MAGISTRATES COURT of TASMANIA

CORONIAL DIVISION

FINDINGS, RECOMMENDATIONS and COMMENTS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 (Tas) into the deaths in custody of:

TROY COLIN MONSON, ROBIN MICHAEL AND SCOTT CLIFFORD MITCHELL

Contents

Record of Investigation into Death (With Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, having investigated the deaths of Troy Colin Monson, Robin Michael, and Scott Clifford Mitchell

Hearing Dates

With an Inquest held at Hobart on 26 and 27 August 2015; 2, 3, 4, 5 and 6 November 2015; 18 December 2015; 4, 5, 6, 7, 11, 12, 13, 14 and 15 April 2016; 25, 26, 27, 28 and 29 July 2016; and 12 September 2016.

Appearances

RB Webster – Counsel Assisting the Coroner

PW Turner –State of Tasmania (Department of Justice, Corrections)

S Taglieri – Dr Wake

W Ash – Correctional Officer J Hitchens

G Barns and C Scott – Mitchell Family

Introduction

1. On 22 June 2015, Troy Colin Monson was transported by prison van from the Launceston Reception Prison to the Risdon Prison at Hobart. When the van arrived and his door was opened, he was found dead having asphyxiated himself using a seatbelt. A week later, on 29 June 2015, Robin Michael was found dead hanging, by a ligature made from shoelaces around his neck, in his cell at Risdon Prison. A month later, on 31 July 2015, Scott Clifford Mitchell collapsed and died in his cell in the Ron Barwick Minimum Security Prison at Risdon.

2. Each death is subject to the *Coroners Act* 1995 (the "*Act*"). The *Act* provides that an inquest must be held where a death occurs in Tasmania and the deceased person was immediately before their death a person held in custody.

3. Section 3 of the *Act* provides a person is in custody if that person was in the custody or control of a police officer, or a correctional or mental health officer, or a person who has custody under the order of a court for the purpose of taking a person to or from court, or a person detained in a prison as defined in the *Corrections Act* 1997. As a consequence, an inquest in each case under examination here was

mandatory. In most other jurisdictions in Australia, an inquest is also mandatory in such circumstances.

4. On 5 August 2015 Coroner McTaggart, holding a delegation from the Chief Magistrate to carry out various of the Chief Magistrate's functions under the *Act*, directed, pursuant to section 50 of the *Act* that the deaths of the three men were to be investigated at one inquest. "Inquest" is defined in section 3 of the *Act* as a public hearing.

5. The ambit of any investigation under the *Act* is defined by the *Act*. Relevantly section 28 of the *Act* provides:

> "**(1)** A coroner investigating a death must find, if possible –
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> **(a)** the identity of the deceased; and
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> **(b)** how death occurred; and
>
> **(c)** the cause of death; and
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> **(d)** when and where death occurred; and
>
> **(e)** the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1999*.
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> **(f)** . . . . . .
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> **(2)** A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.
>
> **(3)** A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.
>
> **(4)** A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.
>
> **(5)** If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care."

6. I observe as I did in the matter of *Mansell* [2016] TASCD 01 that the particulars referred to in section 28(1)(e) are not to be found in either the *Births, Deaths and Marriages Registration Act* 1999 or the regulations made under that *Act* (which deals only with fees). There remains a gap in the legislative scheme. The issue needs to be addressed by legislation.

7. I note the requirement in section 28(5) of the *Ac*t to report on the care, supervision or treatment of each deceased man. The rationale for such a requirement is the public policy reason to ensure that the death of every person who is detained against their will in any state-run institution by reason of an order of a court, tribunal, or the executive is carefully, independently and transparently examined. In Waller's *Coronial Law and Practice in New South Wales* (third edition) at page 28 it is said that:

> "*society, having effected the arrest and incarcerations of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty and is not exacerbated by ill treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion and satisfies the community that deaths in such places are properly investigated."*

Arguably, the requirement for a society to openly and independently examine the deaths of persons in custody is even more pronounced where those deaths are of detainees and not prisoners serving any sentence. That was the case in two of the three deaths the subject of this inquest. Neither Mr Monson nor Mr Michael had been convicted of anything. Neither were serving sentences of imprisonment at the time of their death.

8. Although a judicial officer, the coroner exercises a very different role to other judicial officers. The coroner's role is inquisitorial. She or he is required to thoroughly investigate a death and to make findings with respect to that death. This process requires the making of various findings, but without apportioning legal or moral blame (see *R v Tennent; ex parte Jaeger* [2000] TASSC 64, per Cox CJ at paragraph 7).

9. In *Harmsworth v The State Coroner* [1989] VR 989, it was observed at 995 that "the coroner's source of power of investigation arises from the particular death or fire. A coroner does not have general powers of inquiry or detection. Enquiry must be relevant, in the legal sense to the death or fire; this brings into focus the concept of 'remoteness'."

10. One matter that the *Act* requires a finding to be made about is how death occurred (section 28(1)(b)). This phrase involves the application of the ordinary concepts of legal causation. Any coronial inquiry necessarily involves a consideration of the particular circumstances surrounding the particular death so as to discharge the obligation imposed by section 28(1)(b) upon the coroner (see *Atkinson v Morrow & Anor* [2005] QCA 353).

11. In addition to being required to make findings pursuant to section 28(1) of the *Act* a coroner is required, in appropriate cases, to make 'recommendations with

respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate' (section 28(2)) and to 'comment on any matter connected with the death including public health or safety or the administration of justice' (section 28(3)). *Harmsworth (supra)* and *R v Doogan ex parte Lucas – Smith* [2005] ACTSC 74 are both authority for the proposition that any recommendations or comments need to have a sufficient nexus with the death (or in this case deaths) the subject of inquiry. Put another way, it is important to ensure that any recommendations or comments made by a coroner are not too remote (in a legal sense) from circumstances of the particular death (or deaths).

12. Finally I note the standard of proof applicable in coronial inquests is the civil standard of proof. In other words, where findings of fact are made it is necessary for a coroner to be satisfied on the balance of probabilities as to the existence of those facts. However, if the inquiry reaches a stage where findings being made may reflect adversely upon an individual (or individuals) it is well settled that the standard applicable is that articulated in *Briginshaw v Briginshaw* (1938) 60 CLR 336 (see in particular Dixon J at page 362). The so-called *Briginshaw* test has been repeatedly applied in many cases concerned with coronial proceedings. Examples abound but include *Anderson v Blashki* [1993] 2 VR 1, *Thales Australia Ltd v Coroners Court of Victoria* [2011] VSC 133; *Hurley v Clements* [2010] 1 Qd R 215; *Khan v West* (unreported, Supreme Court of Victoria, 11 September 1997 per Hampel J – and although that decision was overturned on appeal, the application of *Briginshaw* was neither challenged nor doubted).

Circumstances Surrounding the Death of Troy Colin Monson

Mr Monson's Background and Arrest

13. Troy Colin Monson was born on 30 April 1973. He had a lengthy and well-documented history of cannabis and intravenous drug and alcohol problems, homelessness and depression associated with complex psychosocial issues. At the time he went into custody he was living "rough", having no place of abode, and was unemployed. He had spent a good deal of his adult life in prison, both in Tasmania and on the mainland.

14. Mr Monson was arrested by police and taken into their custody on the Northwest coast of Tasmania on 17 June 2015. His arrest was effected by officers from Western Drug Investigation Services who, working in concert with Federal Police and other police officers as part of a national operation, searched an address at Somerset near Burnie. On entering that address, 12 Ronald Crescent, they found Mr Monson asleep in a garage.

15. Police officers questioned Mr Monson at Ronald Crescent and he told one of them, Detective Senior Constable Shane Askew, about the difficulties he was experiencing with his family and personal life. He told Detective Senior Constable

Askew he had arrived at the Ronald Crescent address a short time before, after having used drugs and walking the streets during the night. Mr Monson had a swollen right hand which he said was broken. He was emotional and teary when being questioned by police at the address, especially when talking about his partner and child.

Events at Burnie Police Station

16. At about 11.00am Mr Monson was taken from Ronald Crescent by detectives to the Burnie Police Station. He arrived there at about 11.30am. At about 11.50am, he was introduced by Detective Senior Sergeant David Chapman and Detective First Class Constable Russell Broomhall to the duty (or watch) sergeant, Sergeant Ian Reaney, for processing.

17. During the processing of Mr Monson Sergeant Reaney advised him of his right to communicate with a friend, family member or legal practitioner. Mr Monson declined to exercise that right. Sergeant Reaney said that Mr Monson was, at least in his dealings with him at the point he was presented to him as custody officer, both compliant and cooperative. Sergeant Reaney said he had no concerns for Mr Monson's welfare during their interaction.

18. At 11.58am, after Sergeant Reaney completed the charge record[1] , Mr Monson was taken to the cell block (or as other witnesses described it "remand centre") within the Burnie Police Station. Sergeant Reaney said in evidence at the inquest that it was his belief that Constable Jason Turner then completed the Prisoner Admission and Assessment Form. I am satisfied Sergeant Reaney was mistaken about this. Other evidence, particularly from Detective Senior Sergeant Chapman and Detective First Class Constable Broomhall, satisfies me that Detective First Class Broomhall in fact completed the form, whilst Detective Senior Sergeant Chapman was getting a coffee for Mr Monson. The form was tendered at the inquest.[2] It is signed by Detective First Class Constable Broomhall. The form records that Mr Monson was compliant and making no mention of suicidal ideation or displaying signs of self-harm or similar.

19. There was some variation in the evidence as to whether the form was completed before or after Mr Monson was placed in a cell, but in my view, nothing turns on that issue. I accept the submission of counsel assisting that it is unnecessary to resolve the apparent discrepancy for on any view of the evidence the form was completed at a time when Mr Monson was in the custody of Tasmania Police in the watch house in the cell block of the Burnie Police Station. Where he was situated in the police station, and whether he was in a cell or not, is a matter of no significance.

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[1] Number BU 282-15
[2] Exhibit C29

20. Detective Constable Clare Lucas of the Burnie Criminal Investigation Branch was working day shift at Burnie on 17 June 2015. She said in her evidence that at approximately 11.45am she spoke to Mr Monson while he was sitting on some seats outside the charge room. She said she spoke to him for about 10 minutes before he was taken to see Sergeant Reaney. A matter of minutes after seeing Sergeant Reaney, Detective Constable Lucas saw Mr Monson again. By this time, he was in a police cell.

21. Detective Constable Lucas had a further conversation with Mr Monson in his cell. In that conversation Mr Monson advised Detective Constable Lucas about his drug use and how ashamed he was of what he had done, that is committing the crimes for which he had been arrested. She described him as breaking down in tears.

22. After a further discussion with Mr Monson and also talking matters over with her supervisor, Detective Senior Sergeant Chapman, Detective Constable Lucas took Mr Monson from his cell back into the charge room where she again spoke with Sergeant Reaney who signed Mr Monson's custody over to her.

23. Mr Monson was then interviewed by Detective Constable Lucas and her colleague Detective First Class Constable Robert Gunn. After being cautioned, Mr Monson made a written statement in which he made full admissions to the commission of the crimes of burglary and stealing at a supermarket and a post office in Wynyard.

24. Mr Monson was then taken back before Sergeant Reaney, formally charged, and returned to his cell at 2.55pm.

25. The watch house register[3] was tendered at the inquest. The evidence was that the register was a record of activity in the cell block. It records that at 3.15pm Mr Monson was noted as becoming agitated. He is described in the document as pacing the cell, kicking walls, swearing and yelling. So much is also able to be seen in the video of the Burnie watch house footage from the afternoon of 17 June 2015. Mr Monson is clearly pacing diagonally backwards and forwards in the cell and can be seen kicking a wall. The footage shows him continuing to pace for around 15 minutes.

26. The evidence was that at 3.57pm Mr Monson was taken from the cell and given a cigarette in the day room of the Burnie Police Station by Detective Constable Tracey Rogers.

27. There is a slight discrepancy between Mr Monson's movements as recorded in the watch house register and the Burnie watch house footage but again nothing turns on it. However, Detective Constable Rogers says that when she provided Mr

[3] Exhibit C80

Monson with a cigarette at about 3.57pm she had a conversation with him. In that conversation she reported that Mr Monson appeared visibly agitated and distressed, and he told her he was suffering from anxiety and feeling suicidal. He expressed concern about being in a confined space.

28. Detective Constable Rogers asked Mr Monson whether he wished to seek any medical attention and he said to her that he did not know. As a consequence of this conversation, Detective Constable Rogers made a note to that affect in the watch house register. She also gave evidence (which I accept) that in addition to recording her concerns in the watch house register she verbally relayed them to Senior Constable Ashley Arnold, who was at the time an acting sergeant and performing the role of duty sergeant (having taken over from Sergeant Reaney at 4.00pm). Detective Constable Rogers said in evidence, which I accept, that she also advised Constable Jason Turner, who was responsible for cell watch duties, of the substance of the concerns she had about Mr Monson which she had recorded in the watch house register.

29. At 4.30pm Mr Monson was returned to his cell.

30. I am satisfied on the evidence that Detective Constable Rogers acted appropriately. She notified the people responsible for Mr Monson, that is to say, the duty Sergeant and the officer responsible for all watch duties, of her concerns. She made a record of those concerns in the watch house register. There is no more she could have done to ensure Mr Monson's safety.

31. Constable Turner says that he reviewed Detective Constable Rogers' note but appears to have done nothing else in relation to it. He made some records in the watch house register, in particular a note of a request by Mr Monson at 5.40pm for a doctor, but that request was not actioned. Neither did Senior Constable Arnold take any action at all.

32. The watch house register next records that at 6.35pm Mr Monson had "a rant" but apart from that, there is nothing of any moment recorded in the register. The footage tendered[4] tells a different story. Mr Monson is seen to recommence pacing at 4.17pm, stop pacing, start again at 4.23pm and then vomit at 4.24pm. Pacing and what might be described as "ranting" recommenced at 4.24pm and a minute later Mr Monson is obviously yelling. Over the next few hours, Mr Monson is seen to be relatively calm and compliant except when the time comes for him to be removed from his cell at 8.01pm. At that time, he cannot be described as compliant, clearly struggling and resisting being moved.

33. Counsel assisting submits that the watch house register does not fully and accurately record Mr Monson's actions and behaviour whilst he was incarcerated in the Burnie watch house. I agree. As should be relatively clear from the foregoing, the

[4] Exhibit C335

CCTV footage is inconsistent with what is recorded in the watch house register. Where there is any inconsistency I am satisfied that the CCTV is to be preferred over the records in the watch house register.

34. More should have been done for Mr Monson. All police officers are bound to act in accordance with the Tasmania Police Manual. Section 7.2 of that manual requires the watch or duty sergeant to "ensure immediate medical treatment or care is sought if there is ***any doubt*** concerning the medical condition of the person in custody". [Emphasis added]

35. Counsel assisting submits, given Detective Constable Rogers' conversation with Mr Monson (which I am satisfied occurred as described by her), Senior Constable Arnold must have been aware of concerns about Mr Monson. Mr Monson's erratic behaviour in the cells is evidenced in the register and the CCTV footage. On any view of the situation there should have been at least a doubt concerning Mr Monson's medical welfare.

36. Accordingly, I am satisfied there was a failure to comply with the order in section 7.2.10 of the Tasmania Police Manual and a failure to properly care for Mr Monson whilst he was in Tasmania Police's custody at Burnie. Further, no checks seem to have been made in the Tasmania Police computer records to look at any history, which may have been recorded in relation to Mr Monson. If any had, then it would have been seen that there was a detailed recorded history of mental instability and actual self-harm, which should have alerted police to the need to take action.

37. Finally, I note when giving evidence at the inquest Senior Constable Arnold was unable to recall being told by Detective Constable Rogers about the suggestion that Mr Monson might need medical assistance. I have no doubt that he was told that by Detective Constable Rogers. On his own evidence, Senior Constable Arnold did not read her entry in the watch house register. He said he did nothing about requesting medical assistance because it was his understanding that a medical emergency was a pre-requisite to medical assistance being provided. Such a belief is not consistent with the Tasmania Police Manual section 7.2.10.

38. Therefore I conclude that Mr Monson should have been provided with medical assistance when in the custody of Tasmania Police at the Burnie watch house on 17 June 2015. Section 7.2 of the Police Manual and especially order 7.2.10, puts it beyond doubt that in such circumstances medical assistance should have been obtained for Mr Monson. It was not.

I <u>recommend</u> that all police officers who are responsible for the custody of detainees and those responsible for cell watch duties be clearly reminded of their duties under section 7.2 of the Tasmania Police Manual and particularly order 7.2.10.

Transport to Launceston via Devonport Magistrates Court

39. After his removal from his cell at 8.01pm, the evidence was that Constable Turner transported Mr Monson in the rear of a police divisional van to the Devonport Magistrates Court to attend an after-hours court sitting. Mr Monson appeared in court and was remanded in custody. He was then taken by Constable Turner, assisted by Constable Walker, in the divisional van from Devonport to the Launceston Reception Prison (LRP). Mr Monson was transported in the rear of the divisional van along with another detainee.

40. The transporting of Mr Monson to Launceston from Devonport seems to have been without incident. Constable Walker gave evidence that Mr Monson appeared to be sleeping in the rear of the van for almost that entire journey.

41. Upon arrival at the LRP Mr Monson was handed into the custody of the Tasmania Prison Service (TPS) and the responsibility for his safety passed from Tasmania Police to the TPS. The evidence was that no paperwork was handed over with respect to Mr Monson's mental or physical state when that handover occurred. It is a self-evident proposition that if any risks to health, either physical or mental, are identified by police officers whilst detainees are in the custody of Tasmania Police, then unless that information is drawn to the attention of the TPS, there is no purpose served in recording the information. In the case of Mr Monson, the prisoner admission assessment forms completed by Tasmania Police contained valuable information as to his mental and physical health. They were not provided to the TPS at handover. They should have been. The evidence was that now, since Mr Monson's death, those documents are provided by Tasmania Police to the TPS. However, the documents are in effect useless unless they are continuously updated by Tasmania Police after the time they are first completed.

I recommend that at least fully up-to-date prisoner admission and assessment forms be provided by Tasmania Police to the Tasmania Prison Service at the moment custody of a detainee passes from Tasmania Police to the Tasmania Prison Service.

Launceston Reception Prison

42. Constable Turner said that at the handover of Mr Monson to LRP staff he advised them that Mr Monson's mood and behaviour had been erratic. He gave evidence that he advised LRP corrections staff of Mr Monson's threat of self-harm and that he had made a request for a doctor (in addition to his discussion with Detective Constable Rogers Mr Monson told Constable Turner he wished to see a doctor). Constable Turner also said that he told prison staff that Mr Monson had been compliant during the trip to Launceston. Constable Walker gave evidence that Mr Monson was verbally aggressive towards corrections officers at the handover. I

am satisfied that Constable Turner's account of what happened at the handover of Mr Monson, corroborated as it is by Constable Walker, is accurate.

43. Correctional Officer Aaron Parker was on duty late in the evening of 17 June 2015 when Mr Monson arrived. He said Mr Monson was argumentative and uncooperative. He made a note at 12.41am on 18 June 2015 in which he recorded that Mr Monson had, upon coming into custody, been "argumentative, abusive and non-compliant… [and that Mr Monson] refused to be processed and was extremely non-compliant and abusive towards staff". Correctional Officer Parker described Mr Monson as agitated. He said Mr Monson initially refused to be strip-searched however he ultimately was by Correctional Officer Gavin Armour. Correctional Officer Parker also said in evidence at the inquest that Mr Monson continued to manifest his lack of cooperation during "processing".

44. Correctional Officer Parker described Mr Monson as "blowing up" and "erupting", specifically when Correctional Officer Armour commenced strip-searching him. He said Mr Monson was abusive towards Correctional Officer Armour. I accept Correctional Officer Parker as a reliable witness in this regard.

45. Correctional Officer Gavin Armour was the other officer who dealt with Mr Monson upon his arrival at the LRP late in the evening of 17 June 2015. He made an affidavit as part of the investigation (which affidavit was identical to an internal Prison Service incident report he completed at 12.48pm on 23 June 2015). Correctional Officer Armour also gave evidence at the inquest. Both his affidavit and incident report deal only with events on 22 June 2015,being the day of Mr Monson's death.

46. In his evidence at the inquest about Mr Monson's arrival at the LRP Correctional Officer Armour specifically denied that he was passed any information about Mr Monson's mood and behaviour whilst in the custody of Tasmania Police by either Constable Turner or Constable Walker. I reject Correctional Officer Armour's evidence about this point. It is inconsistent with the evidence of Constables Turner and Walker. As should be clear, the evidence of both police officers impressed me on this point as being reliable and plausible. I have already said I accept their evidence as being accurate.

