QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of George Edgar CHALLIS**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 1999/06(1)
DELIVERED ON:	17 June 2010
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HEARING DATE(s):	30 October 2009, 23 March 2010 & 30 April 2010
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: death in custody, response of prison officers to prisoner on prisoner assaults, preservation of evidence

REPRESENTATION:

Counsel Assisting:	Ms Mr Peter Johns
Bruce Ruddock:	Ms A. Hartvigsen (AMH Lawyers)
Department of Community Safety:	Mr Gavin Handran

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The *Coroners Act 2003* provides in s45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of George Edgar Challis. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

George Edgar Challis died on 12 July 2006, eleven days after being assaulted by another inmate at the Woodford Correctional Centre.

These findings

- confirm the identity of the deceased, how he died and the time, place and medical cause of his death;

- examine the events leading up to the assault and critique the actions of staff and management at Woodford Correctional Centre (WCC) against relevant policies in place at the time;

- consider the adequacy of the forensic and medical response by all relevant authorities to the assault on Mr Challis;

- determine whether the authorities charged with providing for the prisoner's protection and welfare adequately discharged those responsibilities; and

- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

The incident that resulted in Mr Challis' death was reported to the Corrective Services Investigation Unit (CSIU) approximately 1 hour after it occurred on 1 July 2006. A number of officers from that unit attended the scene at 4.00pm and were briefed by Corrective Services Officers (CSO's) and Senior Constable Dale Morrow of the Woodford police who had arrived at the prison within 30 minutes of the assault. The QPS investigation was carried out by Detective Sergeant Pamela Byles.

The scene of the assault, the scene of an earlier altercation and Mr Challis' cell were photographed, video-taped and forensically examined. Swabs were taken of apparent blood stains and various items of property seized for later examination.

All prisoners in the unit block were interviewed (both on the day and, again, 6 days later). Video-taped walk through interviews of the incident were conducted with the three CSO's who witnessed some or all of the assault.

Statements were obtained from these officers and all other CSO's and management of WCC involved in the incident. Prison intelligence records concerning both prisoners were seized and statements taken from intelligence officers.

The prisoner who assaulted Mr Challis, Alexandre Richmond-Sinclair, declined to answer questions in an interview. Injuries to Mr Richmond-Sinclair's body (his hands in particular) were photographed and his cell examined. Intelligence officers at WCC later recorded discussions between Mr Richmond-Sinclair and his mother during a prison visit. DNA samples were taken and he was charged with the murder of Mr Challis.

Statements were later taken from WCC nursing staff, paramedics and PA Hospital staff in relation to their treatment of Mr Challis. Mr Challis' sisters, Dianne Sullivan and Sandra Honey, were contacted by the investigating officer and statements obtained.

CCTV recordings, movement registers and incident reports relevant to the incident were seized from Wolston Correctional Centre. Mr Challis' and Mr Richmond-Sinclair's professional management files, detention files and medical files were seized. All medical records from the PA hospital were obtained. Records concerning earlier incarceration of both prisoners were located and seized.

I find that the investigation into this matter was thoroughly and professionally conducted. I commend the CSIU, and in particular Detective Sergeant Byles, for these efforts.

A failure on the part of some CSO's to follow procedures designed to ensure the preservation of evidence in the minutes following the assault had the potential to jeopardise the integrity of the investigation. Fortunately, no relevant evidence was lost. I will comment on that aspect later in these findings.

An investigation into the incident was commissioned pursuant to s.219 of the *Corrective Services Act* 2000. I have had regard to the findings made as a result of that investigation. It appears to have incorporated a thorough review of relevant policy and procedure. I will also comment on the recommendations made as part of that investigation and the extent to which they have been adopted.

Criminal proceedings

On 28 July 2008 Mr Richmond-Sinclair was convicted of the manslaughter of Mr Challis following a 7 day trial. On 21 August 2008 he was sentenced to a term of imprisonment of 12 years. He was sentenced on the basis he had caused the death of Mr Challis by stomping on his head (rather than by causing him to fall which had been an alternate possibility raised at trial). The trial judge found that when stomping on Mr Challis' head the intent had been to cause grievous bodily harm and that the jury had therefore found Mr

Richmond-Sinclair guilty of the offence of manslaughter on the basis that he had been provoked by Mr Challis in the moments before the final assault.

