend. However, Mr Brooks claimed to have no memory of this. Another issue was that he had attempted to cut his wrists and to overdose. This meant that he was now in an extremely difficult situation and had expressed suicidal intent.

2.11. Mr Brooks had told Dr Clayer that if he were transferred to the Adelaide Remand Centre he would attempt to kill himself. Mr Brooks requested that he be allowed to stay in Brentwood Ward or James Nash House. When Dr James interviewed Mr Brooks, Mr Brooks repeated his threat to attempt suicide if he was sent to the Adelaide Remand Centre. However, when informed by Dr James that he would be returned to the Adelaide Remand Centre he asked Dr James whether he would be able to obtain his testosterone injections at the Adelaide Remand Centre. Dr James attached much significance to this. Dr James considered that if Mr Brooks were really depressed, he would have not been concerned about where he was to be detained. Furthermore, the fact that he was concerned about whether he would continue to receive his testosterone injections indicated that he was contemplating a future thus negating his asserted suicidal thoughts.

2.12. Dr James said that he requested that the Adelaide Remand Centre be briefed upon Mr Brooks' mental state. At T53 he stated that he was present when one of the nurses contacted the Adelaide Remand Centre by telephone. During that telephone

conversation the nurse informed the Adelaide Remand Centre officer (who Dr James understood to be another nurse) of Mr Brooks' difficult background and unusual lifestyle, and the fact:

> '… that he had been claiming that he had been chronically suicidal over many years and that he was likely to be arraigned for a very serious charge as in relation to the death of his former girlfriend and you can never rule out in these situations the suicidality becoming acutely to the fore and therefore they were appraised of that matter.' [1]

Dr James was rather inconsistent in his evidence on this point. Under cross examination at T67 he denied that the conversation just described included any reference to Mr Brooks having been 'chronically suicidal over a number of years'.

2.13. In the result, Dr James really had very little idea of what regime would be applicable at the Adelaide Remand Centre. His attempts to ensure that the Adelaide Remand Centre were aware of and fully briefed about Mr Brooks' mental state were cursory at best. Mr Brooks was not accompanied by his full medical notes when he was transferred to the Adelaide Remand Centre.

2.14. Dr Clayer had formed the view that Dr James was mainly motivated by a desire to clear beds in Brentwood Ward and that was his main reason for revoking the detention orders. Dr James denied this when giving oral evidence. However, he was at pains in his evidence to elaborate upon the need to ensure that patients are cleared from Brentwood Ward at the earliest possible opportunity because of its role as South Australia's only intensive care ward for the mentally ill. Counsel for Dr James and the Department of Health and the Department for Correctional Services opposed the admission of the statement and transcript of interview of Dr Clayer. Despite that opposition the statement and record of interview were admitted. However, it is unnecessary for me to form a view about the actual motivation of Dr James in revoking the detention order. The fact of the matter is that Mr Brooks did not commit suicide until five months after his transfer to the Adelaide Remand Centre. It is difficult to make any connection between the actions of Dr James on 9 December 2002 and Mr Brooks' suicide on 6 May 2003. I will not therefore attempt to reach any conclusion as to the rights and wrongs of the dispute between Drs Clayer and James. However, I do record my concern that Dr James approaches decisions as to

[1] Transcript, Page 53

whether or not to grant a 21 day detention order according to a policy that he will not consider imposing any lesser period of detention.