47. Aside from acknowledging that Mr Monson was "a bit erratic" at the time of his entry into the custody of the TPS at the LRP, Correctional Officer Armour claimed that he was otherwise compliant. I also reject his evidence about this issue. It is contrary to the evidence of Constables Turner and Walker. It is inconsistent with Correctional Officer Parker's evidence, which as I have already noted I accept as reliable on this point.

48. It is also somewhat difficult to reconcile Correctional Officer Armour's evidence about Mr Monson's demeanour at the time of his entry into prison with his behaviour from there on, that is, a refusal to see a nurse the next day, and refusal to eat food and shower until 22 June 2015. Also it does not sit at all comfortably with

Correctional Officer Wills' evidence (which I accept) in relation to the reported difficulties caused by Mr Monson when transported to and from Devonport on 22 June 2015, before his final journey to Hobart later the same day. I am satisfied to the requisite standard that in his evidence to the inquest Correctional Officer Armour endeavoured to downplay his involvement with Mr Monson and downplayed his observations of Mr Monson's mood and demeanour at the time of his entry into prison custody.

49. In summary, I am satisfied that at the time of Mr Monson's entry into the custody of the Tasmania Prison Service, information at least as to Mr Monson's equivocal request for a doctor (about which police had taken no action), his feeling suicidal, his concern about being in a confined space and that his behaviour had been erratic was passed on to Correctional Officers Armour and Parker, albeit not in a written form. I have already commented on the need to ensure fully up-to-date Tasmania Police paperwork accompanies the transfer of any prisoner or detainee.

50. I observe that nothing, at all, seems to have been done by either of the Correctional Officers on duty when Mr Monson went into the custody of the TPS in response to any of the information about Mr Monson from Tasmania Police.

51. The evidence was quite clear that Mr Monson was a long-term prison inmate who had been in the custody of the TPS on and off, and regularly, since 1991. Relevantly, TPS records indicate a Suicide and Self-Harm (SASH) alert was raised on 29 January 2015 (i.e. just six months before Mr Monson's final period of incarceration). The SASH mandatory notification and an immediate support plan were implemented at the LRP on 23 January 2015. All that information should have been (and was in fact) available to all of the officers at the LRP who were dealing with Mr Monson in June 2015. Other TPS records, which all of the officers dealing with Mr Monson at LRP also had access to, showed that Mr Monson had expressed suicidal ideation in 2014 and had engaged in previous SASH behaviour, including sewing his lips together with a paper clip in 2012 and threatening to hang himself with a shoe lace at about the same time.

52. Correctional staff at LRP either knew, or should have known, at the time Mr Monson passed into their custody as at 17 June 2015 that he had a long history of incarceration, significant problems with alcohol and drug abuse (including IV drugs), was recently uncooperative and unpredictable, and that he was a suicide risk given his past and recent threats and behaviour. However, none of the correctional staff seem to have been aware of any of this.

53. Chief Superintendent Joanne Maxfield gave evidence about the processes surrounding Mr Monson's entry into the custody of the TPS, and entry of persons into custody generally. Records in respect of prisoners and detainees (current and past) are kept in the computerised Custodial Information System (CIS). Chief Superintendent Maxfield said that when Mr Monson's details were entered into the

Custodial Information System (CIS) in June 2015 an automatic 'Previous SASH History' alert was generated by CIS. Her evidence was that the generation of such an alert should have led to the corrections staff processing Mr Monson to raise a Mandatory SASH notification. However, no Mandatory SASH notification was raised by any corrections staff at that time, or at all. None of the staff involved in the entry of Mr Monson's details in CIS were able to explain why no alert was raised.

54. Chief Superintendent Maxfield went on to say that in contrast the CIS records recorded that when Mr Monson was remanded into custody on 22 January 2015 at the LRP, the corrections Tier 1 Assessment recorded Mr Monson had indicated no past SASH or current concerns. However CIS generated an alert in relation to past SASH history and staff at the time generated a SASH Mandatory Notification form. This led to Mr Monson being placed on 23 January 2015 on a Level 3 indirect watch at the LRP (a Level 3 observation requires the prisoner or detainee to be seen at 30-minute intervals and that 'indirect watch' means the observations may be carried out not in person but by means of CCTV). The contrast between how Mr Monson was processed and assessed in January 2015 and June 2015 is pronounced.

55. Chief Superintendent Maxfield also said in her evidence that when "processing an inmate Correctional Officers have the capacity to check prior episodes, case notes and assessments each time an offender returns to custody". She said, however, when Mr Monson was processed in June 2015 the receiving Correctional Officer did not check Mr Monson's history. I accept her evidence. No explanation was offered, at all, as to why the correctional officers on duty at the time of Mr Monson's reception into the custody of the Tasmania Prison Service failed to check any of Mr Monson's prior episodes, case notes and/or assessments from his many previous times in custody.

56. On the morning of 18 June 2015, Mr Monson was processed by Correctional Officer Timothy Steer between 7.30am and 8.00am. Correctional Officer Steer said in evidence at the inquest that Mr Monson was the third of three non-compliant prisoners whom he was tasked to process that morning. Apart from being told by the night shift officers (who must have been Correctional Officers Parker and Armour) at what was described as "handover" that Mr Monson was non-compliant, Correctional Officer Steer was told nothing else, at all, about Mr Monson. Specifically, he was not told anything about Mr Monson expressing suicidal ideation to Police or that he had discussed wanting to see a doctor or that he was coming down hard off drugs or that he had been difficult to handle.

57. Correctional Officer Steer conducted the processing in Mr Monson's cell. During the process, he described Mr Monson as being polite, expressing a desire to sleep, and indicating that he was "coming down" off drugs. I observe that this description of Mr Monson's behaviour is in contrast to the behaviour described by both Correctional Officer Parker and the Tasmania Police officers who gave evidence about Mr Monson's demeanour a few hours before, late the previous

evening. It is also inconsistent with other objective evidence of Mr Monson's behaviour whilst incarcerated in June 2015. It sits uncomfortably with the reason why Correctional Officer Steer was tasked to process Mr Monson in his cell in the first place. It is completely inconsistent with the fact that as part of his processing of Mr Monson, Correctional Officer Steer was required to complete a form entitled "Prisoner/Detainee Tier 1 Acknowledgement Form" when processing was complete. That document was not signed by Mr Monson, because Mr Monson refused to sign it, clear evidence of a manifest lack of cooperation on his part. I reject Correctional Officer Steer's evidence as to Mr Monson's demeanour. Like the evidence of Correctional Officer Armour, it appeared to be an effort to consciously downplay his observations of Mr Monson's behaviour.

58. The assessment of Mr Monson involved the completion of a corrections Tier 1 Assessment by Correctional Officer Steer. Confusingly, both the corrections and health arms of the prison service have a process known as Tier 1. Correctional Officer Steer completed the corrections Tier 1. The actual document was tendered as an annexure to the affidavit of Chief Superintendent Maxfield sworn 13 July 2016[5] and also was tendered as a separate document[6]. It is clear enough from both the evidence about the document, and the document itself, that the reason for its completion is to facilitate the entry of a person into the prison system. It deals with, at some length, issues associated with safety and security of the prisoner or detainee. Its purpose, and the manner in which the process of assessment is to be undertaken, is dealt with in Interim Director's Standing Order 2.06. That DSO provides that the purpose of the assessment process is to identify risks to the safety and security of both the prison and the individual prisoner or detainee as well as determine the individual prisoner or detainee's individual needs.

59. Correctional Officer Steer said that he understood the normal process for the completion of a corrections Tier 1 assessment was that the prisoner or detainee would be interviewed in a room in which a computer was present. The electronic form for the completion of the corrections Tier 1 was brought up on the computer screen and filled in as the interview progressed. However, in the case of Mr Monson on the morning of 18 June 2015, this procedure was not followed. As noted, the assessment was done by Correctional Officer Steer in Mr Monson's cell. In his evidence, he said that he asked what he described as the "key questions" of Mr Monson. However, he said he did not take with him a blank printed off corrections Tier 1 form (although there seems no reason why that could not have occurred) to make sure that he asked all, and the correct, questions (as opposed to the 'key' questions) and recorded accurately the answers to those questions.

60. Correctional Officer Steer said that after he had asked Mr Monson various questions he then spoke to a correctional health nurse (other evidence indicates this

[5] Exhibit C309 – Annexure C
[6] Exhibit C321

must have been RN Mathew McGillivray) and then briefed Correctional Supervisor Vandermeer. Only after these interactions with other staff did Correctional Officer Steer complete the corrections Tier 1 on a computer. He said that he used a past corrections Tier 1 to provide some of the answers including the details of Mr Monson's next of kin. Correctional Officer Steer was of the view in his evidence that there was no risk whatsoever of error on his part. This opinion, I accept genuinely held by Correctional Officer Steer, is at best extremely optimistic. As it happens, the correctional Tier 1 he completed did contain clear errors. On page 6 of the document, Correctional Officer Steer has answered "yes" to a question directed to whether or not the Tier 1 completion acknowledgement form had been signed by the prisoner or detainee. As has already been noted in the case of Mr Monson it was not. A further error on the face of the document is that no questions were asked (or if they were asked and answers given, no answers were recorded) in relation to any history of family violence.

61. If Correctional Officer Steer's approach is representative of a broader practice either at the LRP, or more broadly within the TPS, then correctional staff require more training as to the importance of the process and how to complete the document correctly. The procedure adopted by Correctional Officer Steer is unacceptable. It is likely to produce, and in fact in this case did produce, error. Further, as already noted, although it was Chief Superintendent Maxfield's evidence that when processing an inmate correctional officers have the capacity to check prior episodes, case notes and assessments, it is clear (and as Chief Superintendent Maxfield conceded) that no attempt was made whilst processing Mr Monson to check important aspects of his records, particularly with respect to any SASH history, although the records were accessed to obtain details of Mr Monson's next of kin.

I recommend that all officers processing inmates undergo further training as to the proper method of processing inmates including the need to check the inmates' records relating to previous periods of custody.

62. I note also that Interim Director's Standing Order 2.06[7] mandates the completion of the corrections Tier 1 within two hours of a person entering the custody of the TPS. In Mr Monson's case that did not occur. He went into TPS custody before midnight on 17 June 2015 but was not processed, and the corrections Tier 1 not completed, until about 8.00am the next morning. The explanation offered for the failure to complete the corrections Tier 1 as required by Interim DSO 2.06 was that only two officers were rostered on night shift and that as a consequence of safety concerns for those officers the corrections Tier 1 could not be completed until more officers were available when dayshift commenced. The safety concerns of the officers is an entirely legitimate issue in my view but it begs the question why sufficient staff to enable compliance with the interim DSO 2.06 were

[7] Exhibit C324 – Order 6.1 (second occurring)

not rostered on in the first place.

I <u>recommend</u> that adequate staff be rostered on at all times at the Launceston Reception Prison so as to enable corrections Tier 1 assessments to be completed as mandated by interim Director's Standing Order 2.06.

63. I return to the events of 18 June 2015. A decision was made by Correctional Supervisor Vandermeer that Mr Monson was to remain in his cell until he saw a nurse, after which it was envisaged he would be removed later to an observation cell. The evidence was that initially at least Mr Monson refused to see the nurse.

64. Correctional Officer Michael Mione said in evidence that on 18 June 2015 Mr Monson refused to shower, refused breakfast and drinks, and spent the day sleeping. Correctional Officer Mione was rostered on day shift that day. He described Mr Monson as having been a "bit upset" when he arrived at the LRP, and said he was placed in the observation cell as he wasn't able to be processed.[8]

65. RN McGillivray was based at the LRP and was working there on 18 June 2015. Unlike the correctional officers with whom he worked he was not employed by the Department of Justice but rather by the Department of Health and Human Services. It was his role on that day to carry out the health (or nursing) Tier 1. RN McGillivray had had previous dealings with Mr Monson. He said in his evidence that he was aware on 18 June 2015 that Mr Monson was housed in an observation cell. He said this was because of anger issues Mr Monson was experiencing secondary to substance abuse. Before he saw Mr Monson, he was aware that Mr Monson had refused to see him (or someone from health) during the morning. He also knew that Mr Monson had refused to eat.

66. RN McGillivray went to the observation cell with Correctional Officer Steer to discuss with Mr Monson why he was refusing to eat. Mr Monson told him he was angry and that he was coming down off a "heavy" methylamphetamine habit and was "hurting". RN McGillivray told Mr Monson he could assist with his withdrawal from drugs but first they needed to complete the health Tier 1 to enable him to determine what it was that Mr Monson required. Upon being told this RN McGillivray said Mr Monson agreed to cooperate and complete the health Tier 1.

67. What a health Tier 1 involves, its purpose and importance was explained in some detail by Dr Christopher Wake, the Chief Prison Medical Officer. Dr Wake's evidence will be addressed in due course. RN McGillivray explained how he went about completing the Tier 1 with Mr Monson on this day and what his practice was generally. Not unlike Correctional Officer Steer's approach to the completion of the corrections Tier 1, he said he neither used a computer nor a printed off blank health Tier 1 form to take to the interview. It was not his practice to even take with him a

[8] Transcript 5 Nov 2015 at P432

piece of paper with notes on it to prompt him what to ask. RN McGillivray said that to complete a health Tier 1 he took with him only a piece of blank paper, a pen, a blood pressure monitor and a glucometer. He gave evidence that he relied upon his experience to ensure he asked what he described as the "correct questions". It was RN McGillivray's belief that he did not forget any questions. Again such a belief is at best optimistic. RN McGillivray acknowledged in his evidence that if incorrect information were to be imported into the health Tier 1 then the results produced would be incorrect and any treatment plan prepared as a consequence of the process would also be incorrect. So much is relatively obvious. To the extent that confirmation of this evidence was needed Dr Wake confirmed that this was so.

68. I note that another nurse employed at the relevant time at the LRP, RN Janne Elkin, gave evidence about how she goes about completing a health Tier 1. She said because no computers are available in the interview room at the LRP she takes with her to the interview a piece of paper with some notes on it to act as an aid to ensure she does not forget to ask any questions. RN Elkin also said in her evidence that in completing a health Tier 1, it was her practice to use the inmate's answer to every question even if she knew that those were incorrect. She was unable to explain why this was her approach, although she recognised that it is obviously prone to error and will, if followed, produce results from the health Tier 1 assessments that are practically speaking useless. If the practices of RN McGillivray and RN Elkin are representative of practices of the nursing staff generally as to the completion of health Tier 1 then further training in relation to the importance of the process and proper method of completing the health Tier 1 is required. In addition, although taking some notes is better than taking no notes, the best approach would be, for nursing staff required to complete a health Tier 1, to have access to a computer.

I <u>recommend</u> that nursing staff receive further training in relation to the completion of nursing (or health) Tier 1 forms and nursing staff at the Launceston Reception Prison be provided with, trained in the use of, and required to use, a computer upon which to complete such assessments.

69. In any event the evidence was that RN McGillivray completed Mr Monson's health Tier 1. At the inquest RN McGillivray described the results of the health Tier 1 as being "unremarkable". The health Tier 1 document completed in respect of Mr Monson was tendered in evidence[9]. Significantly, the document showed no score at all in relation to mental state examination. RN McGillivray was unable to explain why this was so.

70. In relation to the issue of self-harm, and in answer to the specific question of whether Mr Monson had had any self-harm ideation in the past 12 months, the answer recorded in the health Tier 1 by RN McGillivray was "no". RN McGillivray

[9] Exhibit C365

said that this was the answer given to him by Mr Monson. It is not doubted that Mr Monson told RN McGillivray this, but even a cursory inspection of Mr Monson's extensive health and other records held by the TPS and CPHS would have revealed a number of recorded threats of self-harm, including most recently in January 2015. RN McGillivray could not recall whether he had checked those, or any, records relating to Mr Monson when completing the health Tier 1.

71. The health Tier 1 document created shows that Mr Monson's weight was recorded in the assessment as 65kg. Dr Christopher Lawrence, the Tasmanian State Forensic Pathologist, gave evidence at inquest that at autopsy (less than a week later), he weighed Mr Monson's body and it was 83.5kg. I accept Dr Lawrence's evidence about the weight of the body. It was unchallenged and inherently reliable. RN McGillivray gave a confused account as to from where the weight he recorded in the health Tier 1 was derived. I am satisfied the weight recorded in the health Tier 1 was an error.

72. On any view, Mr Monson's health Tier 1 was completed in an unsatisfactory manner. The result was, like the corrections Tier 1, no mandatory referral to mental health services was produced and in fact no referrals, of any type, at all, resulted from it. Like the corrections Tier 1, if the health Tier 1 had been completed correctly then a mandatory SASH alert and various other referrals would have been automatically generated. The evidence was, from amongst others Dr Wake and Chief Superintendent Maxfield, that an alert and consequent referrals would have led to Mr Monson receiving early appropriate psychiatric and psychological care. Dr Wake demonstrated to the inquest when he gave his evidence how the health Tier 1 ought to have been completed in relation to Mr Monson, the difference in scores that would have resulted had it been done correctly and the notifications which would have been generated. I accept Dr Wake's evidence about this.

73. In any event the results of the health Tier 1 were entered in a summary form by RN McGillivray into Mr Monson's medical record in the system known as Prison Health Pro (PHP) and emailed to Dr Wake (the summary was tendered[10]). The obvious point of course is that if the health Tier 1 is not completed correctly then any treatment plan generated is effectively worthless. Furthermore any other healthcare professional accessing the medical record is likely to be misled by it. RN McGillivray effectively acknowledged as much when he gave evidence to the inquest.

74. RN McGillivray said that after he completed the health Tier 1 assessment of Mr Monson, he spoke with Dr Wake by telephone and recommended that Mr Monson be prescribed Olanzapine, an atypical antipsychotic drug, to assist him with the effects of his withdrawal from methylamphetamine. RN McGillivray said that he requested Mr Monson be prescribed Olanzapine 10 milligrams at night for five days because he understood the drug has beneficial effects including increasing appetite,

[10] Exhibit C42

a sedative effect and works on dopamine receptors (so as to reduce craving for methylamphetamine) and positively effects cognitive functions such as judgment, thinking and reasoning. RN McGillivray said that Olanzapine was commonly used in circumstances of substantial methylamphetamine use.

75. RN McGillivray gave evidence that Dr Wake agreed with this suggestion and wrote the necessary script, not ever having seen Mr Monson (who had seen no doctor since going into custody). Mr Monson was given the drug at about 5.00pm on the evening of 18 June 2015.

76. I note that during the day of Thursday 18 June 2015, Mr Monson appeared in the Devonport Magistrates Court by video link from the LRP. He was formally remanded to appear back in the Devonport Magistrates Court, in person, on Monday, 22 June 2015.

77. Dr Wake confirmed the substance of RN McGillivray's evidence. He described Olanzapine as "useful" in methylamphetamine withdrawal, although acknowledged it was not a drug specific for that condition. He said the drug "induces sleep, aids calmness and promotes weight gain". He agreed that it was not an ideal practice for drugs to be prescribed in the way Olanzapine was for Mr Monson.

78. On the following day, Friday 19 June 2015, Mr Monson was seen by Dr Wake by a video link (or what was described as a "telehealth clinic") from Launceston to Hobart. Dr Wake said that he and Mr Monson knew each other well. He described in court the manner in which he approached consultations via video link. He said it was his practice, which I infer he followed on 19 June 2015, when he saw Mr Monson, to have before him the completed health Tier 1, which he described as an "excellent structure for discussion" (although if completed incorrectly their utility is doubtful). Dr Wake said it was his practice to always have a nurse present with the prisoner or detainee when he conducted a consultation by video link and this occasion was no different; RN McGillivray was present with Mr Monson in Launceston.

79. Dr Wake's evidence at inquest about Mr Monson's presentation on 19 June 2015 was as follows:

> *"It was to my eye abnormal on the 19th. He was dirty, dishevelled and generally looking a bit poor. His speech was normal. He was polite and measured. His mood was low. That's what happens to you when you – he was fatigued. His affect, external emotions were normal. His thought form and context was normal. He interrelated quite well, sensibly, with the process that was going on. His perceptions were normal. He wasn't hallucinating or responding to any external stimuli. His cognition and understanding of what we were discussing was normal and his insight and judgement were normal."*[11]

[11] Transcript – 29 July 2016 p513

80. Despite Mr Monson appearing “abnormal” Dr Wake did not consider that either his self-harm or suicide risk were elevated.

