FINDING IN THE DEATH OF

ADAM DOUGLAS SHIPLEY

THE FACTS

1. Adam Douglas Shipley, aged 36, had been an inmate at Kirkconnell Correctional Centre (Kirkconnell) near Bathurst since his transfer there on 22 March 2007. He was taken back into custody on 24 December 2006 following a breach of parole, and had spent the early weeks of his term at the Metropolitan Remand Reception Centre (MRRC) and at Kirkconnell, then been moved again to the MRRC and thence to John Morony Correctional Centre where he was placed on a RIT (the Risk Intervention Team) protocol following an incident of threatening self harm, (of which he had a lengthy history) on March 3, 2007. His return to Kirkconnell in March was partly because of his threats to self harm again unless he was placed there.

2. Adam Shipley (Adam) was allocated to 4 Unit, a relatively self sufficient group house for Aboriginal prisoners, and put in to Cell 7 alone, or 'one out' at his request. In accordance with standard procedure, at about 4.50pm on 20 May 2007, all units including 4, were 'locked down'. After lock-down, inmates were free to move around the unit. They prepared their own meals. The cells were not locked. Adam did not eat that night, and was not seen, according to fellow inmates Kirt Field and Robert Allen, after about 8.30 pm.

3. At approximately 7.00am on Monday 21 May 2007, Kirt Field and others noticed that the door to Adam's cell was still closed, although Adam was usually one of the first to be up and about. Field went to Adam's cell door, and observed that it was

somehow held shut. He had to pull the door and break what eventuated as a cord holding it closed. Field then entered the cell, and saw Adam hanging by his neck at the end of the bunk bed by a cord made into a noose. He touched him on the shoulder and he was stiff. Correctional Officers were then called and attended, led by C.O. Fred Kentwell.

4. Adam was observed dressed in green tracksuit pants, a green t-shirt and a green jacket. He had a deep indentation to the front of his neck and this extended further up and met the lower section of his skull. No vital signs were detected. Officer Kentwell saw a letter on the bed and a piece of paper under the deceased's shoulder which he picked up, read, and put on a shelf to keep it free of fluids which were seeping on to the floor from Adam's body.

5. The Forensic Pathologist, Dr J Duflou, after autopsy, gave as his opinion in the Post Mortem Report (dated 20 December 2007) that Adam Shipley died somewhere between 1700 hours on 20 May and 07.10 hours on 21 May 2007 at Kirkconnell and that the direct cause of death was by HANGING.

6. The inquest into this death was mandatory pursuant to ss.13A and 14B of the *Coroners Act 1980* (the Act). As State Coroner, I held a view at Kirkconnell, and heard evidence in both Bathurst and Glebe courts, over 8 days from 21 witnesses. The Officer in Charge of the investigation, Detective Senior Constable Edmund Belfanti presented a meticulous lengthy statement which formed part of the Brief of Evidence.

ADAM SHIPLEY'S HISTORY

7. The Department of Corrective Services (DCS) inmate profile for Adam reveals a long and extensive criminal record going back to February 1984. He spent time in custody for varying periods from 1989 until this final episode when he was taken back into custody for a breach of parole on 24 December 2006. He was a diagnosed paranoid schizophrenic with a history of suicidal ideation and self harm. Adam was also known to be non-compliant with his anti-psychotic medication. Staff described him as 'high maintenance', in that he was very demanding of attention, but likeable. He was constantly worried about the relationship with his partner, Bronwyn Irwin, breaking down, and other personal issues. He discussed these worries with many prison officers and welfare staff throughout his time at Kirkconnell, and constantly spoke of self harm. The DCS psychologist, Kim Hyland, gave evidence as to the procedures set out for inmates applying for consultation. Officers Kentwell and Turner, who had in turn been assigned as Adam's case officer, gave evidence that they had never formally conferred with Adam or each other on hand over. Officer Kentwell agreed that the system had not assisted Adam, but that he had 'fallen through the cracks'.