3. Correctional Officer Bonacini

3.1. Evidence was given at the evidence by Mr Bonacini, a Correctional Services Officer. He was working at the Adelaide Remand Centre at the time of Mr Brooks' death. He was an Operations Officer Grade 2. On 9 December 2002 he was working in the admissions area of the Adelaide Remand Centre and admitted Mr Brooks at 4pm that day. He was asked to identify Exhibit C16x as the case management file for Mr Brooks within the Adelaide Remand Centre and did so. Mr Bonacini gave evidence that he completed a document called the Prison Stress Screening Form, a copy of which appears in Exhibit C16x. On that form Mr Bonacini recorded that Mr Brooks responded affirmatively to particular questions about his mental state. He stated that he had been treated in a psychiatric hospital, namely Glenside Campus. He stated that he had been diagnosed as having a psychiatric disorder which he specified as suicide, he stated that he had tried to commit suicide or intentionally hurt himself in the past, and a note was made that he had cut and slash marks on arms, legs and wrists which appeared to have been caused by suicide or self-harm attempts. He responded 'yes' to the questions 'have you thought about committing suicide since you were arrested or imprisoned?', 'do you feel like harming yourself?' and 'have you recently felt that those close to you would be better off if you were dead?'. He stated that he had a special fear about imprisonment, namely a fear of being raped. Mr Bonacini recorded Mr Brooks as having a score according to the Prison Stress Screening Form of 18. According to the form a score greater than 8 means that the prisoner should be considered as being at risk. Furthermore, positive responses to the three questions enumerated above also requires that the prisoner be regarded as at risk. Mr Brooks would have qualified on both of those grounds. Mr Bonacini therefore wrote that Mr Brooks 'must be doubled up'. This was to guard against the risk that if he were in a single cell he might be free to harm himself.

3.2. Mr Bonacini stated that he did not have any notes about Mr Brooks' stay at Glenside Campus. Although on the Prison Stress Screening Form Mr Bonacini recorded that Mr Brooks had been at a psychiatric hospital, mainly Glenside Campus, the form does not make clear when. In cross examination Mr Bonacini stated that he received no information from any other source about Mr Brooks' suicidality, and reached his

conclusions in that regard entirely by reference to the interview between him and Mr Brooks.

4. Dr Craig Raeside

4.1. Dr Craig Raeside gave evidence at the Inquest. Dr Raeside is a Consultant Psychiatrist who provides sessions within the Prison Health Service. As at 2002 and early 2003, Dr Raeside performed a clinic at the Adelaide Remand Centre for one half day per week. His clinic at the Adelaide Remand Centre is now one day per week. A Registrar from James Nash House attends at the Adelaide Remand Centre for a further half day per week.

4.2. Dr Raeside first saw Mr Brooks on 11 December 2002 in his regular Adelaide Remand Centre clinic. Dr Raeside did not remember if he saw any Glenside Campus notes at that stage and thought it would have been unlikely that they would have been available to him then. Dr Raeside recorded a detailed history in relation to Mr Brooks which appears in type written form within the Prison Health Service medical records for Mr Brooks, Exhibit C29. Dr Raeside described Mr Brooks as a 43 year old divorced man, a father of two children 13 and 11. He stated that he was charged with murder but claimed to have no memory of the event. Mr Brooks' history of gender uncertainty was recorded together with the recent suicide attempt. At this interview Mr Brooks revealed that he had been sexually abused at the age of 13 by the uncle of a friend but that this had happened only once. Mr Brooks informed Dr Raeside that he tried to block this out but that it came back sometimes. Dr Raeside assessed Mr Brooks as possibly having an underlying personality disorder or other psychiatric disorder, that he had an adjustment order with depressed mood and remained suicidal. Dr Raeside directed that he remain in the Adelaide Remand Centre infirmary where he was then being detained for further observation and that if he deteriorated further he should be removed to James Nash House. Dr Raeside had considered the prescription of antidepressants but decided to delay that prescription for the time being in order to review Mr Brooks in a week's time at which point his presentation would not be affected by antidepressants.

4.3. Dr Raeside stated that the Adelaide Remand Centre infirmary provided a good level of care for a person such as Mr Brooks. He stated that the level of observations was

good and perhaps as good as James Nash House. He acknowledged though that the staff were not psychiatrically trained.

4.4. Dr Raeside stated that it is to be expected that a person who has recently been charged with murder will have an increased level of suicidality when the victim is someone they were close to. He stated that there may be other times of heightened risk during their incarceration as their legal case continues and develops.

4.5. Dr Raeside stated that he next saw Mr Brooks on 17 December 2002 when he recorded that the suicidal thoughts had gone. However Mr Brooks remained depressed and Dr Raeside commenced him on the antidepressant Avanza. He recommended a gradual introduction into the unit. Dr Raeside considered that Mr Brooks' claim of a lack of memory as to the events involving the strangulation of Ms Foster was most likely due to the fact that at the relevant time Mr Brooks had consumed a large amount of alcohol and drugs.

4.6. In the event, Mr Brooks was keen to go to the unit on 17 December 2002 and specifically asked staff for that to proceed immediately. He was placed in Unit 1 that same day.