I have given consideration to the transcripts of the trial and the sentencing remarks. These findings accede to the findings of fact made in those proceedings insofar as the specifics of the assault on Mr Challis are concerned. In this jurisdiction, however, it is my duty to examine a wider set of facts than may have been relevant to the criminal prosecution in order to consider the issue of safety for prisoners and staff at WCC.

The Inquest

An inquest was held in Brisbane on 23 March and 30 April 2010. In accordance with the requirements of the Act it did not commence until all criminal proceedings in which the cause of Mr Challis' death was in question were completed. Mr Johns was appointed as counsel to assist me with the inquest. Leave to appear was granted to the Department of Community Safety, the successor of the Department of Corrective Services. The Court heard oral evidence from the investigating officer and three witnesses to the assault; one being a prisoner and the others corrective services officers. The General Manager and Assistant General Manager of WCC and the Acting Deputy Commissioner for Custodial Operations, Department of Community Safety also gave evidence in relation to issues of policy and training.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

I determined that the evidence contained in this material and the further evidence provided by way of oral evidence was sufficient to enable me to make the findings required by the Act. Counsel Assisting submitted there was no forensic purpose to be served by calling any further witnesses to give oral evidence in light of the evidence already given at the preceding criminal trial.

A copy of the police investigation report was provided to Mr Challis' family via his sister, Ms Sandra Honey. Ms Honey and other family members attended the pre-inquest conference and the inquest proper. I thank them for their detailed consideration of the material and the issues they have raised constructively with counsel assisting.

At the commencement of the inquest, counsel for the Department of Community Safety made a public apology to the family of the dead man. Although the basis for the apology was not stated, as the department has taken disciplinary action against two officers peripherally involved in the fatal incident, I took the apology to be implicit acceptance that those officers could have responded to the incident more effectively and perhaps prevented the death. In her statement to the court Mr Challis' sister dismissed the apology, seemingly because prison management had failed to respond to her requests for information about the incident soon after it occurred. While I can understand her resentment of that, I nonetheless believe the department's apology was a genuine recognition that its officers had not performed as

would be expected. Official acknowledgment of that was commendable in my view.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Personal history

George Challis was born in Brisbane on 17 September 1965, the youngest of four children of George Snr and Pearlie Challis. Mr Challis grew up with his family at Toowong and attended St. Ignatius primary school and later Toowong and Kelvin Grove State High Schools. He suffered from dyslexia which led to poor academic performance and, in the view of his sister, poor self esteem. This improved somewhat when Mr Challis moved with his sister and brother-in-law to a property near Mackay at the age of 15.

On moving back to Brisbane Mr Challis did some laboring work and soon became involved in drug use which extended to the regular injection of heroin. His criminal history developed from 1983 onwards in a manner one would, unfortunately, expect to accompany ongoing drug use.

Mr Challis made attempts at drug rehabilitation with none being successful, although his most recent attempt showed more promise than most. He maintained a good relationship with his siblings and had been visited by his sister Diane and her husband Barry in prison shortly before his death.

The very detailed statements provided by Mr Challis' family members reflecting on his life paint a picture of a man who was very much loved and continues to be sadly missed.

Custody

Mr Challis was imprisoned at WCC after being refused bail and remanded in custody on a large number of property and dishonesty charges. He had spent significant periods in custody for predominantly property offences since 1986. His prisoner case reports and case notes show that at least since 2005 he was regarded as a quiet and well regarded prisoner, but for one allegation of abuse of staff.

Mr Richmond-Sinclair was on remand for charges of breaching an intensive correction order, imposed for offences of armed robbery and wilful damage. Records show that he had been involved in fighting with another prisoner in April 2003. Case notes from his time in custody indicate a sometimes demanding or abusive attitude and describe a person who has difficulty communicating with others in group settings.

Events of 1 July 2006 prior to assault

There is no evidence to suggest that prior to 1 July 2006 Mr Challis and Mr Richmond-Sinclair had any connection or personal history other than being prisoners in unit N13 at WCC. Unit N13 accommodates up to 35 sentenced and remand prisoners. At the relevant time it housed 6 remand and 28 sentenced prisoners.

At around 11:00am on 1 July 2006 it appears there was a heated discussion or argument between Mr Challis and Mr Richmond-Sinclair. The details of this are scant and for the purposes of Mr Richmond-Sinclair's criminal trial it was regarded as background only. The trial judge specifically rejected a suggestion that Mr Challis had hit Mr Richmond-Sinclair's head against a fence on this occasion.