Suicide and Self-Harm Prevention

81. The corrections and health Tier 1 assessments both formed part of the TPS approach to the prevention of suicide and self-harm on the part of inmates. The issue of suicide and self-harm in custody is a significant problem for prison services throughout Australia. In Tasmania it is no different. As such the TPS has developed an integrated approach to suicide and self-harm prevention that relies upon input from both corrections and clinical staff. Central to the approach is Director’s Standing Order 2.01[12]. That DSO indicates that its purpose is to “ensure prisoners and detainees who are identified as at risk of suicide or self-harm receive appropriate care, support and supervision.” The DSO recognises at Order 7.1 that the TPS has a duty of care to ensure the safety of all prisoners and detainees. The DSO (at Order 7.2) provides “all precautions that are reasonably possible must be taken to prevent incidents of suicide or self-harm” and (at Order 7.3) “suicide and self-harm prevention is the responsibility of all Tasmania Prison Service staff regardless of their rank or position”. The DSO is expressed to be mandatory in its terms (Order 7.4) and expresses a clear intention that TPS and CPHS will work collaboratively and “in a coordinated and inclusive manner to ensure the best possible outcomes for prisoners/remandees identified as at risk” (Order 7.5).

82. The DSO sets out in part 8 the various SASH watch levels that are to be used. Those watch levels are:

- On Watch – Level 1 – Immediate high risk of suicide or self-harm identified or significant risk of attempt during lockdown hours. To be observed either continuously or as identified in Immediate Support Plan/Interim Risk Treatment Plan/Risk Treatment Plan.
- On Watch – Level 2 – Immediate risk of suicide or self-harm identified or significant risk of attempt during lockdown hours or step down from more intensive level of watch. To be observed every 15 minutes.
- On Watch – Level 3 – Risk of suicide or self-harm identified requiring formal observation or step down from more intensive level of management. To be observed every 30 minutes.
- On Watch – Level 4 – Potential risk identified but no evidence of immediate risk identified or step down from higher level of observation. To be observed every two hours.

[12] Exhibit C50

- On Watch – Level 5 – Potential risk identified but no evidence of immediate risk or step down from higher level of observation. Three contacts (documented) with staff per day – contact to be spread across the day.

- On Alert – Previously identified as at risk or history of suicide or self-harm behaviour but no active risk currently identified on clinical assessment. This is an active alert for the current period of incarceration.

- Past Alert – Previous episodes of On Alert or On Watch shown in records. This is not an active alert status.

83. The DSO (at Order 9.1) requires new prisoners and remandees to undergo a suicide and self-harm assessment within two hours of being received into custody. It has already been noted that this did not occur in the case of Mr Monson.

84. The DSO (at Order 10.4) provides that a SASH Mandatory Notification form must be completed where:

- there has been an actual self-harm incident or incomplete suicide attempt;

- a prisoner/remandee threatens, verbally or in writing, to harm him/herself; or

- there are concerns that a prisoner/remandee may be at risk of suicide or self-harm.

85. Order 10.6 requires that SASH Mandatory Notification forms are to be forwarded to the Officer in Charge within two hours of the risk being identified.

86. The DSO then goes on to outline Immediate Support Plans and Interim Risk Treatment Plans at Orders 11 and 12 respectively. An immediate support plan is defined as something designed to “ensure the prisoner/remandee receives appropriate support and monitoring until a Risk Intervention Team or clinical staff review can be conducted”. The purpose of an Interim Risk Treatment Plan is, in terms of the DSO, to “ensure the safe care of the prisoner/remandee until such time as the person can be reviewed by a Risk Intervention Team”.

87. Order 14 of the DSO provides that Risk Intervention Teams (RIT) will operate at all prison facilities. The evidence was that, due to a want of appropriate staff, no RIT operated at LRP during Mr Monson’s incarceration there in June 2015. A RIT is, in terms of the DSO, at a minimum to “include a suitably trained experienced Correctional Supervisor, member of the Therapeutic Services Unit and an appropriately trained experienced Correctional Primary Health Service Nurse.” The RIT is responsible for formulating a Risk Treatment Plan once risk of SASH on the

part of an inmate is identified. It was apparent on the evidence at the inquest that the role of RIT is central to the proper care for inmates, particularly in terms of psychiatric and psychological support and treatment.

88. The transporting of “at risk” prisoners and remandees is also dealt with in the DSO. Order 18.1 provides that if a prisoner or remandee is identified at risk a SASH Mandatory Notification form must be completed prior to transferring the person to another facility. Order 18.3 requires the Officer in Charge of the sending facility to notify the RIT coordinator and Officer in Charge of the receiving facility of the impending transfer of the ‘at risk’ prisoner/remandee.

89. Finally Order 18.4 (mandatory in its terms) requires the Officer in Charge of the sending facility to ensure all necessary steps are taken to ensure the safety transfer of the prisoner/remandee.

Monday 22nd June 2015

90. The evidence is that Mr Monson was at no stage identified as ‘at risk’ and as a consequence no Mandatory Notification form was raised in respect of him. Even if one had been staff shortages meant that no RIT could have been conducted in Launceston. Further, because he was not identified as ‘at risk’ and was not considered by a RIT, no Risk Treatment Plan was formulated for him. He was not identified as ‘at risk’ because neither the corrections nor health Tier 1 were completed correctly.

91. Instead of receiving the psychiatric and psychological treatment which he required and to which he was entitled Mr Monson remained at LRP, housed in an observation cell. Records tendered at the inquest indicate he made at least one telephone call to his partner – whom he was forbidden by reason of a Police Family Violence Order from contacting (and as has been noted already no questions about family violence were asked of Mr Monson during the corrections Tier 1). He remained at the LRP until Monday 22 June 2015. On that day he finally agreed to shower. He also accepted a hot drink and ate breakfast. At about 8.00am Mr Monson was provided with a change of clothes preparatory to him being transported to Devonport for an appearance in the Magistrates Court. Preparation for the journey to Devonport included a strip search and a change back into his own clothing. The evidence was that Mr Monson was agitated at this time. The cause of his agitation appears to have been a missing article of clothing (specifically a black coat). The coat was looked for but apparently was unable to be located, and in any event, Mr Monson left in the escort vehicle at 8.05am. He was the only passenger in the escort vehicle. Correctional Officer Tania Emery drove the vehicle to Devonport while Correctional Officer Parker (who had dealt with Mr Monson when he came into custody late in the evening of 17 June 2015) monitored the surveillance camera fitted to the vehicle.

92. Mr Monson appeared briefly in the Devonport court at 11.20am, and then departed in the escort vehicle back to the LRP (with the two Correctional Officers reversing roles for the return journey), arriving there at 12.40pm, when he was again strip-searched and changed back into his prison clothing. In their affidavits tendered at the inquest neither Correctional Officer Parker nor Correctional Officer Emery made any mention of concerns about Mr Monson's behaviour. Correctional Officer Parker said in his affidavit that he had no concerns about Mr Monson. I reject his evidence about this. Clearly given Ms Gardner's evidence that Mr Monson was discussed at the RIT (about which more will be said shortly), the concerns about his self-harm threats 'post court' must have come from someone, most probably Correctional Officer Parker or Correctional Officer Emery, or both. I say this because Correctional Officer Wills said that Correctional Officer Parker told him that 'this cunt's been a pain in the arse [and that he] had to drag him back onto the truck'. Correctional Officer Parker specifically denied saying this when asked about it at the inquest, but I do not accept his denial. Correctional Officer Wills was in my view the more impressive and frank of the two witnesses. His account finds support generally in the decision to transfer Mr Monson to Hobart and specifically in RN Elkin's entry in Mr Monson's medical records, which will be discussed shortly.

93. Mr Monson was returned to observation cell number 1 and given a coffee. Around this time Mr Monson complained to Correctional Officer Mione of a sore back. Correctional Officer Mione advised Correctional Supervisor Keith Byers and RN Elkin of Mr Monson's complaint. At 1.15pm, Mr Monson was seen in his cell by RN Elkin in the presence of Correctional Officer Armour, Correctional Officer Mione, and Correctional Supervisor Byers. RN Elkin gave him some pain medication, and then he was again strip-searched, again changed back into his own clothing, and given a TPS jumper (in lieu of his own coat), preparatory to being transported to Hobart.

The Decision to Transport Mr Monson to Hobart

94. A considerable amount of evidence was before the court dealing with why it was that Mr Monson was transferred to Hobart at all and in particular on 22 June 2015. The evidence from the correctional officers and nursing staff in Launceston was confusing, conflicting and difficult to reconcile. I am satisfied that the ultimate decision was that of Correctional Supervisor Byers, who decided to have Mr Monson transferred to Risdon Prison Complex so that he could be assessed by a psychologist. Correctional Supervisor Byers said so in his affidavit tendered at the inquest[13]. There is little doubt that Correctional Supervisor Byers was advised by other staff, including at least Correctional Officer Mione, of the difficulties in the behaviour that Mr Monson was demonstrating, namely that he was constantly sleeping, refusing to come out of his cell and refusing to shower. He said that he

[13] Exhibit C44

spoke with RN Elkin and that she agreed with the decision to refer Mr Monson for assessment by TPS therapeutic services.

95. The transfer of prisoners and detainees between different prison facilities in Tasmania is authorised by section 36 of the *Corrections Act* 1997. How transfers under that section are to be affected is dealt with in Director's Standing Order 1.37[14].

96. The evidence was that Correctional Supervisor Byers telephoned Correctional Supervisor Robert Blanden at RPC just prior to midday on 22 June 2015 to advise him that Mr Monson was to be sent to Risdon and that he needed to be assessed upon arrival in Hobart. Correctional Supervisor Byers said in his evidence, confirmed by Correctional Supervisor Blanden, that the reason for the assessment was Mr Monson's refusal to leave his cell, his refusal to shower and his behaviour generally, which meant that he had to be housed in an observation cell.

97. Mr Justin Knight, a psychiatric liaison nurse employed by health and based at the RPC, gave evidence at the inquest that he was working in Hobart on 22 June 2015. He started work at 6.00am that day. He said that sometime during the day he received a telephone call from RN Elkin who informed him "that a prisoner [*sic*] was being transported from [Launceston] to Hobart for further assessment for his SASH (suicide and self-harm risk)". PLN Knight went on to say in his affidavit[15] that RN Elkin 'provided the name of Troy Colin Monson DOB: 30/4/1973 OTS 35530' (the last number being Mr Monson's individual TPS identifying number). In his evidence at the inquest, he confirmed that the nurse who called him about Mr Monson was RN Elkin. He said she told him that Mr Monson was pretty upset, that he needed assessment for self-harm and suicide risk and that she wanted Mr Monson assessed by the RIT.

98. In her affidavit[16] RN Elkin confirmed the substance of the conversation with PLN Knight, and although she said in her affidavit that she thought that the psychiatric liaison nurse at the RPC to whom she spoke was David Noble rather than PLN Knight, she corrected this in her evidence to the inquest. RN Elkin said in her affidavit that she told the RPC Psychiatric Liaison Nurse that Mr Monson "was being transferred to their facility and would need someone to review him upon arrival due to withdrawal and past presentation."

99. In her evidence at the inquest RN Elkin claimed, in effect, that her discussion with PLN Knight about Mr Monson was only in passing and that she had in fact rung him about the other inmate, a Mr Mogford. I set out the relevant portion of the transcript of her evidence below, when being questioned about the issue by Mr Webster, counsel assisting.

"Thank you, and we come to the Monday, another 7 till 7 day?.....Yes.

[14] Exhibit C325
[15] Exhibit C107
[16] Exhibit C41

And then at 11 o'clock, you have a conversation with Keith Byers?.....Yes.

Who's he?.....He's the correctional supervisor on duty that day.

Yes, so he's in charge on this day?.....Yes.

And he's told you that Mr Monson's returning to Launceston?.....Yes.

Sorry, from – returning to Launceston and then on to Risdon?.....Yes.

All right, and then you telephoned – you say David Noble, but we know it's Mr Knight?.....Knight, yes.

And had that discussion with him. So, that "Mr Knight reviewed him on arrival due to withdrawal" that's from the drugs?.....Yes.

"And past presentation"?.....Yes.

So all those matters we've discussed?.....Yes.

All the difficulties we've had with over the years?.....Yes.

So, all in together, we need a psychiatric assessment, all right. So, it's your decision alone to have him assessed by the psychiatric nurse?.....Yes. Custodial staff, if they have an issue, they'll come down and say that they want to refer them on. They can also refer them through to therapeutic services.

Oh so they can do that direct, or through you?.....No they can do that direct.

All right, or did you have a discussion with officer Byers on this day, about your decision to call Justin Knight?.....No, I'd rang about another person.

Right, that was Mr Mogford was it?.....Yes.

And you'd been having difficulties with him?.....Mr Mogford, yes, on having – he was on a SASH – a suicide SASH alert.

Was he?.....Yes.

And what level was he?.....Level 3 I think.

Right, okay, and so, what you're saying I think is, that in passing, you've mentioned Mr Monson to Mr Knight and the requirement for an assessment?.....Yes I'd rang and I was talking about him – Mr Mogford, and in passing I mentioned that if he had time, could he look at Mr Monson.

Right, so, it was – if you didn't phone Mr Knight about Mr Mogford, you wouldn't have phoned just for Mr Monson?.....I can't say, I honestly can't say whether I would have or I wouldn't have.

> *Right. But you thought it was necessary that Mr Monson be assessed?…..Yes.*
>
> *Because of his withdrawal and past presentation–.....Yes*[17]*."*

100. The above passage makes it quite clear that Custodial Supervisor Byers had already made the decision that Mr Monson was to be transferred to Hobart before RN Elkin spoke to PLN Knight. In the same passage RN Elkin suggested that most of the conversation she had with PLN Knight concerned another inmate Mr John Mogford. She claimed this caused confusion due to the fact that both inmates had similar surnames. PLN Knight was not confused. PLN Knight was in no doubt that Mr Monson was being transferred to RPC for the purpose of assessment by the RIT. I do not accept RN Elkin's evidence that she was confused either. Tendered in evidence was a copy of a patient consultation note made in Mr Monson's prison medical record by her at 1.49pm on Monday 22 June 2015[18]. Under the heading "consultation notes" is the following entry:

> *"Troy re-remanded [sic] at court this morning and will return to LRP. Troy states he won't guarantee his safety as he has nothing to keep safe for. Due to past history and present presentation will be moved to RPC for assessment and ongoing management. Phone call to PLN at RPC to inform them of this."*

101. The initials 'PLN' are a reference to Psychiatric Liaison Nurse. In context, this can only be a reference to RN Elkin's telephone call to PLN Knight. There can be no doubt that RN Elkin was well aware that Mr Monson had made that day threats of self-harm. These threats ought to have led to a formal response in accordance with DSO 2.01, and at the very least the raising of a SASH Mandatory Notification form. They did not. I consider that the evidence she gave at the inquest that she rang PLN Knight to speak about another inmate, Mr Mogford, and not Mr Monson, is not credible. I note that even if she had rung to speak about Mr Mogford the evidence was (from amongst others Chief Superintendent Maxfield) she had raised no SASH Mandatory Notification form (or for that matter an Interim Risk Treatment Plan) for Mr Mogford as DSO 2.01 required of her. I am satisfied to the requisite standard that her evidence in this regard was not truthful and was a conscious attempt by her to downplay her involvement in the events leading up to Mr Monson's death.

102. The evidence in relation to the RIT procedure has already been dealt with earlier in this finding. It consists of a mental health (psychiatric) nurse, an appropriately trained and experienced TPS Correctional Supervisor and a therapeutic services psychology team member. The specific purpose of the RIT is to monitor suicide and self-harming behaviours and (according to Dr Wake's evidence) "regulate appropriate levels of watch and other related care requirements". Dr Wake

[17] Transcript 4 Nov 2015, p307-308
[18] Exhibit C42

described the RIT as an intensive "cooperative venture between the TPS and CHS towards the prevention of suicide in Tasmanian Prisons".

103. Ms Helen Gardner, the Senior Psychologist for the TPS and, at the relevant time, manager of Therapeutic Services at the prison, gave evidence at the inquest. In her affidavit[19] she said she had had previous dealings with Mr Monson having first dealt with him in 2012. Ms Gardner was aware that Mr Monson had previously self-harmed whilst in custody and that he had SASH tendencies. She said, after an incident in February 2012 when Mr Monson had used a paper clip to wire his lips together whilst in custody at the LRP, she conducted RIT assessments of him. She said that whilst Mr Monson was in custody in 2014 and 2015, although she was aware he was seen by RIT assessment teams, she had no direct involvement with him then.

104. Ms Gardner said that at 1.00pm every Monday and Thursday a RIT Communication Forum meeting is held to discuss all inmates that are then currently on watch. Her evidence was that the meeting is attended by a representative or representatives from Therapeutic Services, representatives from Correctional Primary Health Service (generally a Mental Health Nurse and quite often the Clinical Nurse Consultant) and a representative from the Correctional Supervisors. Ms Gardner said that the purpose of the meeting was to discuss each inmate on watch, their current issues and presentation, what is happening with them and what their plan for the future is.

105. In her affidavit, Ms Gardner said that on Monday 22 June 2015 she was present at such a meeting with Ms Bronwyn Hocking, Ms Kylie Beard, Ms Kate Lennox, Ms Chloe Hall and Ms Monica Dykes (all from Therapeutic Services), Correctional Supervisor Blanden and PLN Knight. After discussing all inmates on the current watch list as normal, the meeting discussed Mr Monson.

106. Ms Gardner said:

> *"I had been informed that the Launceston Remand Centre were raising a mandatory notification form (MNF) because [Mr Monson] had made SASH threats post court. I can't remember if I was told the details of these SASH threats. We agreed that [Mr] Monson would be reviewed upon his arrival at the Risdon Prison Complex. Bronwyn Hocking was on call for the day, so she was tasked with meeting the transport bus and conducting the RIT assessment with Justin Knight and Supervisor Robert Blandon"*[20].

107. As it happens, and nothing turns on it, Ms Gardner was incorrect as no MNF had been raised in relation to Mr Monson (although as has already been noted, and as was conceded by Chief Superintendent Maxfield, one should have been). In fact,

[19] Exhibit C265
[20] Exhibit 265, p2

numerous steps set out in Director's Standing Order 2.01[21] were not followed whilst Mr Monson was at LRP. As has already been mentioned earlier in this finding, amongst other things DSO 2.01 requires, once a prisoner or remandee is identified as being at risk of SASH, the raising of a Mandatory Notification form and the sending of that form prior to transferring the person to another facility[22]. As has already been mentioned, this was not done. Part 18.3 of DSO 2.01 requires the Officer in Charge of the sending facility (in this case LRP) to notify the RIT coordinator and the Officer in Charge of the receiving facility of the impending transfer of the "at risk" prisoner or remandee. Apart from the telephone call to Correctional Supervisor Blanden, this requirement was not complied with either.

108. As has been set out above, Part 18.4 of DSO 2.01 requires the Officer in Charge of the sending facility (LRP) to "ensure all necessary steps are taken to ensure the safe transfer of the prisoner/remandee." It is difficult to see how anything that was done so far as the transfer of Mr Monson to Hobart from Launceston on the day of his suicide met this requirement.

109. RN Elkin said that the conversation with PLN Knight took place after she had spoken with Correctional Supervisor Byers at about 11.00am. In the conversation with Correctional Supervisor Byers, RN Elkin said that Mr Monson was to be transferred to RPC on the day's "usual escort".

110. As has already been noted, the evidence satisfies me that a decision was made by Correctional Supervisor Byers prior to 11.00am to transfer Mr Monson to RPC for assessment because of his mental state. Notwithstanding this, Correctional Supervisor Byers said in his affidavit that he had no concerns for Mr Monson's mental state in terms of the self-harming but that he wanted him assessed by "the appropriate people" who were based at Risdon Prison. This lack of concern as to Mr Monson's mental state, especially in terms of not being concerned about the risk of self-harm, is inconsistent with the decision to transfer him to Hobart for an assessment in the first place. It is inconsistent with the note made in Mr Monson's records by RN Elkin[23]. It is inconsistent with the evidence of PLN Knight and Ms Gardner. I am quite satisfied that Custodial Supervisor Byers was well aware that Mr Monson had made threats of suicide and/or self-harm that morning, and am quite satisfied, despite his evidence, that he had concerns about his mental state. Indeed, at the risk of repetition, there can have been no other reason for Mr Monson to be transferred to Hobart.