4.7. Dr Raeside was asked about the appropriateness of a decision to place Mr Brooks in a single cell as opposed to a double cell. Dr Raeside stated that doubling up is sometimes used as a method of preventing suicide. However in Mr Brooks' case, because of his gender reassignment issues, single cell accommodation was more appropriate. Furthermore, because he had been physically and sexually abused in the past it was better that he be in a single cell. Dr Raeside considered that Mr Brooks had been chronically depressed during his life and it was not surprising that he was depressed at this stage. Dr Raeside considered that the main issue from a mental health point of view was the acute situation that was presented by the incident involving Ms Foster.

4.8. Dr Raeside saw Mr Brooks again on 14 January 2003 and again on 11 February 2003. By 11 February 2003 Dr Raeside considered that Mr Brooks had returned to his normal mental condition as it would have stood prior to the incidents of 5 and 6 December 2002.

4.9. Dr Raeside next saw Mr Brooks on 18 March 2003. On this occasion Mr Brooks was in the infirmary having been admitted on 13 March 2003. The cause of that admission was that Mr Brooks had produced to correctional services officer material which he had been 'hoarding' in his cell. The material included lengths of torn bed sheets, plastic bags and a sharpened toothbrush. Mr Brooks had informed the staff that the plastic bags were to suffocate himself and that the sharpened toothbrush to stab himself. However, he stated that an impending visit from his family had caused him to change his mind. The infirmary staff decided to admit him to the infirmary on the grounds that he was not coping and had suicidal thoughts and was taking preparations. There is a record that he was not taking his medication. This would be a reference to his antidepressant Avanza.

4.10. When Dr Raeside saw Mr Brooks he was still in the infirmary on 18 March 2003. Dr Raeside said that he had been doing well until some time shortly before 13 March 2003 when he had seen a television news report of a man having been charged with sex offences against children. This made Mr Brooks feel acutely suicidal. However when Dr Raeside saw Mr Brooks on 18 March 2003, Mr Brooks had recovered from his acute episode of suicidality. Dr Raeside stated that this pattern was consistent with Mr Brooks' history, namely a quick onset of suicidal tendencies and an equally quick resolution. Dr Raeside authorised his release to Unit 3 and arranged to see him again in eight weeks. Dr Raeside did not see him again before his death on 6 May 2003.

4.11. Dr Raeside was asked whether he thought that Mr Brooks had committed suicide by reason of a mental illness. Dr Raeside noted that there may be non-psychiatric reasons for suicide, but he classified Mr Brooks' death as a mental health suicide.

5. Dr Christopher Holmwood

5.1. Dr Holmwood was the Clinical Director of the Prison Health Service until quite recently. He was also the Director at the time of Mr Brooks' incarceration. Dr Holmwood painted a picture of a changed Prison Health Service. He stated that a new system has been instituted which involves the use of yellow sheets to indicate that a prisoner has been placed on a self-harm risk management plan. In addition, the prisoner's cell is designated by a particular yellow card to indicate their status to all staff. A High Risk Assessment Team process has also been introduced. The High

Risk Assessment Team meets weekly and consists of the manager of the unit, a doctor and other relevant staff. This process was instituted in mid 2004 and has led to a greater level of communication about prisoners at risk between members of the Prison Health Service and correctional services officers. Dr Holmwood considered that there is good evidence that this change has made a difference to self-harming behaviour by prisoners. There is less evidence that it has impacted upon suicide rates but that is because it is difficult to see trends in suicide rates because of the relatively small numbers of prisoners who do succeed in committing suicide. Dr Holmwood gave evidence about a discussion paper which he prepared some time ago and which was admitted as Exhibit C30 in these proceedings. The discussion paper does not appear to be an officially accepted document as far as the Department of Correctional Services is concerned. It is however a useful document in that, according to Dr Holmwood, it reflects to some extent the system as it would exist today. However, there are certain significant differences between the discussion paper and the system as it exists today. The discussion paper advocates the creation of a Special Needs Unit for prisoners who fall within a category designated "SH1A" within the discussion paper. Such a unit would be for people who are volatile, fragile and at risk. It would not be a disciplinary unit and it would be staffed by selected and trained health staff and correctional staff. It could be used as a place of safety for prisoners such as Mr Brooks. It could also be used for prisoners with disabilities, for example prisoners who suffer from autism. There are certain other differences between the discussion paper and the system as it exists at the moment. However, so far as the yellow sheet system is concerned the discussion paper provides an accurate reflection of that system.