8. There is some evidence that Adam had attempted to commit suicide a few days before 21 May 2007. That evidence only came from inmates in 4 Unit, and none suggests that the alleged failed attempt was ever known to any Correctional Officer.

9. Inmate Field told both the Assistant Superintendent, and this inquest, that, incomprehensibly, he had made a noose for Adam at his request as he was known

amongst the prisoners for doing so. Inmate Field gave evidence that he made the nooses, which he usually lacquered, because they "look[ed] good". He claimed that Officers knew of this hobby and took no action. It seems most likely that he had made the ligature by which Adam was found hanging, and also that it was in fact made from a cord identical to that used as drawstrings in the prisoners' laundry bags.

10. On 20 May 2007, Adam was permitted to make two phone calls to Bronwyn Irwin, the second of which was answered and a transcript made available to the court. Despite Ms Irwin's evidence, the transcript indisputably proves that she made it clear to Adam that their relationship was over, that she was with someone else at the time and had 'moved on'. After lock-down, several of his fellow inmates observed that he appeared down. He was last seen by any of them early that evening. Although one, not necessarily reliable, witness claimed that it was at 8.30pm it seems more likely that he remained in his cell with the door closed after about 5.30 pm.

11. As previously described, he was found hanging the next morning by Field, who had to break the shoelace which had tied the door closed from inside.

THE INVESTIGATORS' REPORTS

12. Three reports were ultimately sought by the DCS from its own Investigations Branch. The first was assigned to Dawn Watson, an Investigator with the Unit, who on the day that Adam was found dead, accompanied by Investigator William Beale, made an initial inspection at Kirkconnell of the unit, the cell and the crime scene. She provided an interim report a week later, which she herself in evidence agreed was 'to furnish the very basic of details to the director of the Investigations Branch'. It

appears there is a format required by the Department which in my view, barely furnishes even 'basic details'. Watson herself merely recommended that Officer Kentwell be reprimanded for moving the note from under the body, on first entering the cell. Soon after, she resigned from the job following a Departmental inquiry into her conduct as an investigator in an unrelated matter. Her evidence was that she signed the interim report, although no signed report of hers was produced to this inquest in answer to either the subpoena or a letter from the Crown Solicitor's Office (dated 6 January 2009).

13. Because of her resignation, the matter was then transferred to a Mr Nigel Webb, but on his almost immediate transfer, Investigator Beale was asked to review Ms Watson's report. His subsequent report was dated 24 September, 2007 and he then went on sick leave for a month. On his return, he found that his report had been substituted by a report prepared by another Investigator Paul Coyne, who had been requested by John Crawford, Director of the DCS Investigations Branch, to review the inquiries made to date, and complete a report in to the death of Adam Shipley in the 'approved format' (the Final Report). Mr Beale was very angry, as Mr Coyne had never been to the scene, had not interviewed any personnel involved, and had primarily repeated the words of Ms Watson. Discussions which followed between Mr Beale on the one hand, and Messrs Coyne, and Crawford on the other, were differently recalled by each, and formed the basis of particular allegations by Mr Beale that there was a 'cover up' by the Department, only a 'benign' report was sought, and therefore his, far more comprehensive and detailed report was 'buried'. As a result of his views, Mr Beale resigned from the DCS on 26 November 2007.

14. These allegations are now the subject of an investigation by the Independent Commission against Corruption (ICAC). Consequently it would be improper for me to make any finding relating to them, and I neither do so, nor determine whose versions of those conversations is the most reliable. I shall, however, make comment upon the general contents of the three reports.

ISSUES

15. Having regard to the foregoing, I consider the issues raised on the evidence at the inquest to be as follows:
    a. Did Adam hang himself, deliberately committing suicide?
    b. Was any recent suicide attempt made, and if so, was it known to Correctional Officers?
    c. Should nooses, cords and other potential ligatures have been allowed within the units by DCS?
    d. Should DCS have taken steps to remove potential hanging points from the units?
    e. Was Adam provided by both DCS and Justice Health with care and treatment appropriate for an inmate who was known to be schizophrenic, non-compliant with medication, upset and with a history of self harm, and RIT placements, i.e. a high risk?
    f. Was Adam's classification to Kirkconnell, and allocation to a one-out cell appropriate for such a prisoner?
    g. Were the investigation reports sought by the DCS accurate, detailed and useful particularly in terms of unearthing possible systemic issues or problems?

h. Should the report of Mr Beale, albeit not in the proper format, have been given closer consideration and/or formed part of the Final Report on the death of Adam Shipley?