111. I am satisfied on the evidence that just prior to 1.00pm Correctional Supervisor Byers spoke with Mr Monson. Mr Monson told Correctional Supervisor Byers that he did not wish to go to RPC, as his back was sore. As a result Mr Monson was seen at about 1.15pm in his cell (as has already been mentioned) by

[21] Exhibit C50 (and also Annexure "A" to Exhibit C309)
[22] Exhibit C50 – Order 18.1
[23] Exhibit C43

Correctional Supervisor Byers, Correctional Officer Armour, Correctional Officer Mione and RN Elkin, and was provided by RN Elkin with Panadol (which was subsequently found to have been present in Mr Monson's body when samples taken at autopsy were the subject of toxicological analysis).

112. Correctional Supervisor Byers gave evidence at the inquest that he then 'checked' with RN Elkin who confirmed that Mr Monson would be 'all right' to travel. The implication is that had Mr Monson been assessed by RN Elkin as not "right" to travel to Hobart, then he would not have been sent to the RPC, at least not then or not by the regular escort. I do not consider any such implication is open. As I have already said, it is quite clear that Custodial Supervisor Byers had already made a decision to transfer Mr Monson to Hobart by the normal escort that afternoon two hours ***before*** Mr Monson was seen by RN Elkin. He had made a telephone call to Correctional Supervisor Blanden to apprise him of Mr Monson's pending transfer and the need for Mr Monson to be assessed by the RIT. RN Elkin had made a telephone call to PLN Knight in much the same terms. I am satisfied all this occurred well before Mr Monson was seen in his cell about his back pain.

113. I do note that in June 2015, the evidence was[24] that because LRP lacked the appropriately qualified staff mix (although both a Correctional Supervisor and a Psychiatric Liaison Nurse are on duty at that facility seven days a week) there was an inability to assess risk and develop Immediate Support Plans and Interim Risk Treatment Plans. In other words, no inmate in Launceston could be assessed fully by the RIT. The evidence also was that since June 2015, and as a response to Mr Monson's death, TPS has implemented a video link system to enable the conducting of RIT assessments for inmates with a SASH alert. In my view it would be preferable if the RIT was able to operate in accordance with the applicable DSO.

I <u>recommend</u> that the Tasmania Prison Service ensure that the appropriate staff mix is available at the Launceston Reception Prison to enable Risk Intervention Teams to operate at that facility in accordance with Order 14.1 of Director's Standing Order 2.01.

114. Returning to the events of 22 June 2015 the evidence was that, preparatory to the vehicle returning to Hobart, a seating plan for the transport van was prepared by another officer working in the control room at LRP, Correctional Officer Michael Eade. Correctional Supervisor Byers checked, approved and signed the seating plan. That seating plan was tendered in evidence[25]. It provided for Mr Monson to be housed in Pod 6 of the transport vehicle, on his own. The seating plan form has at the top of it the six (6) transportation categories. The categories on the seating plan form (Form 5 A Z – Version 1.0) do not accord with the categories contained in the

[24] Exhibit C309 affidavit of Chief Superintendent Maxfield 13 July 2016, page 5
[25] Exhibit C47

Director's Standing Order with respect to External Escorts[26] . The seating plan shows Mr Monson's transportation category as T3, which the seating plan records as mainstream. However, DSO 1.20 says TC [*sic*] 3 is the protection classification. DSO 1.20 defines mainstream as TC [*sic*] 2. This inconsistency is likely to mislead and needs to be rectified.

I <u>recommend</u> that the Tasmania Prison Service Launceston/Hobart escort seating plan form be amended so that it accords with the categories contained in Director's Standing Order 1. 20 – External Escorts.

115. I do note however, that on any view of the situation with respect to Mr Monson on 22 June 2015, his proper category, in accordance with the categories contained in DSO 1.20, was TC5. That category, in terms of DSO 1.20, "relates to prisoners at the Risdon Prison Complex Primary Health Centre and those identified at Suicide and Self-Harm Prevention (SASH) Risk Levels "On Watch – Level 1 and 2" but may also include prisoners from other prison facilities." DSO 1.20 makes it clear in respect of that category of prisoner or detainee that escorting arrangements are to be determined by the "relevant Correctional Manager in consultation with appropriate medical personnel". On the evidence at the inquest, apart from a discussion with RN Elkin after she had given Mr Monson Panadol and well after he had decided to transfer him to Hobart, Correctional Supervisor Byers consulted with no medical personnel at all about Mr Monson. In my view Correctional Supervisor Byers' discussion with RN Elkin falls well short of "consultation with appropriate medical personnel". He had already made the decision that Mr Monson was to be transported on the normal escort. Again, at the risk of repetition, although Mr Monson had not been formally identified as being at suicidal or self-harm risk, given what was recorded by RN Elkin amongst everything else he should have been.

116. Correctional Officer Armour, who has been mentioned already in this finding, in his affidavit[27] dealt briefly with his dealings with Mr Monson on 22 June 2015. He confirmed the administration by RN Elkin of Panadol to Mr Monson prior to his departure. He claimed that Mr Monson appeared to him to be in a good mood. Custodial Supervisor Byers also said in his affidavit that Mr Monson was "in a good mood and was joking around … and laughing". I do not accept this evidence that Mr Monson was in a good mood. It is inconsistent with the decision taken by Custodial Supervisor Byers to transfer him to Hobart. It is inconsistent with the advice Custodial Supervisor Byers provided to Custodial Supervisor Blanden in Hobart. It is inconsistent with the observations of Mr Monson by Correctional Officers Wills and Hitchens who were on escort duty. It is inconsistent with the evidence of RN Elkin about her discussion with PLN Knight at RPC to advise that Mr Monson would need to be reviewed on arrival. It is inconsistent with the note she made to Mr Monson's

[26] Exhibit C50 – DSO 1.20
[27] Exhibit C51

health records. It is inconsistent with the evidence of Ms Gardner, who gave evidence of the content of the discussion at the RIT meeting at 1.00pm on 22 June 2015. Finally, it is inconsistent with the evidence of Correctional Officer Wills as to what he was told by Custodial Supervisor Byers just after lunch and prior to the anticipated departure time from LRP to RPC. Correctional Officer Wills said, and I accept, that he was told by Correctional Supervisor Byers that a prisoner was 'coming down from the coast' (that is to say, the North West Coast), that they had trouble with him in the watch house, and that he was to be transferred to RPC to the Crisis Support Unit (CSU). This was confirmed in substance by Correctional Officer Hitchens. Correctional Officer Wills and Correctional Officer Hitchens were both told that Mr Monson had been difficult to handle. Both were aware he was going to Hobart for psychological assessment for one reason or another.

117. I am satisfied to the requisite standard that the evidence of Correctional Supervisor Byers and Correctional Officer Armour as to Mr Monson's mood immediately before being placed in the escort vehicle for his trip to Hobart was not true.

The Trip to Hobart

118. The transport vehicle travelled from RPC to LRP and back again on 22 June 2015. As has already been noted the correctional officers in the transport vehicle were Correctional Officer Wills and Correctional Officer Hitchens. Correctional Officer Wills was the driver and Correctional Officer Hitchens was assigned the role of escort officer. Shortly after 8.00am, they departed Hobart for Launceston with four prisoners in the vehicle. They drove to Launceston without stopping, arriving at about 11.20am. After unloading the prisoners and having some lunch, they were ready to depart about midday, when, as has already been mentioned, Correctional Supervisor Byers told Correctional Officer Wills and Correctional Officer Hitchens that a prisoner was coming down from North West Coast, and that there had been some trouble with him in the watch house and that he was to be transferred to the CSU at RPC. That prisoner can only have been Mr Monson. The evidence of Correctional Officers Emery and Parker was that the only prisoner transported that morning from the North West Coast to the LRP was Mr Monson.

119. After a time, Correctional Supervisor Byers provided to Correctional Officer Hitchens and Correctional Officer Wills the seating plan mentioned earlier for each of the prisoners. Six of the seven pods in the vehicle were loaded.

120. I note that while both Correctional Officer Wills and Correctional Officer Hitchens gave evidence that they had been told by correctional officers in Launceston, including Correctional Supervisor Byers, that Mr Monson had been difficult to handle and that he was to be taken to Hobart for psychological assessment, they were not told the reason for the psychological assessment. Specifically, neither was told that he had made threats of self-harm nor that not long

before he was to be transported Mr Monson had told RN Elkin that he could not guarantee his own safety as he had nothing to keep safe for.

121. In order to understand Mr Monson's final journey, it is necessary to describe in some detail the vehicle (known by call sign 'Mobile 2') in which Mr Monson and the other prisoners were transported. The following description is taken from the operators manual[28], as summarised by counsel assisting in his submissions:

- The van is 2.4 metres high, 2.3 metres wide and approximately 6.5 metres long;
- A cell pod body has been fitted to the cab chassis. The pod contains seven two-person cells, with three being directly accessible from each side of the vehicle. Each cell is accessed via a sequential, double door arrangement and automated steps. Adjacent near side and offside cells are connected by a locked emergency exit door, for use if one side of the vehicle is obstructed.
- Each cell has a non-operating window, which is tinted for privacy and security. Damage resistant lighting is included and electronic duress, public address and observation recording systems are fitted;
- Each cell is air-conditioned and features two individual, rear facing, fibreglass seats and seatbelts. The air conditioning can heat or cool. The cells are devoid of any fittings, objects or protrusions that may be used as weapons or for self-harm. The seatbelt stalks have been reinforced with a fibreglass wrap;
- The cells are fitted with two external doors. The outer door is opened to access the inner security door and steps. The inner doors are fitted with slam and padlocks and have a refreshment door and lashing ring built in;
- The passenger cabin is fitted with a centrally located console providing access to the body controls including door open monitoring, internal and external lights, and air conditioning. The console is also fitted with the observation and duress response systems;
- The driver side of the vehicle has four cells (numbered 1 to 4) whereas the passenger side of the vehicle has three cells (numbered 5 to 7) and a storage compartment at the rear on the near side;
- Mounted in the cabin between the passenger and driver is the control console with two video screens, the top one being the observation monitor for cells 1 to 4 and the bottom screen being the observation monitor for cells 5 to 7;
- The seats in a pod of the vehicle, the lighting, observation camera and microphone and duress call panel appear on page 15 of the manual;
- The procedure to open the cell outer doors and lower the steps is explained on page 23;
- Opening and closing the cell inner doors is explained on page 24;
- The operation of the cell lights is explained on page 27 and the operation of the intercom/duress system is set out on page 28; and

[28] Exhibit C329

- The operation of the observation system and use of the monitors is dealt with on page 29.

122. Tendered in evidence was an internal TPS document entitled “Escorting Officer Duties”.[29] The document outlines in detail the duties to be carried out by the escort officer when travelling between Hobart and Launceston in either direction. The duties of any correctional officers performing escort duties are also dealt with in DSO 1.20.

123. In summary, upon departure from Launceston for Hobart the escort officer is required to contact Prisoner Processing at RPC and Master Control at RPC to advise the escort is en route, confirm the number of prisoners on board and indicate the estimated time of arrival.

124. The escort officer is also obliged to contact the Tasmania Police radio room on departure, and when the vehicle passes through Campbell Town and past Oatlands, and upon arrival in Hobart. The radio room is also to be informed as to the number of prisoners on board.

125. The order of loading and the manner in which prisoners are to be loaded is also dealt with in DSO 1.20. There was no issue about the manner in which Mr Monson was loaded. However, of particular importance is Order 8 of DSO 1.20.

126. The relevant parts of that order are:

> 8.11 “Escort vehicles must not be stopped between departure and destination points or deviate from established routes unless an emergency occurs or Tasmania Police or the Correctional Manager of the despatching/receiving facility issues a specific direction. Any situation or emergency that requires deviation from standard escorting procedures must be reported to the receiving facility and Tasmania Police as soon as possible."
>
> 8.13 "Prisoner transportation compartments must not be unlocked during an external escort except in extreme emergencies and only then after additional correctional officers or Tasmania Police officers have arrived to provide assistance."
>
> 8.14 “**Regular monitoring must occur while an escort vehicle is in transit to ensure the safety and wellbeing of the prisoners is maintained.**"

[Emphasis added].

127. The evidence from Correctional Officer Wills and Correctional Officer Hitchens was that, relatively speaking, the journey from Hobart to Launceston in the morning was unremarkable. Of note though was the fact that Correctional Officer Wills and

[29] Exhibit C328

Correctional Officer Hitchens both gave evidence as to an interaction with an inmate that Correctional Officer Hitchens had observed not sitting upright and who refused to cooperate. The inmate, a Mr Stanley, was seen on the monitors provided for that purpose pretending to be unconscious. He was given a direction to sit up with which he did not comply. Correctional Officer Hitchens sought advice from Correctional Officer Wills as to the appropriate manner to deal with the inmate. The matter was dealt with by Correctional Officer Hitchens threatening to report (or 'book') Mr Stanley for a disciplinary offence. The monitors all were working sufficiently well in the morning, and Correctional Officer Hitchens was sufficiently observant, to see that an inmate was pretending to be unconscious and was able to deal with that inmate.

128. Tendered in evidence was the CCTV footage taken from the transport vehicle, which depicted Mr Monson's final journey[30]. Mr Conabeer, Head of Intelligence at the TPS, gave evidence that a discrepancy in time, that is to say, the date and time stamped on the CCTV footage being one hour in advance of the actual time, was due to a failure to adjust the system for daylight savings.

129. The footage was viewed during the inquest. Taken from that footage is the following approximate timeline:

- 13:39:10 hours – Mr Monson is loaded into the prison escort van and secured;
- 13:42:30 hours – Mr Monson is observed handling the seatbelt nearest the secured door;
- 13:55:00 hours – Mr Monson uses his left middle finger to gesture at the camera;
- 13:55:30 hours – Mr Monson can be seen handling the seatbelt to the other pod seat next to the central divider wall;
- 13:59:00 – Mr Monson can again be seen handling the seatbelt nearest to the secured door;
- 13:59:14 – Mr Monson can be seen placing the seatbelt around his neck;
- 16:24:00 – the food hatch to the secured door is opened and then re-secured;
- 16:24:58 – the seat belt around Mr Monson's neck is removed and he is placed on the ground of the prison processing sally port of RPC.

130. It is clearly able to be seen on the CCTV footage that between 13:59 hours (1.59pm) when Mr Monson placed a seatbelt around his own neck and 16:24 hours (4.24pm) when the seatbelt was removed there is no sign of movement from Mr Monson at all to suggest he was alive. He remains seated for the whole time (nearly 2 ½ hours) in the foot well of pod 6 with his head resting against the seat closest to the door.

[30] Exhibit C97

131. Moreover, in all of the footage between 13:59:14 (1.59pm and 14 seconds) and 16:24:58 (4.24pm and 58 seconds) the seatbelt is clearly visible as a taut 'V' behind Mr Monson.

132. Correctional Officer Hitchens said in his affidavit sworn on 22 June 2015[31], that it was his responsibility to watch on the CCTV monitors the prisoners inside the truck during the whole of the journey. He said the monitors were of poor quality and they "flicker" leading to a loss of continuity for up to a second. Correctional Officer Hitchens claimed the screen was inadequate because the resolution was too low and the footage not clear enough to tell if someone was "visibly crying".

133. In the same affidavit, Correctional Officer Hitchens said that if it had been "visibly clear" that Mr Monson was attempting to asphyxiate himself he would have noticed. He said in the affidavit that on his looking at the monitors he could not see whether Mr Monson had anything around his neck. Correctional Officer Hitchens said in his affidavit that he last checked the monitor as the van was approaching RPC, and that at that stage Mr Monson was still alive. Finally he said that had Mr Monson been interfering with the seatbelt around his neck he would have seen it.

134. The contents of Correctional Officer Hitchens' affidavit, as summarised in the above paragraph, cannot be correct. Mr Monson was not alive as the van approached the RPC. He had been dead for in the order of two hours before that occurred. He had been dead since about the time the escort vehicle passed through Perth just south of Launceston as the video footage and GPS tracking data show beyond any doubt. I reject Correctional Officer Hitchens' account in his affidavit that he could not see whether Mr Monson had a seatbelt around his neck. The seatbelt was plainly in view on the footage between 13:59:00 (1.59pm) and 16:24:58 hours (4.24pm and 58 seconds). The video footage speaks for itself. In addition, Chief Superintendent Maxfield acknowledged on behalf of the TPS in her evidence, that Correctional Officer Hitchens' evidence in his affidavit was inconsistent with the recorded CCTV footage and that the CCTV footage clearly showed Mr Monson's actions leading to his death in their entirety.

135. Given the clear and unequivocal evidence of the CCTV footage, as well as the concession by Chief Superintendent Maxfield, the only conclusion open is that Correctional Officer Hitchens did not regularly monitor the screens as he was required to do by Order 8.14 of DSO 1.20. As counsel assisting submits, this conclusion is also supported by the notes of Ms Gardner, who provided counselling and support to Correctional Officer Wills and Correctional Officer Hitchens in the immediate aftermath of the arrival of the van at RPC. Ms Gardner said in her evidence that either Correctional Officer Wills or Correctional Officer Hitchens (she could not say who) made a comment about not checking the monitors, although the monitors had been checked on the journey from Hobart to Launceston.

[31] Exhibit C104

136. It was submitted on behalf of Correctional Officer Hitchens that there are only a handful of occasions of actions on the part of Mr Monson, each of no more than 5 to 10 seconds duration, which he did not see. It was also submitted on his behalf that the image on-screen on the monitors appeared to freeze regularly. Both submissions are inconsistent with Correctional Officer Hitchens' own evidence and the unarguable fact that Mr Monson did not move from about Perth onwards. Both are inconsistent with the fact that the seatbelt is clearly depicted in the footage as a taut 'V' behind him. Both submissions overlook the unchallenged and inherently credible evidence of Mr Conabeer, which I accept, with respect to the footage not freezing. Both submissions are inconsistent with the concession made by Chief Superintendent Maxfield in her evidence. Both submissions are rejected.

137. For the sake of completeness, I note that evidence was given at the inquest by all of the other inmates present on the journey from Launceston to Hobart on the afternoon of 22 June 2015. Those inmates were Andrew Giovanoff (pod 5), Jacob Hall and Ricky Badcock (pod 1), John Zammit (pod 2), Melissa Hill and Toni Leary (pod 3), and John Mogford and Anthony Joyce (pod 4), (pod 7 was unoccupied). Their evidence added nothing to the evidence outlined above. No inmate who travelled on the escort between Launceston and Hobart on the afternoon of 22 June 2015 seems to have communicated at any stage with Mr Monson during the journey. Mr Joyce, Mr Hall, Mr Giovanoff and Mr Mogford all said they did not know Mr Monson. Mr Zammit said he spoke briefly to Mr Monson, whom he also did not know, prior to commencement of the journey. No inmate on the vehicle seems to have noticed anything amiss generally and certainly not with Mr Monson during the course of the journey.

138. Mr Mogford said in his affidavit that he (Mr Mogford) was concerned about getting onto the vehicle and that it was his belief that the water at the RPC is poisoned. As counsel assisting submits, given Mr Mogford's demeanour in the witness box and the contents of his medical records, these allegations ought be, and are, disregarded as being without any basis in fact.

Arrival in Hobart

139. The transport van arrived in Hobart and unloaded two female prisoners at Mary Hutchinson Women's Prison and other male prisoners at medium security before heading into the RPC sally port. At 16:24:58 (4.24pm and 58 seconds) Mr Monson was discovered, inert and deceased, in pod 6. He was removed from the escort vehicle.

140. It is necessary to consider now the response by TPS and RPC staff to the discovery of Mr Monson. The emergency operating procedures in the case of a "Code Blue" was tendered in evidence[32]. That document deals with the procedures

[32] Exhibit C116

to be followed by TPS staff in the event of an emergency of the type (that is to say a serious medical issue or death in custody) with which staff were confronted with late in the afternoon of 22 June 2015. The examination of the response is in two parts. First, it is necessary to consider whether the emergency operating procedures were adhered to, and second, consideration must be had as to whether or not the emergency operating procedures are themselves adequate.

141. The following summary of the evidence is taken from the written submissions of counsel assisting. No challenge by any counsel for any interested party to this summary was advanced. The summary is entirely consistent with the evidence. I find accordingly that the sequence of events was as follows.

142. After the transport vehicle entered the RPC processing sally port at 4.15pm, officers commenced to remove inmates from the vehicle. Inmates Zamitt, Mogford and Joyce were removed before the process of removing Mr Monson was commenced. Only Mr Giovanoff remained in the vehicle at that stage.