5.2. I note that Dr Raeside gave evidence that there was no guarantee that as at 6 May 2003 Mr Brooks would be a prisoner of 'yellow sheet status'.

5.3. Dr Holmwood also gave evidence of mental health training for correctional services officers. Apparently, despite some early resistance from prison officers, such training is now rolling out. The purpose of the training is to assist officers to identify that something is amiss with a particular prisoner and to develop their skills in dealing with such issues.

5.4. Dr Holmwood noted that when one looks at Mr Brooks' health records of his stay in the Adelaide Remand Centre there are what he described as 'some big gaps' when Mr Brooks was not seen by medical staff. This is concerning.

6. Stephen Raggatt

6.1. Mr Stephen Raggatt gave evidence at the Inquest. He has been General Manager of the Adelaide Remand Centre for nineteen months and has worked for the Department for Correctional Services for twenty years. He was the Unit Manager of Units 3 and 4 in the Adelaide Remand Centre in 2003.

6.2. Mr Stephen Raggatt gave evidence about a document called the self-harm notification form. This form has been in use for some years. It can be placed on the prisoner's case file at the request of a medical practitioner in the Prison Health Service. Once it goes on the prisoner's case file it remains there forever. He stated that a large percentage of prisoners would have such a form on their case file. He stated that because it appears in so many files it no longer serves any useful purpose so far as the Department for Correctional Services is concerned. He stated that these forms have been superseded by the High Risk Assessment Team process and the use of the 'yellow sheets'. He said that the High Risk Assessment Team consists of the General Manager, three case management coordinators, a social worker, a psychologist, an Aboriginal liaison officer, a nurse from the infirmary and a Community Mental Health Service worker from James Nash House.

6.3. Mr Stephen Raggatt stated that once a prisoner is placed on a yellow sheet they can only come off that status by means of the High Risk Assessment Team determining to that effect. Even then, the yellow status remains for one week beyond the decision by the High Risk Assessment Team group that the prisoner is to come off that status.

6.4. Mr Stephen Raggatt stated that over the last twelve months there would have been twelve prisoners on yellow sheets status at any one time within the Adelaide Remand Centre.

6.5. Mr Stephen Raggatt gave evidence that a prisoner's yellow sheet status is to be flagged on the Justice Information System when a prisoner's file is accessed by means of that system. The Justice Information System is an electronic system which is shared by the Department for Correctional Services and certain other agencies to track

the status of persons within the criminal justice system. It is effectively an electronic case file for the Department for Correctional Services purposes. Clearly it would be useful if the yellow sheet status of a prisoner were made available to users of the Justice Information System which include correctional services officers.

7. Evidence of Correctional Officer of Patrols during the early hours of the morning of 6 May 2003

7.1. Correctional Services Officers Steele, McCulloch, Campbell and Hugo gave evidence at the Inquest. I will not traverse their evidence in detail. The effect of it was that those four officers were on the night shift in the Adelaide Remand Centre in the early hours of the morning of 6 May 2003. While two of them remained in the control room the other two performed patrol inspections of the cells at midnight and at 2am. These patrols involved a visual inspection of each cell within the Adelaide Remand Centre. This would have included Mr Brooks' cell. The prison officers noted that prisoners are generally aware of the times of these inspections, and if they wished to achieve anything without any scrutiny during the night, they would be well aware of the times at which they could achieve this without the likelihood of an inspection intervening. The officers gave evidence that many prisoners sleep with their heads towards the cell door thus making it difficult, if not impossible, for the prison officers to see the heads and shoulders of prisoners during the regular patrol inspections. The officers stated that further patrols were conducted at 4am and 6am. These patrols are conducted by the two officers who, during the earlier patrols, were on duty in the control room and the officers who conducted the earlier patrols assume duties in the control room for this second half of the shift. None of the officers observed anything unusual and the effect of their evidence was that Mr Brooks' cell would have been examined during each of the inspections. However, even if Mr Brooks had the plastic bag over his head which eventually caused his suffocation at the time of one of these inspections, the prison officer would not necessarily have been able to see that it was around his head by reason of the fact that Mr Brooks was sleeping with his head towards the cell door, and for the reason referred to previously, prison officers are not able to obtain a direct visual sight of a prisoner's head during these inspections because of the configuration of the cells and the bunks.