THE LAW

16. Under ss.13A and 14B of the Act, this was a mandatory inquest, because Adam died in custody. I am required to make findings as to the identity, place, date, manner and cause of death of Adam Shipley. S. 22A of the Act provides for recommendations to be made if the Coroner considers it necessary or desirable to do so in relation to any matter connected with the death under investigation. S. 22A (2) states that public health and safety, and a recommendation that a matter be investigated or reviewed by a specified (person or) body are examples of matters that can be the subject of a recommendation.

17. I had the benefit of Mr Lonergan as Counsel Assisting, instructed by the Crown Solicitor, while Mr Saidi represented the DCS, Mr Singh Justice Health, and Ms O'Sullivan Adam's mother, Lynette Shipley. All counsel made written final submissions, to some of which I shall refer.

CONCLUSIONS ON THE ISSUES

18. There is sadly clear evidence that Adam Shipley died as a result of hanging and further, that he hanged himself with the intention of taking his own life. I must be satisfied to the Briginshaw Standard[1] that Adam suicided. It is obvious that he tied

1 *Briginshaw v Briginshaw* (1938) 60 CLR 336.

himself in to his room, and there is evidence that there was no sign of forced entry other than that by Field witnessed by other inmates after fears for him had arisen. There is a suicide note written by him, his history of depression and self harm, the relationship difficulties or ending with Ms Irwin, as well as with his daughter and new grand daughter, and recent disappointment over legal advice. He apparently sought out an effective noose. It may be that he had made a previous attempt to hang himself a few days before. On the evening of 20 May 2007, events had overtaken Adam.

19. It is likely that Adam had, as previously stated, made a prior suicide attempt, by similar means, within the last few days. A few prisoners may have known of this. There is no evidence to suggest that any staff either of DCS or Justice Health had any information or knowledge whatsoever of that attempt.

20. The question of the availability of hanging points and materials for making ligatures is difficult in this case. Kirkconnell is a minimum security institution which allows some inmates to work in the afforestation camp or in outside day release programmes preparing prisoners for return to the freer community. Considerably greater latitude is allowed to its inmates than in prisons with higher inmate classification gradings. Units for about 12 prisoners, although 'locked down' from 4.30 pm till 7.30 am nightly, allow for inmate's independence inside the unit between those hours. Officers do not enter the units unless in an emergency; prisoners prepare their own meals and govern themselves as a group or individually. In such an environment,

hanging points and the availability of rope, cords and other tying devices are virtually impossible to restrict, let alone eliminate.

21. Unit 4 was particularly designated for Aboriginal prisoners so that they could share their culture and understanding. Adam particularly wanted to be in that unit. The views of several staff were that it would have been a huge deprivation to him had he been refused, and placed where he would have been better supervised or observed.

22. Similarly, he had asked to be allocated a one-out cell. One wonders why the authorities allowed this, given his history. It is understandable that many prisoners may prefer privacy, but had Adam had a cellmate to keep any eye on him, he may have been able to talk of his feelings, and discouraged from acting upon them – indeed, this death may not have occurred.

23. It is difficult not to conclude that the relative freedom allowed prisoners at Kirkconnell did not assist Adam's mental health and may not have been the optimal placement for him.

24. There is a considerable amount of evidence to indicate that at Kirkconnell, Adam received extensive help and assistance from individual DCS staff to help him cope with his personal and emotional problems, as was amply demonstrated by the evidence relating to his interaction with DCS Welfare Officer Michelle Hadley. I agree that there is no criticism of persons such as Ms Hadley that he was not given attention, advice and assistance to deal with his ongoing difficulties, particularly with his relationship with Ms Irwin.