143. Correctional Officer Oppitz said that when the door to Mr Monson's pod was opened he saw that Mr Monson was blue in the face and his tongue was partially sticking out. Mr Monson was removed from the transport vehicle by Correctional Officer Hitchens and Correctional Officer Oppitz (Correctional Officer Wills having opened the door). His body was then placed on the ground, and Correctional Officer Oppitz called a "Code Blue" over a portable radio he was carrying.

144. Correctional Officer Danielle Cranage commenced a log immediately after the Code Blue was called by Correctional Officer Oppitz. She said in her evidence that she checked the inmates who were in the processing area against the transport list and the episode summary reports, and was able to determine it was Mr Monson who was lying on the ground of the sally port. She went to the door of health services and called for assistance. Ms Christine Castles, a Clinical Nurse Consultant (CNC), and PLN Knight responded to her call.

145. As this was happening Correctional Officer Oppitz commenced CPR on Mr Monson, assisted initially by Correctional Officer Wills. Both officers continued CPR until the arrival of CNC Castles and PLN Knight, which on the evidence was within a minute of their being called. The nursing staff had with them, *inter alia*, a defibrillator. CNC Castles and PLN Knight immediately commenced to attempt to resuscitate Mr Monson. Some of Mr Monson's clothing was cut off his upper body during this process to enable defibrillator pads to be affixed to his chest.

146. Correctional Officer Oppitz, CNC Castles and PLN Knight continued with CPR until about 4.35pm when the first ambulance arrived. It was noted that Mr Monson had black marks (being bruising) around his neck.

147. Correctional Supervisor Patrick Blake gave evidence that he was rostered on as the supervisor of the Tamar Unit of the RPC on 22 June 2015. He said as he was

approaching the sally port to assist with processing he heard a Code Blue announced over the radio (which can only have been the Code Blue call made by Correctional Officer Oppitz). He said that as Team Leader First Response at RPC (by virtue of being supervisor of Tamar Unit on the day) he immediately went to the processing doorway and made his way to the sally port. He came upon the scene with Mr Monson apparently unconscious next to the escort vehicle. He saw Correctional Officer Oppitz commence CPR. As Team Leader First Response he gave the following directions:

- Correctional Officer Oppitz and Correctional Officer Wills were to continue compressions;
- Correctional Officer Perry was to advise RPC Master Control, by phone from Processing, that an ambulance was required and she was to obtain an emergency kit from processing;
- Another member of staff (Correctional Supervisor Blake was unable to say who, although other evidence makes it clear it must have been Correctional Officer Cranage) was directed to attend health services and bring a nurse through to the sally port;
- Correctional Officer Cranage was directed to treat the area as a crime scene, to restrict the movement of people and to commence the maintenance of the log. He noted that Correctional Officer Cranage did not have a watch so gave her his watch so that she could maintain accurate times as events unfolded;
- Correctional Officer Gordon and Correctional Officer Hibberd were placed on standby to give assistance to staff already attending; and
- Correctional Officer Hitchens was directed to keep clear and help maintain the crime scene.

148. After the arrival of the first ambulance, the paramedics on-board that vehicle took over CPR. The evidence was that at no time prior to the arrival of the first ambulance did CPR cease.

149. A second ambulance arrived with another two paramedics at 4.37pm. All four paramedics continued attempts to resuscitate Mr Monson until at 4.55pm when all agreed that any further efforts at resuscitation were futile, that Mr Monson was deceased, and that the treatment should cease. Treatment duly ceased.

150. At 4.55pm upon cessation of resuscitation attempts, Incident Commander Superintendent Tony Allanby (who was at that stage watching proceedings from outside sally port cage) telephoned Tasmania Police to attend the scene. Ambulance personnel then left and the correctional staff waited for the arrival of Tasmania Police preserving the sally port as a crime scene until the arrival of Police officers.

151. Correctional Officer Wills and Correctional Officer Hitchens were both removed from the sally port at some stage by Superintendent Allanby after

Correctional Officer Wills had given Superintendent Allanby the keys to the transport vehicle. Correctional Officer Wills and Correctional Officer Hitchens spoke to Ms Gardner. The substance of that conversation has already been set out earlier in this finding.

152. After the arrival of uniform, Forensic and Criminal Investigation Branch officers, the investigation of Mr Monson's death pursuant to the provisions of the *Act* was commenced at the scene. Statements were taken from witnesses present at the scene. Photographs of the sally port, Mr Monson's body, and the vehicle, were all taken *in situ*. The vehicle was secured for further forensic examination (after its removal from the sally port). The mortuary ambulance eventually arrived and Mr Monson's body was placed in a body bag, onto a stretcher and transported to the mortuary at the Royal Hobart Hospital. Mr Monson's body was formally identified, both at RPC and subsequently at the mortuary.

153. At approximately 9.15pm a debriefing session was held for all prison staff in the RPC involved in Mr Monson's death. Those who attended the debrief included, Correctional Officers Adam Morton, Rhys Hibberd, Graeme Buttery, Superintendent Tony Allanby, and Deputy Chief Superintendent Robert McCafferty. All gave evidence broadly consistent with the above summary. So too did CNC Castles and PLN Knight. Officers stationed in the master control room (Correctional Officers Colraine, Fairhurst and Quigley) all gave evidence as to activities in the master control room and in particular, their operation of cameras to observe and record what was taking place.

154. A number of general duty and CIB police officers as well as forensic officers gave evidence at the inquest in relation to their involvement in the investigation into Mr Monson's death. Those officers gave evidence as to attending at RPC, being briefed, and obtaining records relevant to the investigation. CCTV footage taken from cameras controlled from the master control room (specifically cameras 1101 and 621), which recorded the events unfolding at the RPC reception sally port between 4.10pm and 4.50pm, was obtained and downloaded onto a DVD and then presented as evidence at the inquest.

155. The CCTV footage[33] of the scene at the RPC corroborates and supports the summary of evidence set out above.

156. As has been mentioned, the emergency operating procedure dealing with Code Blue situations was tendered in evidence[34]. The document runs to some eight pages. It prescribes comprehensively the response to a serious medical issue or accident or death in custody. The document clearly describes the roles of the first responding officer, CPHS staff, the master control room officer, Team Leader First Response (or most senior officer on duty), on-call superintendent or chief

[33] Exhibit C92A
[34] Those applicable to both the RPC - Exhibit C116 and RBMSP- Exhibit C117

superintendent are all made quite clear. The document is comprehensive but simple and easily understood. I am satisfied that it was adhered to in the case of Mr Monson's death by all of the officers involved in responding to the emergency. I am also satisfied the documented procedures in Emergency Operating Procedure 03 themselves are adequate. However, I will say more about Emergency Operating Procedure 03 in the context of Mr Michael's death in due course.

Forensic Pathology Evidence

157. After Mr Monson's body was removed to the mortuary at the Royal Hobart Hospital, an autopsy was carried out by Dr Christopher Hamilton Lawrence, the Tasmanian State Forensic Pathologist. Dr Lawrence, who gave evidence at the inquest, expressed the opinion, which I accept, that Mr Monson died as a consequence of a partially suspended hanging. He said that Mr Monson:

> "was in the prison bus and found dead in the foot well of his compartment with a 104 cm long lap belt around his neck. Autopsy reveals a ligature mark consistent with a partially suspended hanging. There are also petechial and conjunctivae which would fit with a partially suspended hanging. There is a small amount of blood in the left ear, which appears to be coming from the outer ear. There are no other apparent significant traumatic injuries. The appearances are consistent with partially suspended hanging. Hanging is neck compression generated by dependent body weight. The body does not need to be fully suspended. The weight of the head and neck are sufficient to occlude blood supply to the brain. There is a videotape of the events on the bus which shows him slumped in the wheel well some time out of Launceston[35]."

158. Toxicological analysis of samples taken at autopsy found therapeutic levels of Olanzapine and Panadol to have been present in Mr Monson's body at the time of his death.

159. I make the following formal findings on the basis of the evidence pursuant to section 28(1) of the *Act* in respect of the death of Troy Colin Monson:

a) The identity of the deceased is Troy Colin Monson;
b) Mr Monson's death occurred as a result of partially suspended hanging, an action undertaken by him voluntarily and with the express intention of ending his own life;
c) The cause of Mr Monson's death was asphyxia; and
d) Mr Monson died in a Prison Van whilst on route from Launceston Reception Prison to the Risdon Prison Complex at Risdon in Tasmania on 22 June 2015.

[35] Exhibit C295 at pages 9-10

Mr Monson's Care, Supervision and Treatment whilst in Custody

160. The care, supervision and treatment afforded to Mr Monson whilst in the custody of Tasmania Police at Burnie on 17 June 2015 was not of an acceptable standard. Specific concerns that Mr Monson was feeling suicidal were recorded and passed on by an officer but were ignored. No medical practitioner was called. No written information about Mr Monson's suicidal ideation or behaviour generally was passed on to TPS when Mr Monson's custody passed from Tasmania Police to TPS.

161. The care, supervision and treatment afforded to Mr Monson whilst in the custody of the TPS in Launceston between 17 June 2015 and 22 June 2015 was not of an acceptable standard. Mr Monson was not processed within two hours required by DSO 2.06 (Order 6.1 second occurring). No assessment in relation to suicide and self-harm was conducted within two hours of his being received into custody contrary to Order 9.1 of DSO 2.01. The corrections Tier 1 completed after 8.00am on 18 June 2015 was deficient. The health tier 1 completed on the same day was deficient. The fact that Mr Monson was prescribed an atypical antipsychotic medication without being physically seen by a medical practitioner was unacceptable. The fact that no RIT assessment was carried out on Mr Monson while he was in custody between 17 and 22 June 2015 was unacceptable. That no RIT operated at LRP in June 2015 (in breach of order 14.1 of DSO 2.01) was unacceptable. The fact that Mr Monson was not identified as being 'at risk' of suicide or self-harm at any time whilst in the custody of TPS in June 2015 was unacceptable. The decision to transfer Mr Monson to Hobart on 22 June 2015 was made without reference to any guidelines. No steps were taken, at all, to ensure Mr Monson's safety during the transfer. The decision to transport him on the ordinary escort was a poor one. He was wrongly classified in terms of DSO 1.20. No SASH Mandatory Notification form was raised in breach of DSO 2.01. No interim risk treatment plan or risk treatment plan was raised in breach of DSO 2.01. The escort officer and driver were not advised as to the reason for Mr Monson's transfer and in particular that he had expressed suicidal ideation shortly before he was placed on the escort vehicle. The escort officer failed to monitor Mr Monson in his pod, adequately or at all, in breach of DSO 1.20.

Circumstances Surrounding the Death of Robin Michael

Arrest and Entry into Custody

162. Robin Michael was at the time of his death held on remand in Sorell A block, medium security section, RPC. He was in custody pending his trial on a charge of murdering his wife.

163. The background in relation to Mr Michael is that he was born on 17 August 1951 and that apart from a history of type I diabetes in the decade or so leading up to his incarceration and death, his health appears to have been good. The evidence was that he was a highly experienced senior health administrator who apparently

enjoyed (or considered that he enjoyed) a measure of social standing in Adelaide, South Australia. Evidence from those that knew him well indicated that he was regarded as intelligent and accomplished. He was the father of three adult children.

164. It is evident that Mr and Mrs Michael had suffered, in the lead up to her death and his incarceration, a period of matrimonial disharmony. Mr Michael seems to have formed the view that his wife was having an affair, a view that appears to have been without any foundation in fact. The couple were holidaying in Tasmania and following an argument whilst bushwalking on the top of Mt Roland on the North West Coast, Mr Michael bashed his wife to death with a rock, left her body where she fell, and returned to the couples' caravan at the East Devonport Discovery Caravan Park where, in an attempt to commit suicide, he took an overdose of drugs.

165. On the morning of 12 February 2015, Mr Michael was located by uniform police in the couples' caravan. Police were concerned to locate Mr and Mrs Michael because of a message posted by him on Facebook. Sergeant Luke Bishop located the couples' caravan and after turning off the gas and breaking into the caravan with the assistance of a locksmith, found Mr Michael lying in the centre of a double bed at the end of that caravan. Sergeant Bishop said in his evidence that Mr Michael was unresponsive, his eyes were partially open and he was making “gurgling” noises. Sergeant Bishop immediately called for assistance and in particular an ambulance. He saw a number of medical items on a bench in the caravan. He placed Mr Michael in the recovery position and noticed a large amount of fluid come from his mouth.

166. Constable William Smith was the next officer to attend the caravan park. He assisted Sergeant Bishop in searching the caravan in an effort to attempt to locate information as to Mrs Michael’s whereabouts. He remained with Mr Michael until the arrival of ambulance paramedics.

167. Upon the arrival of the ambulance, Mr Michael was transported to the Mersey Community Hospital at Latrobe. Constable Smith travelled in the ambulance with Mr Michael whilst Sergeant Bishop remained at the scene. Constable Smith gave evidence that Mr Michael regained consciousness in the ambulance. Upon his regaining consciousness, he was cautioned and then asked questions about the whereabouts of his wife. Constable Smith said, and I accept, that he remained in the presence of Mr Michael for some hours and had a number of conversations with him during that time. He said that it was his view Mr Michael seemed disinterested in finding his wife and showed no concern at all that she was missing. In Constable Smith’s opinion, Mr Michael was only concerned about his sugar level (in respect of his diabetes) and the obtaining of a drink, as he was thirsty[36].

168. Detectives attended the Mersey Community Hospital and spoke to Mr Michael. During that conversation, he made admissions about assaulting his wife

[36] Exhibit C157, Page 3.

with a rock and gave an indication as to where her body would be found. Police were then able to search for, locate and recover Mrs Michael's body using a helicopter.

169. Mr Michael was initially charged with assault. Later the same day (that is, on the afternoon of 12 February 2015) after the discovery of Mrs Michael's body on Mt Roland, he was charged with her murder.

170. The next day, 13 February 2015, having been assessed at the Mersey Community Hospital and deemed medically able to be interviewed by police, an interview took place. During that interview, he made admissions to police about repeatedly striking his wife to the head with a rock following an argument at the top Mt Roland. After his release from hospital the same day, he was conveyed to the Devonport Police Station and there he was presented to the duty sergeant and formally charged with murder. He was detained for appearance at the Devonport Magistrates Court. After appearance in court, he was remanded in custody and transferred to the custody of the TPS.

Mr Michael's Medical Treatment in Custody

171. At the inquest, all of Mr Michael's medical records held by CPHS were tendered[37] and able to be examined in detail. I am satisfied that those records were complete. The following findings are based upon an analysis of those records together with evidence from relevant health care professionals involved in Mr Michael's management. His first contact with CPHS was shortly after his custody was transferred to TPS on 13 February 2015. Registered Nurse Daniel Fassett completed a health Tier 1 with Mr Michael. The health Tier 1 returned a total prison index score of 23%, self-harm scope of 15, socio-economic score of 10 and a worry score of 12. The evidence was that the scores were such as to be indicative of moderate risk and the need for urgent referrals to be considered. RN Fassett recorded all of this in the medical records and made a plan in his note of 14 February 2015 indicating mandatory notification, partial RIT, daily review, medical officer review and the need to discuss medication and diabetes. The records show that Mr Michael was reviewed on 15, 16 and 17 February and then transferred to the Needs Assessment Unit (NAU) at RPC on 18 February 2015.

172. The evidence was that on 18 February 2015, RPC was notified of the need for review by a PLN, upon Mr Michael's arrival at that facility. The records also indicate that prior to his being remanded in custody the management of Mr Michael's diabetes was identified as a medical issue.

173. Upon his arrival at RPC on 18 February 2015, Mr Michael was reviewed by Registered Nurse David Noble. RN Noble gave evidence. His notes were in evidence[38]. Those notes indicate that Mr Michael claimed he could not remember the

[37] Exhibit C360
[38] Exhibit C360, Patient Consultation Summary List, Page 4

events that brought him into prison (I observe that this is contrary to the admissions that he made to police). The notes indicate Mr Michael denied being able to recall attempting to kill himself. The notes indicate that he felt in a better frame of mind after speaking to a lawyer and denied any previous self-harm history. RN Noble noted that he considered that Mr Michael presented as unrealistically optimistic and positive, that he appeared to be endeavouring to overcompensate, and that boredom and an inability to communicate with family would pose challenges for him.

174. RN Noble noted that there were challenges to housing him in the prison hospital because the cells were not safe, and that he would need a "custodial officer outside his cell at all times if he [was] to be on a level of watch". Evidence was that Mr Michael was initially put on level 3 watch.

175. The medical records indicate a full RIT was conducted on 20 February 2015 by Ms Fiona Montgomery, Ms Chloe Hall and Correctional Supervisor Blanden. The evidence in relation to that procedure was that Mr Michael appeared to those conducting it to be settled in, coping well, but seemed to have no proper understanding of the likelihood of the length of time he would spend on remand. He specifically denied any ongoing SASH ideation or intent. He claimed that his recent suicide attempt related to being "out of control" of his circumstances (I observe that two days after claiming to have no memory of an attempt to kill himself he was now explaining that action). The notes indicate that Mr Michael identified that incarceration was difficult to adjust to, especially the loss of control of his diabetes medication. His watch level was reduced from 3 to 4 but he remained housed in the inpatient section of the hospital at RPC[39].

176. Dr Wake spoke to him the same day in relation to the management of his diabetes. He made notes of that consultation in Mr Michael's medical records. The notes indicate that the consultation was unremarkable although they do record that Mr Michael, not surprisingly, was having difficulty adjusting to life in prison.

177. Another RIT review, this time conducted by Mr Simon Walker, Ms Chloe Hall and RN Noble, occurred on 25 February 2015. As a result, Mr Michael was moved from the prison hospital. It was recorded that he appeared to have unrealistic expectations but was noted to be polite and easier to engage with. Observations of him continued but were reduced to every two hours.

178. He was reviewed again on 2 March and 11 March 2015, the latter being another RIT conducted by Ms Amanda Beard, Ms Fiona Montgomery and Correctional Supervisor Blanden. Again, he denied SASH ideation or intent. He appeared settled and relaxed. He was reduced on alert and cleared for transfer from the NAU to the medium section of RPC, discharged from RIT but left to be followed-up by TSU.

[39] Exhibit C360, Patient Consultation Summary List, Page 5

179. The evidence in the medical records indicated reviews on 17 and 25 March, which were both unremarkable. A "Code Blue" was called at 5.00pm on 29 March 2015 when Mr Michael appears to have suffered from a hypoglycaemic attack. This was notwithstanding his self-reporting a blood sugar level, which was not sufficiently low to cause a hypoglycaemic attack. The medical notes indicate a question arising as to whether or not his measurement was accurate or whether there had been self-sabotage on his part. In any event, he was transferred to the inpatient section of the prison hospital at RPC for further monitoring. The notes record that he expressed gratitude for the care he received.

180. Some further problems with Mr Michael's insulin regime, and the management of his diabetes, are noted in his medical records on 1 April 2015. On 5 and 6 April, he was reviewed again in relation to a dental abscess and insulin management respectively.

181. On 7 April 2015, Mr Michael made a complaint to the Health Complaints Commissioner about his medical treatment in prison, in particular with respect to his diabetes management. That was responded to by Dr Wake on 24 April 2015. Dr Wake's response was tendered in evidence[40]. The response summarises the care provided by the CPHS. That summary is as set out above. Counsel assisting submits the care provided to Mr Michael was completely appropriate. The complaint to the Health Complaints Commissioner was in my view without any merit whatsoever.

182. Mr Michael was reviewed again by Dr Wake on 27 April 2015. Once again, it was noted that Mr Michael was bored with the prison environment. Mr Michael reported that the prison environment did not allow him the type of mental stimulation he was used to in the community. Dr Wake noted that he did not go into issues of self-harm or suicide on that day, but that he would "rate [Mr Michael] at potential high risk in the future if his case [did] not go well". Issues with respect to his diabetes management review were discussed. Dr Wake even discussed with Mr Michael, given his experiences as a health administrator, that he might be engaged to assist CPHS with accreditation. The suggestion was not followed up.

183. The notes reveal that Mr Michael underwent dental treatment on 14 May 2015. He received anti-inflammatory gel on 16 May 2015, and sought an appointment with a physiotherapist to treat right elbow pain on the same day. On 28 May 2015, he had more dental treatment when a tooth was extracted.