8. Correctional Services Officer Mary Martin

8.1. Mary Martin is a correctional services officer and has been for five years. She was on duty commencing in the morning of 6 May 2003. Ms Martin gave evidence at the Inquest that she discovered Mr Brooks when she went to unlock prisoners in Unit 3 on that day. She said that when she arrived at Mr Brooks' cell, number 23, she noticed that he was still in bed. Ms Martin banged on the door and noticed that there was no response. Then Ms Martin looked more closely through the window in his door and noticed that there was some plastic around his neck. She asked Officer Hoban to come along and he looked too and agreed that there was a problem. Another officer then attended and Officers Martin and Hoban entered Mr Brooks' cell. Ms Martin said that she saw that Mr Brooks had a plastic bag on his head. In addition to that there was a pillow case over his head. There was some disparity between Ms Martin's first statement to Senior Constable Huntley and her evidence at the Inquest as to whether the plastic bag was inside the pillow case or the pillow case inside the plastic bag. Either way I do not regard this issue as important. The fact of the plastic bag whether directly around Mr Brooks' head or on the outside of a pillow case around his head would make no difference to the ultimate result. She stated that Officer Hoban removed the plastic bag and she pulled the blanket off Mr Brooks' body. She then noticed that his hands were tied and that his feet were also tied. His hands were tied by means of pieces of sheet which had been torn up. The sheets were then joined together under his bed. A similar arrangement was in place with his legs. Ms Martin went to get the resuscitation equipment but it was needed because medical staff arrived in the meantime. Ms Martin said that the whole process from the time that she saw that something was wrong until the cell was unlocked was very quick, maybe less than one minute.

9. Conclusions

9.1. In my opinion no criticism should be levelled at any individual officer of the Department for Correctional Services in this matter. It appears to me that the individual prison officers all performed their various duties in an appropriate manner.

9.2. It is concerning that Mr Brooks was never the subject of one of the self-harm notification forms that existed at the time of his incarceration. Perhaps no great significance should be placed on this because of the evidence of Mr Stephen Raggatt

that these forms tended to be undervalued by reason of their frequency of use. This may have served to cause any officer who perused the case file to think that Mr Brooks was one of the minority of prisoners who were not at risk of self-harm at some point. However, there is no evidence that any prison officer was misled in that way. Furthermore, given that the forms are now, and even then were, somewhat obsolete, any prison officer who noticed this fact may have thought nothing of it.

9.3. Perhaps more tellingly, Mr Brooks was at all times in single cell accommodation. The message that this sent to the custodial staff was that he was not considered to be at high risk of self-harm. From the point of view of the average member of the custodial staff, there would never have been any reason to think that Mr Brooks was at a particular risk of self-harm. The very fact that he was in single cell accommodation would have been an indication, according to the normal order of things, that the reverse was true. It will be recalled that at that time the yellow sheet status with the yellow plaque on the front of the cell had not been instituted and there was no High Risk Assessment Team. If Mr Brooks were incarcerated in the year 2006 no doubt he would, at least for some part of his incarceration, have had a yellow sheet and yellow plaque on his cell. This would have pointed him out as a prisoner who was at some risk of self-harm at some time. However, by reason of the movement of prisoners and staff through the system, it would by no means follow that any member of the custodial staff would have cause to remember that Mr Brooks was once the subject of a yellow sheet when the yellow sheet status was revoked and he was no longer considered to be at high risk.

9.4. It is interesting to note that the post-mortem toxicology reports for Mr Brooks do not show levels of Avanza (mirtazaine) in his blood stream. On the other hand, the medical records show that he was being provided with this medication daily until his death. It may be that at some point he ceased taking the medication. The evidence showed that medication was provided to prisoners at 8:30pm daily when they were in their cells. If a prisoner chooses not to take his medication and instead disposes of it in the toilet within the cell, that fact would never be known by the prison management or staff or the Prison Health Service. Counsel for the Department for Correctional Services was opposed to any suggestion that prisoners should be specifically required, by duress if necessary, to take their medication when they are not in the infirmary.