25. However, at no stage after he was taken into custody as and from 24 December 2006 does it appear that there was any coordinated review or response with regard to Adam's psychological and emotional welfare, with his long history being well documented. At his inmate screening on admission, it was noted that he had a long custodial history, was schizophrenic and had both threatened and acted upon self harm many times. There is simply no evidence to indicate that the relevant DCS or Justice Health staff turned their minds to the need for a coordinated, ongoing and pro-active management of Adam Shipley. He was placed on a RIT protocol on 3 March 2007, and discharged from it two days later, yet no ongoing plan or follow up was activated, or apparently even considered, by the DCS.

26. It is appreciated that many prisoners enter the system with mental health problems. However, Adam was at the high end of the spectrum according to his records, and it has to be said that there was a complete deficiency of any plan for his psychological/psychiatric well-being.

27. The 'case officer system' also failed Adam, in that the significant observations and interaction with Officer Catherine Turner, relating to his self-harm threats , were not passed on to his next 'case officer', Officer Kentwell who in his three weeks in that position, did not have the opportunity to meet or formally conference with Adam because of his workload and shift roster. Further, Officer Turner agreed that she had not documented any of Adam's self harm threats (although conceding this was desirable), a matter of obvious concern given the potential significance of such threats. I acknowledge that both officers were commendably open and frank in their

evidence, and agreed that to be the case. It is the lack of system which urgently needs improvement. There was clearly also some intervention in the provision of care provided by Justice Health personnel Ms Parker and Mr Muller. Overall responsibility for Adam's welfare, however, rested with the DCS.

28. The report format required by the Investigations Branch of the DCS, is in my view, inadequate, in that it elicits very little information other than the utterly basic. While I acknowledge that Ms Watson's report was incomplete and interim, the only concern it contained was the fact that Officer Kentwell, in what was actually an attempt to preserve forensic evidence, moved some pills and the note left by Adam Shipley, before the police attended. I am also concerned that despite her being adamant that her report had been signed, no signed document was ever produced, and that, as with those of both Messrs Beale and Coyne, the reports were not produced to this inquest despite a subpoena, until a further letter of demand was sent by the Crown Solicitor. (The Final Report produced by Investigator Coyne mirrors Watson's exactly, with the addition of a few further paragraphs, but without any useful further information and ostensibly, without any independent analysis).

29. Investigator Bill Beale was tasked to undertake the review of Ms Watson's investigation after her departure. He was a highly experienced investigator, previously with both ICAC and the Special Investigation Unit for the Attorney General's Department. His evidence was that he was surprised at the brevity of the Watson report and that he delved into Adam's file, analysed what he found, spoke to Detective Belfanti, and made his report on 24 September 2007. Mr Beale's report is detailed, relevant in the main, and compassionate, albeit not in the 'required' format.

In it, he is critical of the fact that there was no evidence of a coordinated, ongoing and proactive management of (Adam) as someone at risk. He makes a number of (apparently unwanted) suggestions and recommendations for an improved plan for such inmates.

30. Mr Beale then went on sick leave from 15 October 2007 until 26 November 2007. On his return he discovered that his report had been substituted with one prepared by fellow Investigator Coyne. Mr Coyne, while agreeing in evidence that the investigatory role is to identify, inter alia, any systemic issues and failings observed, nevertheless admitted that he was told to put his report in the proper form, and that he did not interview any personnel involved in the matter at all. As previously said, his report is merely a copy of Ms Watson's other than five paragraphs in which he includes a little information not previously obtained by her. His instructions from Mr Crawford, the Director of the Investigations Branch, appear to have centred on his using the approved format, as opposed to that of Mr Beale. He had not been shown Mr Beale's report, nor had he read the report of the '*Royal Commission into Aboriginal Deaths in Custody*' (1987 – 1991), nor does he make any reference to hanging points and ligatures. Nevertheless, he claimed that his was a 'thorough and comprehensive report' into the death of Adam Shipley. It is of narrow focus, and silent upon many relevant issues concerning the treatment and lack of care of Adam, as well as upon any systemic issues whatsoever. Like Ms Watson, the only concern he raises is the 'failure' of Officer Kentwell to maintain the crime scene.