184. He was next seen on 12 June 2015 when a partial RIT was conducted as a consequence of a mandatory notification raised as a result of concerns expressed by an inmate Mr Andrew Semmens. The partial RIT was unremarkable. It was conducted by RN Geoffrey Clifford and Ms Kylie Beard, a counsellor from TSU. It was agreed that placement of Mr Michael in the RIT process was not required. That

[40] Letter Dr Wake to Ms Therese Lesek, Health Complaints Commission 24 April 2015 (Part of Exhibit C360)

decision in my view is unassailable. The notes reveal at the review that Mr Michael was settled and engaged. He discussed his current activities, future goals and intentions with respect to his upcoming court case, and the possibility of a transfer to prison in South Australia. He specifically denied any SASH ideation or intent and, perhaps for the first time, was realistic about the length of time he may be in prison.

185. The evidence in relation to the medical care afforded to Mr Michael whilst he was in custody leads only to the conclusion that it was of an appropriate standard at all times. His physical and mental health was as well catered for as the circumstances of his incarceration allowed. Appropriate mental health assessments of him were conducted and acted upon. His mental health and well-being was monitored. When concerns with respect to his mental health were passed on by another inmate the concerns were treated seriously and the subject of proper investigation. Whilst incarcerated he received appropriate dental treatment and the necessary level of management and support in relation to his diabetes. His records indicate he was seen by CPHS nearly 100 times between 12 February 2015 and 16 June 2015.

186. It is plain, given the benefit of hindsight, that Mr Michael was a suicide risk. He was accurately assessed as such by Dr Wake but he kept the warning signs hidden from those with the responsibility of caring for him and those close to him. Counsel assisting submits that in the absence of any objective warning signs, there was little CPHS, TSU and TPS could have done to prevent Mr Michael's death in custody. I agree.

Mr Michael's Death

187. I turn to consider the response of TPS personnel on 29 June 2015. CCTV footage of movements in and out of the Sorell A unit was tendered in evidence[41] and viewed during the inquest. The footage supports entirely the testimony of both inmates in Sorell A as to their movements and reactions and also the evidence of correctional and other prison staff.

188. The evidence was that Mr Michael had been housed since March 2015 in Sorell A block of the medium security area of RPC. Photographs of that block and the floor plan relating to it were tendered in evidence[42]. It housed, in addition to Mr Michael, inmates Brett Bonnitcha, Robert Bowden, Mark Mason, Peter Robertson and Craig Field. Each of those inmates gave evidence at the inquest. The evidence of the inmates was that Mr Michael was having no difficulty with any other inmate. Aside from the usual concerns associated with prison life, no one was conscious of any special difficulty Mr Michael was experiencing. There seems no suggestion that

[41] Exhibits C166 and C167
[42] Exhibit C9

anyone was threatening him or having problems with Mr Michael nor was Mr Michael having any problems with any other inmate.

189. Another inmate (already mentioned), Mr Semmens, serving a sentence for murder and also housed in medium security (but not Sorell A), also gave evidence. He said that he met Mr Michael in February 2015, they became friendly and that he supported Mr Michael as he, Mr Semmens, was accustomed to the prison system.

190. Mr Semmens gave evidence that they spent time together for a couple of hours most days and in that time would discuss life in general, prison life, family and such like. Mr Semmens gave evidence that Mr Michael indicated he was finding it hard to keep himself entertained and, because of his age and education, (he was older and better educated than most inmates), he was finding it hard to relate to other inmates. Nonetheless, there is no evidence or any suggestion he was having any particular difficulty with any particular inmate. Indeed, Mr Semmens says Mr Michael was friendly and got along with other inmates.

191. Mr Semmens said that a couple weeks prior to 12 June 2015 Mr Michael asked him (Mr Semmens) if he had ever considered committing suicide. The pair discussed the topic a few times over the next couple of weeks and as a consequence of Mr Semmens becoming concerned about Mr Michael's state of mind he spoke to a member of staff of CPHS. This discussion led to the partial RIT assessment occurring on 12 June 2015, already mentioned in this finding.

192. Mr Semmens also gave evidence that in mid-June Mr Michael told him that his son had asked him to not call every day and that, the request had "got him down". Mr Semmens said that he told Mr Michael that he couldn't commit suicide now, as his son would think it was his fault. Mr Michael told Mr Semmens that he would not do so. It should be noted that two other inmates housed in Sorell A gave evidence that was broadly consistent with Mr Semmens' account of Mr Michael being distressed by reason of one or other of his sons suggesting a reduction in contact. However, for reasons that will be discussed later in this finding, I am not satisfied that there was any such request by either of his sons, although it may be Mr Michael thought there was.

193. On the day before his death, Mr Michael went to see Mr Semmens who was engaging in boxing training. Mr Semmens said that he was busy and told Mr Michael as much. He said that he told Mr Michael he would come and see him later. After completing training and showering he forgot to go and see Mr Michael. Mr Semmens gave evidence at the inquest that he now believes the purpose of Mr Michael's visit on 28 June 2015 was to say goodbye. He may well be correct, but it is impossible to express a concluded view about that.

194. Returning to the issue of telephone contact with his sons, a review of telephone call records does not support the conclusion that there was a reduction in any way in contact between Mr Michael and either of them. The records demonstrate

that he was in regular contact with both (as well as with his sister) from when he went into custody until his death. By way of example, in the two weeks prior to his death he spoke to his son Brett for periods in excess of three minutes on 17, 20, 22, 24, 26 and 28 June. He spoke to his son Ben for periods in excess of three minutes on 19, 26 and 28 June. On 28 June 2015, he spoke to both of his sons and his sister.

195. Indeed, there is no discernible pattern at all as to the frequency of contact other than that the calls to his sons and sister remained reasonably regular and certainly did not diminish in the lead up to his death.

196. Evidence was given at inquest by Mr Michael's son, Brett Michael, and Mr Michael's sister, Janet Michael. Brett Michael said that sometimes his father's calls would occur whilst he (Brett) was at work and in meetings and so he endeavoured to encourage his father to ring at more suitable times but did not request any reduction in calls. He said there was never any mention of self-harm or suicidal ideation by his father. Brett said he rang and spoke to his father the day before his suicide and nothing seemed out of the ordinary.

197. Janet Michael, gave evidence. She also last spoke to her brother on 28 June 2015 (the day before his death). She described him as lacking his normal vitality and demonstrating little animation and that he appeared hollow and empty, but noted there was nothing out of the ordinary mentioned in the conversation on 28 June 2015. Specifically, there was no mention by Mr Michael of any intention to self-harm or commit suicide.

198. Mr Michael spent the evening of 28 June 2015 as normal. None of the other inmates with whom he shared Sorell A block noticed anything unusual about his behaviour. At about 5.30pm he went to his cell and locked his door (the cells doors in the unit are able to be locked from the inside, but also opened by officers from the outside). No one saw him alive again.

199. At about 7.00am on 29 June 2015 Inmate Peter Robertson alerted prison guards via the Sorell A intercom of concerns in relation to Mr Michael. Mr Robertson gave evidence that he had gone to bed and locked his cell door at 9.00pm the night before. At about midnight, and again at about 4.00am, he got up to go to the toilet and noticed that Mr Michael's cell light was on. He said he got up at 6.00am and again noticed Mr Michael's light still on. Concerned, he looked under the door of Mr Michael's cell at about 7.00am and could see one of Mr Michael's feet on the ground. He said he called out to Mr Michael but received no response and saw no movement. As a consequence, he alerted the prison guards by the intercom immediately. His evidence was that the prison guards took 5 to 10 minutes to arrive. However, I am satisfied that is not correct when regard is had to the CCTV footage. The objective evidence is that it was at 7:02am when the Code Blue was called over the radio. Several correctional officers responded immediately and arrived in less

than three minutes. Officers entered the cell and found Mr Michael hanging with what appeared to be a shoelace around his neck. He was cut down and thereafter attempts were made at CPR, even though it was clear that Mr Michael was obviously dead. An ambulance and nurse were sought by radio and a crime scene log was commenced.

200. At 7.23am paramedics arrived and told prison staff to stop CPR. They did.

201. A review of the actions of the correctional staff leads to the conclusion that the collective and individual response was entirely appropriate. It was in accordance with the documented standard operating procedures (emergency operating procedure 03). Nothing could have been done to save Mr Michael. By the time prison officers intervened (and the response was extremely timely once alerted) Mr Michael was dead and had been for some time.

202. I commend the efforts of the officers involved in doing everything they could for Mr Michael. In particular I comment that the efforts of Correctional Supervisor Gavin Rutledge and Correctional Officer Roger Moore in commencing and continuing CPR on Mr Michael are worthy of recognition.

203. Nurses from CPHS, namely Nurses Dobson, Cormie and Bucirde responded in a way that was timely and appropriate. The nurses attended with the appropriate emergency equipment including a defibrillator and oxygen. They confirmed the observations of the correctional officers to the effect that Mr Michael was stiff, his tongue was completely blue and swollen, and his teeth clamped shut. No pulse was able to be located.

204. TPS staff contacted Tasmania Police shortly after 7.30am. Uniform police attended first where upon their arrival they were escorted to the Sorell A unit. First responding officers, Constables Benjamin Reid and Kade Walsh, were met and briefed by Deputy Chief Superintendent McCafferty. Other uniform, forensic and Criminal Investigation Branch officers followed. The investigation in relation to Mr Michael's death commenced at the same time. Witnesses were interviewed and statements taken. Relevant CCTV footage was reviewed and saved. Arrangements were made for the formal interview of all witnesses, including prisoners and prison officers. Mr Michael's body was removed from the scene by mortuary ambulance and transported to the Royal Hobart Hospital where an autopsy was carried out by Dr Christopher Lawrence. Samples taken at autopsy were subsequently reviewed and subject of toxicological analysis at the laboratory of the Forensic Science Service Tasmania. That analysis proved unremarkable. Paracetamol and ibuprofen were found to be present in therapeutic and sub-therapeutic amounts respectively.

205. Dr Lawrence expressed the opinion,[43] which I accept, that the cause of Mr Michael's death was hanging. The autopsy revealed a typical suspended ligature

[43] Exhibit C297, page 10

mark. Dr Lawrence identified no unusual features but did note that Mr Michael appeared to have been hanging for some time, a conclusion he reached as a consequence of his observing the marked dependent lividity.

206. A search of Mr Michael's cell revealed that the ligature had been made from plaited shoelaces. The ligature would have taken some considerable time to make. In turn, it was attached to a piece of ribbon, which was then threaded through heater vents in the ceiling of the cell. After placing the ligature with a slip knot around his neck it is apparent he stood on a chair in his cell and then suspended himself.

207. The efforts Mr Michael went to to construct the ligature suggest that his suicide was one planned some time in advance of the actions which led to his death.

208. Based on the evidence summarised above I make the following formal findings pursuant to section 28(1) of the *Act* in respect of the death of Robin Michael:

a) The identity of the deceased is Robin Michael;
b) Mr Michael's death occurred as a result of hanging, an action undertaken by him voluntarily and with the expressed intention of ending his own life;
c) The cause of Mr Michael's death was asphyxia; and
d) Mr Michael died in Cell 5 of Sorell A Unit, Medium Security Precinct of the Risdon Prison Complex between 28 and 29 June 2015.

Mr Michael's Care, Supervision and Treatment whilst in Custody

209. It is necessary to report in relation to the care and treatment of Mr Michael. Counsel assisting submits, and I find, that Mr Michael was appropriately treated by CPHS staff, appropriately treated by TSU staff, appropriately cared for and supervised by TPS staff, and appropriately treated by Ambulance Tasmania personnel.

210. I am quite satisfied that his death was properly and fully investigated by Tasmania Police.

211. Mr Michael's actions were not impetuous. Given his efforts in constructing the ligature, it is plain that he had been planning to take his own life for some period of time. He had discussed suicide with Mr Semmens. There can be little doubt that he was suffering psychological difficulties in adjusting to prison life and the consequences of the killing by him of his wife. It is not surprising that he chose to take his own life. He kept the warning signs well hidden from those charged with his care. There were no objective warning signs and in their absence little that anyone could have done to have prevented this death in custody.

212. It was clear on the evidence that it was apparent to everyone who entered Mr Michael's cell on the morning of 29 June 2015 that he was dead and had been for a considerable period of time. He was described as stiff with his tongue protruding out

of his mouth. He was blue in colour and his mouth and tongue were swollen. One officer, Correctional Officer Nathan O'Dowd, said that Mr Michael's legs and arm stayed in the same position when CPR was performed upon him as when he had been hanging. Plainly, *rigor mortis* had set in (and Correctional Officer O'Dowd recognised as much). Medical professionals in the form of nurses were present. The decision to continue CPR in accordance with Emergency Operating Procedure 03 'Code Blue' was futile and must have been distressing to the officers performing it. In my view, the applicable Emergency Operating Procedure needs to be reviewed. It is ambiguous in that step 7 provides that First Aid (which necessarily must include CPR) is to be continued 'until CPHS staff attend and/or a paramedic or doctor pronounces death'. To the extent that it is capable of being read as requiring CPR to be continued in the circumstances that occurred with Mr Michael it is pointless and, as has already been noted, likely to cause quite unnecessary distress to officers responding to an emergency.

I recommend that the Tasmanian Prison Service review Emergency Operating Procedure 03 'Code Blue' regarding the continuation of CPR.

213. I note that on the evidence there was a slight delay, inconsequential in the context of this case, but potentially life threatening in similar cases, in obtaining a cut down knife. The evidence from Chief Superintendent Maxfield was that on 10 July 2015 all RPC staff were directed that from that date all first and second response teams were to carry a cut down knife. In addition to this, cut down knives are now located in each accommodation area and also in the escort vehicles. These changes to procedures with respect to the location and utilisation of cut down knives are to be commended.

I recommend that the carrying of cut down knives by first and second response teams continue and that cut down knives continue to be located in each accommodation area and carried in escort vehicles.

214. Mr Michael was able to commit suicide by hanging as a result of hoarding many pairs of shoelaces from which he was able to fashion the ligature with which he hanged himself. The question arises as to whether or not there is any need at all in a secure prison environment for lace up shoes. Put another way, the question as to whether or not all inmates should be issued with slip on or Velcro fastening shoes as appropriate needs to be considered. It is accepted that nothing perhaps might have been done to prevent Mr Michael, determined as he was, from taking his own life, but no reason appears why shoelaces should be available within the prison, presenting as they do a convenient ligature for those inmates contemplating suicide by hanging (and in that regard see also in re Noel Alan Percy [2014] TASCD 000, a

matter also concerned with the suicide by hanging of a remandee in a cell in medium security who also used a shoelace as a ligature).

215. Accordingly, although acknowledging the submissions of Mr Turner, counsel for the TPS, on this point, I am satisfied it is appropriate to make a recommendation.

I <u>recommend</u> that slip on footwear replace all footwear with laces for all prisoners and detainees in the Tasmania Prison Service.

<u>Circumstances Surrounding the Death of Scott Clifford Mitchell</u>

Mr Mitchell's Background

216. Scott Clifford Mitchell was born on 26 June 1992. He died of natural causes on 31 July 2015 and was therefore 23 years of age when he died. He was serving a period of imprisonment, having been sentenced for aggravated robbery. He was first incarcerated on 15 July 2014 on that charge.

217. Mr Mitchell was single and had no children, and at the time of his imprisonment was unemployed. He was educated to high school level. Mr Mitchell developed a habit of personally injecting methylamphetamine on a daily basis. Anecdotal evidence suggests that this habit continued until about four months prior to his imprisonment.

218. Mr Mitchell's prison record was tendered at the inquest[44]. It reveals the following movements:

a) He went into custody on 15 July 2014 and was transferred to LRP;
b) On 16 July 2014 he was transferred to RPC;
c) Between 16 July 2014 and 8 August 2014 he was housed in the maximum security area of RPC;
d) On 8 August 2014 he was transferred to LRP;
e) Between 8 August and 13 August 2014 he was housed at LRP;
f) On 13 August 2016 he returned to maximum security at RPC (Derwent A);
g) On 15 September 2014 he was transferred to RBMSP and was housed in Division 4 cell 37;
h) Between 15 and 18 September 2014 he was housed in cell 21 of Division 4 of RBMSP;
i) Between 18 September 2014 and 3 January 2015 he was housed in cell 28 of Division 4 of RBMSP;
j) Between 3 January and 1 March 2015 he was housed in cell 10 of Division 4 of RBMSP; and

[44] Exhibit C345

k) From 1 March 2015 until his death, he was housed in cell 35 Division 4 of RBMSP.

219. Mr Mitchell was eligible for parole in September 2015. His earliest release date without parole was 17 January 2016. His latest release date was 4 June 2016.

Mr Mitchell's Health

220. A good deal of the evidence at the inquest as far as it concerned Mr Mitchell's death related to a review of his medical records both before, and during, his period of incarceration. Tendered in evidence were records from his general practitioner's practice in Devonport, the Valley Road Medical Centre[45].

221. According to the records, Mr Mitchell attended that practice twice in May 2010, twice in May 2011, once in October 2011, twice in July 2013, once in September 2013, twice in November 2013 and once in December 2013.

222. The attendances in July 2013 dealt with substance addiction (amphetamines) a 'violent outburst' and some suicidal ideation. He was referred to the Department of Emergency Medicine at the public hospital in Burnie but after assessment by their mental health team, he was determined to be neither psychotic nor suicidal.

223. Upon his entry into the Tasmania Prison System, there was no indication of physical or mental health concerns. The results of his health Tier 1 conducted by RN Fassett on 15 July 2014 were, relatively speaking, unremarkable. His total prison risk index score of 10% was low[46].

224. Thereafter he was in reasonably regular contact with the prison health service. He was reviewed in August and September 2014 and issues such as his hepatitis C status and sleep difficulties were addressed. In late December 2014, both blood and a urine specimen were taken and he received treatment on 30 December 2014 for an open graze on his left knee. Treatment in January 2015 and February 2015 dealt with a carpet burn, received during a sports day, and diarrhoea.

225. His health seems to have been relatively unremarkable and his treatment regular and appropriate.

226. Chief Superintendent Maxfield gave evidence in relation to Mr Mitchell's accommodation whilst serving his sentence. She explained to the inquest that the Sentence Management Review Panel is the entity with responsibility for reviewing a prisoner's security classification and then determining appropriate accommodation placement. Classification placement is dealt with in DSO 2.04. The Sentence Management Review Panel applies DSO 2.04 to appropriately determine the prison

[45] Exhibit C258
[46] Exhibit 309

security requirements and to ensure that the prisoner or detainee is accommodated properly.

227. Evidence from Chief Superintendent Maxfield was that after classification, Mr Mitchell was one of but a handful of inmates transferred from maximum security directly to minimum security without spending at least some time in medium security. This occurred because the Assistant Director of Prisons granted the minimum security rating to Mr Mitchell (notwithstanding the Sentence Management Review Panel's recommendation that he be rated "medium") because Mr Mitchell was compliant in his behaviour, very willing to work, and desirous of furthering his education.

228. After his classification as minimum security on 15 September 2014, Mr Mitchell was, thereafter, until his death, housed in the RBMSP. Extensive evidence was given by the officer in charge of that facility Superintendent Shaun Wheeler. He explained that the duties of the superintendent of RBMSP are to oversee the operations of that facility. He explained at some length the method by which prisoners can access medical services. Importantly, Superintendent Wheeler said that the TPS has no input into when medical assistance will be provided (the only exception being that if TPS first call an ambulance before CPHS is notified). Superintendent Wheeler explained ordinarily most medical information is not shared with TPS by CPHS due to patient confidentiality. His evidence coupled with the evidence of CPHS medical staff satisfies me that there was no impediment to inmates in RBMSP to accessing appropriate medical treatment in a timely manner, at the time of Mr Mitchell's incarceration, or subsequently.

229. Superintendent Wheeler gave evidence in relation to Code Blue emergency procedures for the RBMSP. The procedures are not materially different from those in other areas of the TPS.

230. Evidence also was given with respect to the physical layout of the six divisions that comprise RBMSP. At the time of his death, Mr Mitchell was housed in Division 4. An overhead photograph which dealt with all six divisions and a plan with respect to the layout of the division were tendered[47].

231. Evidence from staff and inmates alike in relation to Mr Mitchell was that he seemed healthy, was very popular with his fellow inmates, "happy-go-lucky", and fully engaged in prison life, including in particular Australian Rules football. He was employed as a wardsman whose job it was to deliver meals to fellow inmates. He seemed to have had a good work ethic and a wide circle of friends.

232. The evidence was that the daily routine in the RBMSP at the time of Mr Mitchell's death followed a fixed timetable. The nightly curfew came to an end at 6.30am in the morning at which time inmates are permitted to move from their cells.