We will never know whether Mr Brooks would have taken his own life had he had a therapeutic level of Avanza in his bloodstream. One might speculate that in that event he may not have done so.

9.5. Clearly prisoners cannot be regarded in the same way as ordinary members of the public. If an ordinary member of the public chooses not to take his or her medication then that is one thing. However, prisoners are in a very different situation. They are vulnerable and may not always act rationally. In my opinion a case could be made for the introduction of a system which would ensure that if a prisoner is refusing to take his medication that fact would be reported to the treating medical practitioner. The medical practitioner could then make some assessment as to whether the prisoner should be required to take the medication or not. In my view, detention under the Mental Health Act would not be required in order to authorise the administration by duress of medication to a prisoner who was not willing otherwise to comply. Of course, the very unwillingness to comply with a course of medication required by a medical practitioner may itself give rise to consideration of the need to impose a period of detention under the Mental Health Act. However, if that is simply to achieve the administration of medication, in my view if the medical advice is that the medication is necessary for the prisoner's welfare, the custodial staff have the authority and duty to administer it by duress if necessary without any further authorisation under the Mental Health Act.

9.6. An investigation was carried out within the Department for Correctional Services into Mr Brooks' death. A report was produced as a result of that investigation, and certain recommendations were made by the investigator. Some of those recommendations have been adopted. Exhibit C26a is a letter from the Chief Executive to the State Coroner dated 16 May 2006. I will not set out all of the actions taken in response to the recommendations of the investigator in these findings. I am satisfied that those actions which have been taken are appropriate.

9.7. I accept the evidence of Dr Raeside that Mr Brooks was chronically depressed and that he was liable to acute deteriorations of his depression if certain triggers occurred. I accept that it would be extremely difficult to predict in advance when any such acute deterioration brought on by an external influence might occur.

9.8. The Prison Health Service appears to me to operate in relation to a prisoner in much the same way that the mainstream health system operates in relation to ordinary members of the public. Prisoners can request to see a doctor or a nurse and in that event some effort is made to ensure that the prisoner is seen. Once the doctor or nurse sees the prisoner, the doctor or nurse may make a decision to offer medication. The doctor or nurse then assumes that the prisoner, like any member of the non-prison community, should be free to decide whether to take the medication or not take the medication. If a prisoner is admitted to the infirmary, then no doubt he is treated in the same way as a member of the public who is admitted to a hospital. The infirmary staff would ensure that any prescribed medications are taken by prisoners. No doubt some prisoners may be non-compliant, but I assume that at that point specific medical consideration is given to a prisoner's refusal to comply. A similar situation prevails in the ordinary hospital system, leaving aside mental health detention.

9.9. In my view, this situation is not altogether satisfactory within the prison system. The exchange of information between the custodial system and the Prison Health Service is not without restrictions. No doubt it has improved greatly since 2003, but it remains restricted in the same way, and for the same reasons, that exchange of information between medical advisers and persons other than their patients is restricted in the general community. In my view something more than this is required of a Prison Health Service.

9.10. I note that the Prison Health Service is not the subject of specific statutory recognition. I consider that some advantage might be obtained by a statutory codification of the existence and role of the Prison Health Service. Some relaxation of the ordinary obligations of confidentiality imposed upon a medical practitioner might be provided for in such a code if the provision of information were in the best interests of the prisoner. A statutory codification of the Prison Health Service might also afford an opportunity to modify the relationship of the health service to the prisoner in a way better designed to recognise the realities of the prison system than the current approach which is largely based upon the same system which applies to persons who are not imprisoned.

10. Recommendations

10.1. I recommend pursuant to Section 25(2) of the Coroners Act 2003 that the Department for Correctional Services gives consideration to the introduction of measures of the kind referred to above.

10.2. I recommend pursuant to Section 25(2) of the Coroners Act 2003 that the Department of Health gives consideration to the introduction of measures of the kind referred to above.

Key Words: Death in Custody; Psychiatric/Mental Illness; Suicide; Prison Health Service

In witness whereof the said Coroner has hereunto set and subscribed his hand and Seal the 25th day of September, 2006.

State Coroner