31. Mr Beale, Mr Coyne and Mr Crawford differ on their respective versions of discussions which followed Mr Beale's return and discovery that his report had been

replaced by Mr Coyne's. These are matters which will no doubt be ventilated fully during the course of the ICAC investigation. What is clear is that as a consequence of events and conversations, Mr Beale tendered his resignation from the Department that day, and wrote a few days later, to another officer of the Department within the Employment Branch setting out his concerns, which in both letters reflect the evidence he gave to this court.

32. The Beale report, albeit not in the DCS approved standard format, does contain an in-depth analysis of the history of Adam. It identifies some systemic issues with respect to DCS actions that if corrected, may have led to the better management of Adam. Many of Mr Beale's observations and opinions were specifically agreed with by the DCS Clinical Coordinator, Jenny Barton in her evidence, unlike the DCS Acting Principal Advisor, Psychology, Ms Spilsbury. Mr Beale may have stepped outside his realm of experience at some points in the report, for example in his recommending the ANZ Safety Standards, which really were not applicable to the custodial situation. He may have far exceeded what was asked of him, and what the Investigations Branch required. He was clearly not an employee who blindly accepted 'the rules'. However, it is difficult to understand why his considerable knowledge and analysis was neither given proper consideration nor included in the Final Report. Mr Crawford admitted that Mr Beale, was a 'competent investigator'. But because of the report's lack of correct format, he seems to have ignored it, saying that he found it unbalanced and unsubstantiated. For him to have preferred the cursory and repetitive report of Mr Coyne defies belief that there was any real desire on the part of the DCS to explore the circumstances of Adam's death.

33. Although I make no finding as to the Beale allegations for the reasons noted above, I otherwise consider Mr Beale ought be commended for his strength of conviction and apparent professionalism in undertaking his investigative duties. Moreover, I found his report to be of assistance for the purposes of the inquest.

34. Ultimately, however, this inquest is about how an Aboriginal man in the custody of a government department, known to be at high risk, and diagnosed as a schizophrenic, was able to take his own life without being discovered probably for several hours. It is not primarily about reports and investigators. Documents tendered to the court clearly demonstrate that the DCS has in recent years seriously addressed the issue of deaths in custody and reduced the number of suicides. This is hugely to its credit. The question is raised by the tragic death of Adam Shipley however, of the usefulness of its own Investigation Branch and its protocols. If investigatory reports are not to look at all aspects of a death and to make recommendations, for whose good are they? Of what use? How do they assist in the reduction in future deaths?

35. Finally, I commend Detective Senior Constable Belfanti for a comprehensive and thorough brief of evidence prepared for my assistance.

FORMAL FINDING

36. I make the following formal finding:

> *That ADAM DOUGLAS SHIPLEY died on 21 May 2007 at Kirkconnell Correctional Centre sometime between 17.00 hours on 20 May and 7.10 hours on 21 May 2007 as a result of hanging himself with the intention of taking his own life.*

RECOMMENDATIONS

37. Under s. 22 of the Act, I make the following recommendations to the Minister for Corrective Services:

    1 That the Department of Corrective Services review the systems and protocols in place for inmates known to be at-risk, to determine whether these presently provide for a coordinated and pro-active management plan for such inmates (including involving Correctional Officers and mental health professionals), particularly following a release or discharge from a RIT protocol.

    2 That the Department of Corrective Services review its Investigative Services Branch and the requirements of reports made by its investigators to ensure that full information is gathered, systemic issues are identified, and, if necessary any recommendations are made, by the Investigators both for the use of the Coroner, and for full consideration by the Department.

    3 That the Department of Corrective Services provide all investigation reports undertaken by or on behalf of the said Department into deaths in custody to the Office of the State Coroner immediately upon finalisation (subject to any legal claims made).

Magistrate Mary Jerram Chambers, Glebe, Sydney

State Coroner 3 June 2009