[47] Exhibit C221

At 7.15am, a morning muster parade was held followed by medication parade at 7.30am. At 8.00am, inmates moved to the respective industry, labour, or education programs. At 11.45am, all inmates returned to accommodation and a muster parade was held preparatory to lunch. Lunch was served at noon. At 12.30pm, inmates returned to their work, education, or were able to exercise on the oval and take part in, and receive, visits. Another medication parade was held at 4.00pm and the evening meal served at 4.45pm. At 6.00pm, the final muster for the day was carried out in the division. The gates of the RBMSP were then locked. Inmates were free to move around inside the division until 9.30pm when inmates were required to be locked away in their cell as the night curfew commenced.

233. The evidence was that on Friday 31 July 2015 inmates and staff in the RBMSP followed the routine set out above. During the day, Mr Mitchell worked in the kitchen with Inmate Toby George and others. Work finished there at about 2.00pm. Mr Mitchell then was involved in the delivery of the evening meal within his division. Inmate Brodie Challis saw him in the afternoon between 2.00pm and 3.00pm and Mr Mitchell appeared to him to be fine. Mr Challis saw him later delivering the meals and again he seemed fine.

234. A matter of minutes before his collapse, Mr Mitchell walked past the cell occupied by Inmate Timothy Briers. They shared a joke, and according to Mr Briers, Mr Mitchell seemed well and in good spirits.

235. Just prior to the delivery of meals, Inmate Tristan Neulist, housed in Division 4 cell number 24, spoke to Mr Mitchell. He had known Mr Mitchell for most of Mr Mitchell's life. Mr Neulist was in Mr Briers' cell when he described Mr Mitchell entering the cell at about 5.00pm. Mr Neulist described Mr Mitchell as being his "usual self". He said he was "happy, mucking around with everyone. He seemed fit and healthy to [him], basically a normal 20 odd [*sic*] years old".

236. The evidence was that at 5.31pm Mr Mitchell was seen to enter his cell. At 5.44pm, he was discovered motionless on the floor of the cell by Mr Neulist, who described seeing Mr Mitchell's arms up over the toilet bowl. He asked Mr Mitchell if he was all right but received no response. After attempting CPR, Mr Neulist called out for help and very shortly thereafter correctional officers arrived.

237. CCTV footage taken from the three cameras in the division was tendered.[48] It was played at the inquest. I conclude that the timings relating to Mr Mitchell's death were as follows:

238. 5.44.30pm Mr Mitchell was discovered in his cell by Mr Neulist who immediately called for help. At precisely 5.46.16pm the first correctional officers entered Mr Mitchell's cell. Less than two minutes later, at 5.48pm, nurses from the medical centre, Ms Alice Cormie and Ms Lyndell McManus, carrying the appropriate

[48] Exhibit C332

medical resuscitation equipment, arrived at Mr Mitchell's cell. I am satisfied on the evidence that correctional officers were in Mr Mitchell's cell almost immediately after the Code Blue was called. There was no delay whatsoever in relation to the response of TPS staff. Nor was there any delay in relation to the response of prison health staff. Correctional Officers Blair Saville and Nicola Gornik responded to the alarm raised by Inmate F (who in turn seems to have reacted to Mr Neulist's call for help). Correctional Officer McMahon also responded. The officers arrived together and commenced competent CPR. The nurses arrived as already indicated within two minutes of the first three officers and took over the attempts to resuscitate Mr Mitchell. A defibrillator was attached to his chest, which advised no shock (indicating that no heart rhythm was detected). CPR continued until the arrival of the ambulance crew 10 minutes or so later. An attempt was made to resuscitate Mr Mitchell using the ambulance defibrillator but without success. Adrenaline was administered by ambulance paramedics without success. Compressions continued until 6.34pm (the compressions being carried out by correctional officers under the direction of paramedics) when at that time they were instructed by ambulance officers to cease as Mr Mitchell was deceased. A clean doona was placed over Mr Mitchell by one of the correctional officers, and the door was locked and guarded until the arrival of police.

239. The investigation in relation to Mr Mitchell's death was commenced at the scene by uniformed police, forensic officers and officers from the Criminal Investigation Branch. Nothing was located in the cell occupied by Mr Mitchell, which gave rise to any cause for suspicion or concern. CCTV footage was secured and subsequently able to be furnished during the inquest. Witnesses were interviewed and statements taken. The scene was inspected by Dr Christopher Lawrence, the State Forensic Pathologist, who, after examining Mr Mitchell's body, pronounced life extinct. Photographs were taken and the scene was extensively forensically examined.

240. After formal identification, Mr Mitchell's body was removed from his cell and transported by mortuary ambulance to the Royal Hobart Hospital where an autopsy was carried out by Dr Lawrence. Dr Lawrence gave evidence at the inquest about Mr Mitchell's autopsy. A comprehensive report he prepared was tendered in evidence. At the time of conducting the autopsy and subsequent preparation of his report, Dr Lawrence had access to hospital notes from the North West Regional Hospital with respect to Mr Mitchell. The notes to which Dr Lawrence had access to indicated that as at 2 July 2013 Mr Mitchell had a three-year history of methylamphetamine use.

241. Dr Lawrence expressed the opinion that[49]:

> *"Scott Clifford Mitchell died of cardiac arrhythmia due to ischaemic heart disease and cardiomegaly due to methyl amphetamine use and high*

[49] Exhibit C299 a p10

cholesterol and triglycerides. His obesity may have contributed. In plain English he died of a heart attack due to narrowing of the arteries of the heart and the effects of methylamphetamine on the heart…… Examination at the scene suggests a possible cardiac cause of death. There are no significant traumatic injuries apart from some minor cuts to the left second and third fingers.

Autopsy reveals an enlarged heart which weighs 565 g and moderate to severe coronary atherosclerosis with 50 – 60% narrowing of the left anterior descending coronary artery. There is advanced atherosclerosis for a man of 23. This is probably due to two factors

1. *past methyl amphetamine use; and*
2. *high serum cholesterol and triglycerides.*

Normally ischaemic heart disease usually only causes death if there is a 75% stenosis, however there is cardiac hypertrophy and fibrosis consistent with amphetamine cardiomyopathy which may trigger an arrhythmia at less significant stenosis especially where collateral circulation has not had time to develop.

There may also be genetic/familial inherited high serum cholesterol triglycerides and the family members should probably have their serum cholesterol and triglycerides [tested] as they may also be at risk of premature ischaemic heart disease.

Toxicology reveals a nicotine level of .07 mg/L which is regarded as non-toxic. The presence of home-made cigarette in the toilet suggests he may have been smoking at the time of his death."

242. I accept Dr Lawrence's opinion as to the cause of Mr Mitchell's death. I note the evidence was the average weight of a heart is in the order of 300 grams and thus Mr Mitchell's heart was significantly enlarged. I advise members of Mr Mitchell's family to undertake the testing of serum cholesterol and triglycerides suggested by Dr Lawrence.

243. Samples taken at autopsy were subsequently analysed toxicologically at the laboratory of Forensic Science Service Tasmania. Those toxicological results were unremarkable. No drugs, either legal or illegal, were discovered as being present in the samples. Particularly important in the context of issues that arose at the inquest is that no evidence of any Panadol (or similar drug) was located as being present in those samples. The significance of the absence of Panadol or any similar medication is that had, as was suggested by Inmates Kent, Challis and George, Mr Mitchell been provided with Panadol in response to a complaint of chest pains then presumably he would have taken it. If he had then it would have been identified as being present in his body at the time of his death. The absence of Panadol or similar

medication in Mr Mitchell's body at the time of his death is one reason, of several, to positively disbelieve the story advanced by some of his fellow prisoners, a story I am satisfied which is without basis in fact. I cannot determine whether it was a deliberate lie on the part of the inmates who advanced it, presumably in an effort to discredit the CPHS and/or cause trouble in a general sense, or they were all in some way mistaken. In either case it was not true.

244. The evidence of Mr Kent is wholly incredible in the proper sense of that term. He said that on the day of Mr Mitchell's death he went to the nurse for a hepatitis injection and whilst there spoke to Mr Mitchell. In the discussion, Mr Mitchell (according to Mr Kent) said he was going to see a nurse because he had chest pain and felt a bit lightheaded. Later, according to Mr Kent, Mr Mitchell told him that he had seen a nurse and been given a couple of Panadol. However, Mr Kent's medical records show he was given a hepatitis B injection on 9 June 2015, a second one on 15 June and a third one on 30 June 2015. His medical records show no attendance on a nurse for a hepatitis injection, or indeed any purpose at all, on the date of Mr Mitchell's death. I am satisfied that Mr Kent's evidence about his interaction with Mr Mitchell on the day of his death was either deliberately untruthful or at least very badly mistaken, but in any event completely inaccurate.

245. I am unable to determine the motivation of the inmates who gave evidence about the provision of Panadol to Mr Mitchell by prison health staff on the day of his death. However it is quite clear to me that there is no truth whatsoever in that evidence. It is, as counsel assisting rightly pointed out, as unreliable as the demonstrably false evidence many of them gave that CPHS nursing staff dawdled to Mr Mitchell's cell. A significant amount of evidence was heard at the inquest from the various nurses who worked at the dedicated health centre at RBMSP and at the RPC. The evidence dealt with the procedures that attend complaints of chest pain and the dispensing of all medication (including 'over the counter' drugs such as Panadol).The evidence of the various nurses was not challenged. It was inherently plausible and reliable. The evidence also was that there was no record of any complaint, at any time, of chest or heart pain by Mr Mitchell. There was no record of any treatment, at any time, of Mr Mitchell for chest or heart pain. There was no record, at any time, of Panadol ever being dispensed to Mr Mitchell. In summary the weight of evidence is overwhelming that at no stage did Mr Mitchell seek treatment for chest or heart pain and at no stage was he given Panadol following a complaint of chest or heart pain, or for any reason.

246. I cannot leave the issue without observing that this wholly baseless claim caused unnecessary grief to Mr Mitchell's family at a time of great suffering for them. This is to be regretted.

247. In the same way several inmates, namely Mr Challis, Mr George, Mr Briers, Mr Neulist, Mr Bennett, Mr Cowie, Mr Rafter and Mr Williams suggested that the nursing staff did not hurry to Mr Mitchell's cell so as to provide him with treatment

after his collapse. There is no truth, whatsoever, in this allegation either. The CCTV footage tendered in evidence puts the issue beyond any argument. Two nurses were in Mr Mitchell's cell within three minutes of the initial code blue having been called. The CCTV shows one nurse (probably Ms McManus) jogging and the other walking briskly. Why the inmates would make the allegation they did is difficult to understand.

248. Although completely without any basis in fact, sadly Mr Mitchell's mother accepted there was truth in it. The untrue allegation, apart from reflecting unfairly on the professional response of the nursing staff that attended and attempted to resuscitate Mr Mitchell, also served to cause unnecessary grief to Mr Mitchell's family. It too is to be regretted.

249. The final issue which emerged for consideration was the issue with respect to the intercom call button at the front of division 4 in RBMSP. The evidence was that at the time of Mr Mitchell's death it was only in use after lock down, something since rectified. However in light of the findings with respect to the speed with which both TPS and CPHS staff responded to the Code Blue, the fact that the intercom did not operate during the day was irrelevant and had no impact at all in relation to Mr Mitchell's death.

250. I make the following formal findings on the basis of the evidence pursuant to section 28(1) of the *Act* in respect of the death of Scott Clifford Mitchell:

a) The identity of the deceased is Scott Clifford Mitchell;
b) Mr Mitchell's death occurred as a result of him suffering a heart attack in his cell whilst serving a period of imprisonment;
c) The cause of Mr Mitchell's death was cardiac arrhythmia due to ischaemic heart disease and cardiomegaly due to methylamphetamine use, high cholesterol and high triglycerides. Obesity may have been a contributing factor; and
d) Mr Mitchell died in the Ron Barwick Minimum Security Prison at Risdon in Tasmania on 31 July 2015.

Mr Mitchell's Care, Supervision and Treatment whilst in Custody

251. The care, supervision and treatment of Mr Mitchell whilst in the custody of the TPS were of an acceptable standard. He was appropriately treated and cared for by CPHS staff, appropriately cared for and supervised by TPS staff and appropriately treated by Ambulance Tasmania personnel.

Systems Issues - Corrections

252. It is convenient to turn to deal with broader systems issues concerning the deaths of each of the three inmates. A convenient starting point is the evidence from Chief Superintendent Maxfield who swore a number of detailed affidavits, which

involved, *inter alia*, a review of each of the deaths from the standpoint of the institutional responses to each[50].

253. From the correctional systems' point of view, the death of Mr Monson is without question the most troubling. That is not to diminish the significance of the deaths of Mr Michael and Mr Mitchell; however, the death of Mr Monson reveals multiple systems failures from both a Tasmania Prison Service perspective and to a much lesser extent Tasmania Police all of which contributed, in my view, to Mr Monson's death. Moreover, but for the multiple systems failures on the part of the TPS, Mr Monson's death was eminently avoidable.

254. Chief Superintendent Maxfield's evidence dealt in substantial detail[51] with the various identified shortcomings in relation to Mr Monson's care and supervision by the TPS. The candour of Chief Superintendent Maxfield is appreciated. Her identification of the various shortcomings is clearly supported by other evidence. As a consequence of her evidence, counsel assisting in detailed written submissions urged the following findings to be made. I accept those submissions and make the following findings.

255. When Mr Monson's details were entered into the CIS an automatic "previous SASH history" alert was generated on 18 June 2015 by CIS, however no mandatory SASH notification was raised by the correctional staff on a previous occasion. When Mr Monson was remanded in custody on 22 January 2015 at the LRP the Tier 1 stated no past SASH or current concerns, however CIS again generated an alert in relation to past SASH history, and staff at the time generated a mandatory notification on 23 January 2015 at which time Mr Monson was placed on a level 3 indirect watch i.e. observations at 30 minute intervals by CCTV.

256. When processing inmates, as has already been noted in these findings, correctional officers have the capacity to check prior episodes and case notes each time an offender returns to custody; however, in June 2015 at least so far as Mr Monson is concerned this did not occur as it should have. It is clear from the evidence at inquest that Mr Monson had a previous history of SASH. Even the most cursory check of Mr Monson's record would have shown this to have been obvious, well documented and a cause for concern in and of itself.

257. The corrections Tier 1 completed by Correctional Officer Steer and signed off by Correctional Supervisor Vandermeer on 18 June 2015 in respect of Mr Monson was not carried out properly.

258. Despite Correctional Supervisor Byers passing information on to Correctional Supervisor Blanden in Hobart that Mr Monson needed to be assessed by the RIT (indeed this was the reason for his being sent to Hobart in the first place),

[50] Exhibits C308, 309 and 310.
[51] Exhibit C309

Correctional Supervisor Byers did not raise a SASH Mandatory Notification form or put in place an interim risk plan.

259. There was a breach of order 9.1 of DSO 2.01[52] which requires a SASH assessment to be conducted within two hours of a prisoner being received. In the case of Mr Monson it was not. In addition to that, no SASH mandatory notification was raised at any stage and no interim risk treatment plan or risk treatment plan was raised at any stage.

260. Order 11 of DSO 2.01 deals with circumstances in which an immediate support plan is required. Chief Superintendent Maxfield said in her evidence that if orders 9 and 10 of that order had been followed an immediate support plan would have been implemented in respect of Mr Monson. Those were not complied with and, as a consequence, no immediate support plan was ever developed, let alone implemented.

261. Order 11.3 of DSO 2.01 provides the plan must provide for a prisoner's safety until the transfer to an observation cell or intensive care unit is facilitated. Plainly that did not occur, in any form, in the case of Mr Monson. Chief Superintendent Maxfield said in her evidence that Mr Monson might still be alive even if just some of DSO 2.01 had been followed. I agree. At the very least, the escort may not have occurred on the day that did (at least so far as Mr Monson was concerned). Chief Superintendent Maxfield's evidence was that given changes to procedures that have been adopted since Mr Monson's death he would not have been transported in the way that he was on the day of death.

262. Order 14 of DSO 2.01 provides for the operation of the RIT. As has already been mentioned it consists of a correctional supervisor, member of the therapeutic services unit, and an appropriately trained experienced CPHS nurse. Whilst Chief Superintendent Maxfield says LRP did not have that staffing mix to enable a full RIT to be conducted, given the staffing mix as at June 2015, it was at least possible then to assess risk and develop Immediate Support Plans and Interim Risk Treatment Plans. However, nothing of that nature was done in relation to Mr Monson. Further, LRP should have had the appropriate staff available to enable RIT assessments to be conducted.

263. Order 18 of the DSO 2.01 requires that if a prisoner is identified as a "high risk" a SASH notification must be completed prior to transfer. Again that did not occur in this case because Mr Monson was not identified as being at risk when, at the risk of repetition, clearly he should have been.

264. DSO 2.01 sets out the steps that should have been followed if Mr Monson was assessed as at risk (and clearly it was something TPS staff at the LRP either knew or should have known). Chief Superintendent Maxfield says steps 1 to 6

[52] Exhibit C50

and12 and 16 should have been followed. It is quite clear that not one of those steps was followed.

Escort Duties

265. A considerable amount of evidence in relation to the experience and training of the officers involved in the transportation of Mr Monson (and other prisoners and detainees) from Launceston to Hobart was provided to the inquest. Neither Correctional Officer Wills nor Correctional Officer Hitchens had extensive experience in relation to the carrying out the role of escort officer and in the case of Correctional Officer Hitchens, his experience was limited.

266. Aside from training provided as part of the recruit training module undertaken by all trainee correctional officers, the evidence from Chief Superintendent Maxfield was that no specific specialised training for the role of the escort officer was provided. The only training devoted to the role of the escort officer was, as has been mentioned, in the recruit Induction Course, a course that runs for 13 weeks. Chief Superintendent Maxfield described the induction course as generic and explained that it involved six modules. Part of the fifth module, the module entitled “Supervising Prisoners”, deals with prisoner transportation and escorting. The module also covers:

- Situation Communication;
- Manipulation;
- A tour of both RBMSP and MHWP;
- Respond to and Preserve Crime and Incident Scenes (both theoretical and practical);
- Motivational Interviewing;
- Working with Prisoners with an Acquired Brain Injury;
- Psychopathy;
- Working with Violent Offenders;
- Prisoner Bullying and Harassment;
- Radicalisation and Extremists [*sic*] Awareness;
- Disciplinary process (theoretical, practical, report writing and prisoners’ rights and privileges);
- Correctional Primary Health;
- Blood Spill Clean-up;
- What is forensic health – including health of prisoners;

- Public Health Issues;
- Alcohol and other Drugs;
- Inducting Prisoners into an Accommodation Unit;
- Harm Minimisation;
- Suicide and Self-Harm – specifically the Director's Standing Order (DSO) dealing with this topic;
- Aboriginal cultural competence – E learning;
- Decency module;
- Blood Borne Viruses;
- Prisoner Correspondence (both mail and telephone);
- Overview of Integrated Offender Management;
- Personality Disorders, Intellectual Disabilities, signs and symptoms;
- SASH – TPS Process/model, Therapeutic Services Role, NAU;
- Introduction – Case Management;
- Major Mental Illness and CPHS/FMHS (Forensic Mental Health Services) Referral Process;
- Section 42's [*sic*];
- Stress Management;
- WHS – TasTAFE;
- SASH - Correctional Officer's Role and Responsibilities;
- Transition To Case Work;
- Tier 2 (both referrals and sentence plans);
- Victims Assistance Unit;
- Family Violence Orders;
- Custodial Information System – Examine FVOs and Discuss;
- Prisoners on Protection;
- Urinalysis (both theoretical and practical);
- Prisoner Contract System;
- Case Audit – report backs; and

- Security Management System training (SMS)[53].

267. The module concludes with a final examination. Obviously the matters that need to be covered as part of a recruit induction course for a correctional officer are very broad. However, it is equally quite clear that the training with respect to the role of the escort officer is limited, apart from training received outlined above. No further training in that role is provided and specifically no refresher training is provided for officers. This is in contrast to other areas to which staff members undergo refresher training such as, relevantly in the context of this inquest, SASH (annually) and first aid (annually).

268. Chief Superintendent Maxfield said that a number of changes had been implemented (after an internal review of Mr Monson's death by TPS) with respect to improving the manner in which escort duties are carried out. She said that a variety of changes came into effect on 6 July 2015. The changes relate to each of the three TPS inmate transport vehicles - Mobile 1, 2, and 3. Each vehicle has been issued with a laminated list of duties relating to prisoner/detainee escorts. The laminated sheets remind escorting offices of their obligation to inspect and search the escort vehicle both before and after every trip and the need to ensure damage is reported and reports are completed. They also cover requirements to ensure cameras, intercoms and seatbelts are fully functional (which requires the escorting officer to enter each pod and engage the seatbelt during vehicle inspection).

269. In addition, and particularly importantly in the context of Mr Monson's death, the SASH watchlist is to be checked and any prisoner or detainee on a level 1 or 2 watch must undergo a risk assessment to be conducted by the RIT before being transferred. Finally, once the journey commences the escorting officer is to conduct regular visual checks of all passengers as well as make regular contact using the intercom with all passengers throughout the duration of the journey, no less than three times per hour. Escort officers are now obliged to record each of the checks made in a register also supplied.

270. However the evidence was that prisoner escort duties are not a specialist role as such. In my view, a factor that contributed to Mr Monson's death was the inexperience of the escort officer. I consider that a properly resourced full-time prisoner escort unit should be established, such unit to be responsible for all regular escorts. The establishment of such a unit would likely eliminate any issues with respect to lack of training or experience on the part of escort officers.

I <u>recommend</u> the establishment of a specialist Tasmania Prison Service escort unit.

[53] Exhibit C308

271. I consider that on the evidence Mr Monson should not have been transferred by normal escort on the day of his death. Had he been properly assessed and identified as at risk then he ought to have been transferred by special escort. In fact as Chief Superintendent Maxfield indicated any prisoner or detainee assessed as requiring watch levels 1, 2 or 3 should be transferred by special escort. The evidence was a new, dedicated vehicle is required to enable such prisoners or detainees to be transported in a manner safe for correctional staff as well as the inmate.

I recommend an appropriate vehicle be purchased to enable special escorts to be safely carried out.

Seatbelts in Escort Vehicles

272. Mr Monson took his own life using a seatbelt fitted in the pod in the escort van in which he was travelling. Had no seatbelt been fitted in the pod then Mr Monson would not have been able to use one to take his own life. An argument therefore might be thought to exist for the removal of seatbelts from escort vehicles. However, such a position does not accord with the vehicle standards contained in the Standard Guidelines For Corrections in Australia revised in 2012[54] , which deals with guidelines for corrections in Australia, does not accord with State vehicle law and does not accord with broader considerations of the safety and well-being of prisoners and detainees being transported between the various prison facilities and courts in this State.

273. Evidence was given that a Victorian engineering firm is assisting Corrections Victoria with the design of a modified seatbelt for use in vehicles during prisoner transportation. The evidence was that the seat belt is 700mm in length, red in colour to help provide contrast for surveillance purposes, woven with Kevlar yarn to strengthen and provide tamperproof qualities and has a buckle in the middle. It is noted that centre buckling seat belts are not in accordance with Australian design requirements and the evidence was that the TPS would need to obtain the permission of Transport Tasmania (or possibly an exemption under the relevant legislation) for such seatbelt to be used.

274. However, there is much to commend the introduction and use of a seatbelt of this type. It strikes the appropriate balance between general prisoner and detainee safety by the provision of a seatbelt to protect the person wearing it in the event of a crash or similar and at the same time denying a means of suicide or self-harm to a prisoner or detainee intent upon that path.

I recommend all prisoner escort vans in Tasmania be fitted with a seatbelt of the type designed by Cartech Engineering, Victoria for Corrections Victoria.

[54] Annexure C of Exhibit C309

First Aid – Response and Training

275. Each of the deaths the subject of this inquest involved a first aid and medical response by corrections and medical staff when the bodies of the men were discovered. In each case, the evidence at the inquest of the responses by prison staff (both correctional and health) satisfies me that the responses were appropriate and first aid assistance rendered appropriate. Training in relation to first aid is provided during the recruit induction course as part of module four which involves training in the Roles and Function of a Correctional Officer. Like module five, discussed above, many other issues are covered in module four. However, it is clear from the evidence that the first aid response in each case was of a high standard. The evidence also was that all correctional staff participate in an annual first aid refresher upon their return from annual leave.

276. The evidence allows me to conclude that the first aid training provided by TPS to all staff, and in particular correctional staff, was demonstrably of an appropriate standard. In each case the attempts made to resuscitate Mr Monson, Mr Michael and Mr Mitchell were appropriate. No want of skill in the performance or application of first aid played any role in the death of any of the men.

Systems Issues – Medical

277. The role of the prison medical service was a central concern at the inquest. Each of the inmates whose deaths were investigated had dealings with the service. In each case the role of the service in diagnosing (or failing to diagnose) and treating (or failing to treat) physical and psychological conditions suffered by Mr Monson, Mr Michael and Mr Mitchell was scrutinised at the inquest. Consequently, a significant amount of evidence was led in relation to the provision of medical services within the Tasmanian prison system.

278. The evidence satisfied me that broadly speaking CPHS operates well under trying circumstances. Certainly there is no reason, at all, to criticise the system generally or particular members of it. It was quite clear that all those who make up the CPHS are dedicated professionals.

279. The evidence was that in common with all other jurisdictions within Australia the main primary health care afforded to inmates is organised and delivered by registered nurses. Dr Wake, a Senior Specialist Medical Practitioner employed by the Tasmanian Health Service and head of Department in CPHS, said that the reason for this is the underfunding of prison health services nationally coupled with the scarcity of doctors who are both qualified and willing to work in the prison environment. Dr Wake, who has been practising prison health since 1992 (in Tasmania and on the mainland), said that it was not uncommon in many prisons throughout the country to have no doctor service at all. Many other prisons on the mainland utilise a visiting general practitioner for one or two sessions a week.

280. Dr Wake explained that the prison environment, necessarily, is controlled by correctional services. It follows that access of prisoners and detainees to health care services is subject to the control of correctional services. Dr Wake said that access of prisoners and detainees to health care is a problem in all jurisdictions in Australia. He gave evidence that he has been in his current position since 2006 and said that that was his experience in the TPS. Dr Wake said by way of example that there was a significant exacerbation of the problems associated with access of prisoners and detainees to health care professionals when the new Risdon Prison Complex opened in 2006. He attributed this to the institution of what he described as a "structured prison day". Dr Wake said the result of this was less time and priority being afforded to the health of prisoners and detainees.

281. The situation was further exacerbated, according to Dr Wake, in about 2010 when the Schedule 8 pharmacotherapy program became larger due to increased patient load. Schedule 8 drugs are substances and preparations for therapeutic use which have high potential for abuse and addiction. Dr Wake said that the TPS response was to 'unilaterally close' an afternoon health clinic in order to be able to service the Schedule 8 drug patients. His evidence about this was not challenged. I accept it. He went on to say that in the three years leading up to the inquest only two (2) working hours in each working day were available for prisoners and detainees to access CPHS. All this serves to illustrate, starkly, the practical reality which surrounds the delivery of health care services to inmates in the TPS.

282. The evidence was that the prison medical service in any one year in Tasmania cares for approximately 1500 prisoners and detainees. Somewhere in the order of 26,500 consultations are carried out and roughly 7000 prescriptions are written each year.

283. A challenge for the CPHS was the number of inmates is increasing and has been for several years. In addition, the number of inmates using methylamphetamine has increased from 37% as at July 2015 to in excess of 50% as at the end of 2016. Dr Wake's expectation was that the figure would continue to increase.

284. A further challenge is that, as Dr Wake said, "most inmates fall into the complex group having multiple comorbidities. Those comorbidities include drugs and alcohol, mental health, personality disorder, self-harm, social dysfunction and disability. There is often a fast changing clinical environment which can be further confounded by dysfunctional behaviour."

285. Medical services need to be provided to the six different facilities, namely:

- Risdon Prison Complex;
- Ron Barwick Minimum Security Prison;
- Mary Hutchinson Women's Prison;
- Hobart Reception Prison;

- Launceston Reception Prison; and
- Ashley Youth Detention Centre.

286. The fact that medical services have to be provided to 6 different facilities in three discrete geographical locations is another challenge for the prison medical service. Part of the response to that challenge is the use of telemedicine (i.e. videoconferencing) as much is possible. This is particularly important in relation to the LRP. No CPHS doctor is stationed in Launceston. No external doctor was apparently available to conduct consultations in Launceston either at the time of Mr Monson's incarceration or at the time Dr Wake gave his evidence in July 2016. There seems no reason, at all, why a doctor could not be engaged on a part time or as needed basis by CPHS.

287. Because no doctor is available in Launceston, heavy reliance is placed upon mental health trained nurses at the LRP. Dr Wake explained, as was the practice in relation to Mr Monson, it is quite common to prescribe psychotropic medicine for prisoners and detainees in Launceston on what was described as remote consultation (i.e. video link, email or telephone). The lack of availability of a medical practitioner to provide face-to-face consultation for prisoners and detainees in Launceston is unacceptable. The reliance on nurses, no matter how experienced, especially with respect to the prescription of psychotropic and similar medicines is also unacceptable. The efforts of Dr Wake and all other members of the prison medical staff are acknowledged and the use of telemedicine linkages is recognised. However, they are no substitute, as was acknowledged, for face-to-face consultation with the patient.

I <u>recommend</u> that the Tasmania Prison Service engage a medical practitioner to enable face-to-face consultations to occur as and when needed at the Launceston Reception Prison.

288. A stark example of the difficulties associated with lack of availability of medical practitioners to work in the prison system is to be found in staffing levels at the time of Mr Mitchell's entry into the prison system, in July 2014. Dr Wake said that at that time he was away for two weeks as was the doctor responsible for the Hobart Reception Prison. This meant only one doctor was available to look after the whole prison population. It was not clear whether this was a result of poor rostering practices or something that was unavoidable by reason of personal or family emergency but whatever the reason the situation is unacceptable. Whatever the reason, steps must be taken to ensure it is not repeated in the future. It is noted that the memorandum of understanding governing the provision of health care within the Tasmania Prison Service includes the following statement:

> *"the quality and availability of services [provided to prisoners and detainees] should not be significantly different to that made available by and through DHHS to the general Tasmanian community".*

Dr Wake acknowledged that while this statement sets a commendable standard to which the service should aspire, given resourcing and the necessary restrictions in prison life, it is not necessarily achievable. The situation is made even worse when the availability of medical practitioners is restricted in the way it was in July 2014. Adequate access to a sufficient number of suitably trained medical practitioners is essential for the proper functioning of the prison health service.

I recommend that a sufficient number of suitably trained medical practitioners are always rostered on by Correctional Primary Health Service.

Prison Health Pro System

289. Dr Wake gave evidence that when he took up his current position in 2006 there was no electronic recordkeeping within the prison medical service whatsoever with regard to prison health and medical information. He built the current electronic system known as Prison Health Pro System (PHP). It was Dr Wake's view that the PHP "has improved the clinical service and outcomes" of the prison medical service "many fold". Whilst this may be correct (and in fact the only evidence was that there had been a significant improvement in record keeping since its introduction) the evidence was that the system has never been formally evaluated by the DHHS (or any other entity or person) in Tasmania. It is essential that it is properly evaluated. Counsel assisting submits that a proper evaluation of the system needs to be conducted and if as a result of that evaluation improvements can be made to the system then those improvements should be implemented. Dr Wake also supported such a review. I consider that such a review is warranted.

I recommend that a proper evaluation of the Prison Health Pro System be carried out and if as a result of that evaluation it is identified that improvements can be made to the system then those improvements be implemented.

290. Dr Wake provided the inquest with a good deal of helpful information in relation to the manner in which PHP operates. Part of the material provided was printed educational material[55]. However, his evidence was that he had only ever provided one training session in relation to the use of the PHP. The obvious point is of course that nursing staff will come and go which means that a fundamental tool to be utilised by them may be something they had never encountered anywhere else and had received no training in the use of. Evidence was that the responsibility for training nurses was, because of the organisational structure of prison health, the role

[55] Annexure C of Exhibit C352

of nursing managers and not Dr Wake. It is clear that formal training and refresher training in the use of PHP is essential to the proper operation of the prison health system. The difficulties with the manner in which the system was used by some nurses (examples of RN McGillivray and RN Elkin are obvious ones) and the resulting potential for inaccuracies and plainly misleading information to result, is obvious.

I recommend that formal training be provided to all new nursing staff in the proper use of Prison Health Pro System and that refresher training be provided to all nursing staff at least once per year.

291. Access to the 'outside' medical records of inmates is important to ensure the highest practicable standard of health care is afforded to inmates in custody. Dr Wake gave evidence concerning the difficulties associated with obtaining medical records in the North and North West regions of Tasmania. I agree with the submission of counsel for Mr Mitchell's family that it is little short of extraordinary that today bureaucratic barriers still seem to operate to make difficult what really should be very straight forward – the provision of medical records from one area of the Tasmanian Health Service to another part of the same service. I acknowledge that in fact that any difficulty accessing records of Mr Mitchell had no bearing on his death, but conceivably in other cases early access might be critical. To that end a recommendation to ensure early and easy access to external medical records on the part of the CPHS is justified.

I recommend that the external medical records of any inmate going into custody are to be made available within 48 hours of any request being made by Correctional Primary Health Service.

Conclusion

292. A summary of the recommendations that I have made pursuant to section 28(2) of the *Coroners Act* 1995 is annexed to this finding and marked 'A'.

293. A summary of my reports pursuant to section 28(5) of the *Coroners Act* 1995 in relation to each death is annexed to this finding and marked 'B'.

294. A glossary of acronyms used in the evidence and hence this finding is annexed to this finding and marked 'C'.

295. I extend my thanks to all counsel who appeared at the inquest for their assistance and in particular acknowledge the very great assistance of counsel assisting Mr RB Webster, now Chief Commissioner Webster of the Tasmanian Workers Rehabilitation and Compensation Tribunal.

296. I thank in particular First Class Constable K Luck for her coordination of the 130 individual witnesses who gave evidence and the 371 documentary exhibits

tendered at the inquest and her general assistance in relation to the preparation for the running of the inquest.

297. I acknowledge and thank Detective Senior Constable T Keenan for the extremely professional manner in which he oversaw this complex investigation.

298. I extend my condolences to the friends, family and loved ones of Mr Monson, Mr Michael and Mr Mitchell on their loss.

Dated 30 June 2017 at Hobart in Tasmania.

Simon Cooper
Coroner

Annexure A - Summary of Recommendations

1. ***I recommend that all police officers who are responsible for the custody of detainees and those responsible for cell watch duties be clearly reminded of their duties under section 7.2 of the Tasmania Police Manual and particularly order 7.2.10.***

2. ***I recommend that at least fully up-to-date prisoner admission and assessment forms be provided by Tasmania Police to the Tasmania Prison Service at the moment custody of a detainee passes from Tasmania Police to the Tasmania Prison Service.***

3. ***I recommend that all Tasmania Prison Service officers processing inmates undergo further training as to the proper method of processing including the need to check the inmates' records relating to previous periods of custody.***

4. ***I recommend that adequate staff be rostered on at all times at the Launceston Reception Prison so as to enable correctional Tier 1 assessments to be completed as mandated by Director's Standing Order 2.06.***

5. ***I recommend that all Correctional Primary Health Service nursing staff receive further training in relation to the completion of nursing (or health) Tier 1 forms and nursing staff at the LRP be provided with, trained in the use of, and required to use, a computer upon which to complete such assessments.***

6. ***I recommend that the Tasmania Prison Service ensure that the appropriate staff mix is available at the Launceston Reception Prison to enable Risk Intervention Teams to operate at that facility in accordance with Order 14.1 of Director's Standing Order 2.01.***

7. ***I recommend that the Tasmania Prison Service Launceston/Hobart escort seating plan form be amended so that it accords with the categories contained in Director's Standing Order 1. 20 – External Escorts.***

8. ***I recommend that the Tasmanian Prison Service review Emergency Operating Procedure 03 'Code Blue' regarding the continuation of CPR.***

9. ***I recommend that the carrying of cut down knives by first and second response teams continue and that cut down knives continue to be located in each accommodation area and carried in escort vehicles.***

10. I recommend that slip on footwear replace all footwear with laces for all prisoners and detainees in the Tasmania Prison Service.

11. I recommend the establishment of a specialist Tasmania Prison Service escort unit.

12. I recommend an appropriate vehicle be purchased to enable special escorts to be safely carried out.

13. I *recommend* *all prisoner escort vans in Tasmania be fitted with a seatbelt of the type designed by Cartech Engineering, Victoria for Corrections Victoria.*

14. *I recommend that the Tasmania Prison Service engage a medical practitioner to enable face-to-face consultations occur as and when needed at the Launceston Reception Prison.*

15. I *recommend* *that a sufficient number of suitably trained medical practitioners are always rostered on by Correctional Primary Health Service.*

16. *I recommend that a proper evaluation of the Prison Health Pro System be carried out in it and if as a result of that evaluation it is identified that improvements can be made to the system then those improvements be implemented.*

17. I recommend that formal training be provided to all new nursing staff in the proper use of Prison Health Pros System and that refresher training be provided to all nursing staff at least once per year.

18. I recommend that the external medical records of any inmate going into custody are to be made available within 48 hours of any request being made by Correctional Primary Health Service.

Annexure B – Summary of Reports Pursuant to Section 28(5)

Troy Colin Monson

The care, supervision and treatment afforded to Mr Monson whilst in the custody of Tasmania Police at Burnie on 17 June 2015 was not of an acceptable standard. Specific concerns that Mr Monson was feeling suicidal were recorded and passed on by an officer but were ignored. No medical practitioner was called. No written information about Mr Monson's suicidal ideation or behaviour generally was passed on to TPS when Mr Monson's custody passed from Tasmania Police to TPS.

The care, supervision and treatment afforded to Mr Monson whilst in the custody of the TPS in Launceston between 17 June 2015 and 22 June 2015 was not of an acceptable standard. Mr Monson was not processed within two hours required by DSO 2.06.(order 6.1 second occurring). No assessment in relation to suicide and self-harm was conducted within two hours of his being received into custody contrary to order 9.1 of DSO 2.01. The corrections Tier 1 completed after 8.00am on 18 June 2015 was deficient. The health tier 1 completed on the same day was deficient. The fact that Mr Monson was prescribed an atypical antipsychotic medication without being physically seen by a medical practitioner was unacceptable. The fact that no RIT assessment was carried out on Mr Monson while he was in custody between 17 and 22 June 2015 was unacceptable. That no RIT operated at LRP in June 2015 (in breach of order 14.1 of DSO 2.01) was unacceptable. The fact that Mr Monson was not identified as being 'at risk' of suicide or self- harm at any time whilst in the custody of TPS in June 2015 was unacceptable. The decision to transfer Mr Monson to Hobart on 22 June 2015 was made without reference to any guidelines. No steps were taken, at all, to ensure Mr Monson's safety during the transfer. The decision to transport him on the ordinary escort was a poor one. He was wrongly classified in terms of DSO 1.20. No mandatory SASH Mandatory Notification form was raised in breach of DSO 2.01. No interim risk treatment plan or risk treatment plan was raised in breach of DSO 2.01. The escort officer and driver were not advised as to the reason for Mr Monson's transfer and in particular that he had expressed suicidal ideation shortly before he was placed on the escort vehicle. The escort officer failed to monitor Mr Monson in his pod, adequately or at all, in breach of DSO 1.20.

Robin Michael

The care, supervision and treatment of Mr Michael whilst in the custody of the TPS were of an acceptable standard. He was appropriately treated and cared for by CPHS staff, appropriately cared for and supervised by TPS staff and appropriately treated by Ambulance Tasmania personnel.

Scott Clifford Mitchell

The care, supervision and treatment of Mr Mitchell whilst in the custody of the TPS were of an acceptable standard. He was appropriately treated and cared for by CPHS staff, appropriately cared for and supervised by TPS staff and appropriately treated by Ambulance Tasmania personnel.

Annexure C - Glossary of Acronyms

RPC – Risdon Prison Complex

RBMSP – Ron Barwick Minimum Security Prison

TPS – Tasmania Prison Service

CPHS – Correctional Primary Health Service

LRP – Launceston Reception Prison

NAU – Needs Assessment Unit

RIT – Risk Intervention Team

SASH – Suicide and Self-Harm

PHP – Prison Heath Pro System

PLN – Psychiatric Liaison Nurse

MHWP – Mary Hutchinson Women's Prison

DSO – Director's Standing Order

DSU – Directorate Security Unit

CIS – Custodial Information System

RN – Registered Nurse

CNC – Clinical Nurse Consultant

MNF – Mandatory Notification Form

TSU – Therapeutic Support Unit