In the early afternoon of the same day, the prisoners, including Messrs Challis and Richmond-Sinclair, were in the exercise yard of Unit N13. The adjoining CSO station is constructed to oversee both units N12 and N13. Each unit is assigned an officer and the two CSO's share the assistance of a support officer. At the material time the officers' station contained CSO's Bruce Ruddock (N13 Unit Officer), Ian Janson (N12 Unit Officer) and Denise Musgrove (N12/N13 Support Officer).

At about 1.49pm CSO Janson observed Mr Richmond-Sinclair throw two punches hitting Mr Challis in the face. It now seems that this was the culmination of an argument in which Mr Challis was heard to ask, '*Why did you call me a maggot?'*. In her evidence at the criminal trial, CSO Musgrove stated that she had observed Mr Challis on the ground of the exercise yard having seemingly been knocked over.

CSO Ruddock, having been alerted to the incident tapped on the officer station window and ordered the prisoners to stop. Further verbal exchanges between Challis and Richmond-Sinclair took place before the prisoners entered the unit.

CSO's Janson and Musgrove recall seeing another prisoner intervene in the altercation around the same time as the tap on the window took place. They gave varying accounts of the other prisoner having an arm on or around Mr Challis seemingly guiding him back into the unit. CSO Ruddock did not recall the involvement of that third prisoner.

Mr Richmond-Sinclair was the first to enter the unit followed very shortly afterwards by Mr Challis. At the inquest Mr Ruddock estimated that it might have taken up to a minute between his tapping on the window and the prisoners arriving at the officers' station inside the unit. I accept this as a reasonable estimate having regard to the distances involved and the accounts of the other officers. During this period the three CSO's remained inside their station.

In his evidence at the inquest CSO Ruddock stated that he spoke to the two prisoners as they entered the unit from the exercise yard, that he asked them

if there was any trouble and was told by them that there was no problem. This, was the first he had mentioned any such conversation. In several previous accounts and on his initial account at the inquest, CSO Ruddock referred only to his giving instructions to the prisoners. I am of the view that he did speak to the two prisoners but that it was only to tell them they were to be locked in their cells.

Mr Challis and Mr Richmond-Sinclair seemingly did not immediately comply with the direction they had been given. It seems they initially walked away from the officers' station in different directions. Electronic records show their cells doors (number 22 and number 28 respectively) were enabled at 13:51:43 hours. The CSO's were not certain as to what if any injuries had been sustained by Mr Challis at this point.

The assault

Once inside the unit Mr Richmond-Sinclair went to the kitchen area. Mr Challis was then observed to approach and speak to him. At the inquest CSO Ruddock estimated that up to another minute had passed between his ordering the prisoners to their cells and the two prisoners again coming together. The three CSO's were still in the officers' station at this time. After making a call for the two cell doors to be opened, CSO Ruddock says his intention was to enter the unit and interview the two prisoners in order to obtain further details about the altercation. At the inquest he took the position that his execution of this intended course of action had not been unduly tardy despite his evidence of there having been up to two minutes pass.

CSO's Ruddock and Janson then observed Mr Richmond-Sinclair grab Mr Challis by his clothing and drag him several metres past some cell doors. It appeared at this point Mr Challis was attempting to get away but he was hit twice in the face area by Richmond-Sinclair before falling to the floor.

CSO Musgrove unlocked the day room door to gain access to unit N13. There is conflicting evidence over exactly when this happened. The inspectors appointed under the Corrective Services Act interrogated the electronic locking system and established that the airlock to the unit had been opened at 13:54:44 hours. However I accept the evidence of the two CSOs who said they entered the unit through a door without electrical locking and that the time referred to by the inspectors was the time other officers who responded to the unit officer's call for assistance entered the unit.

At the inquest various time estimates were heard as to the period from when Mr Challis was first assaulted in the exercise yard until when the second assault commenced. Considering all of the evidence I am of the view the best estimate is about 3 minutes. Importantly, it was clear on the evidence that had CSO Ruddock, who was in charge of Unit N13, decided to enter after being advised of the initial assault, he would have been in the unit well before the second assault commenced.

CSO's Janson and Ruddock rushed into the unit after the assault commenced and saw Mr Richmond-Sinclair kick Mr Challis with his right foot before raising

his right leg and bringing it down in a sharp motion on Mr Challis' head. Mr Richmond-Sinclair was sentenced on the basis that he had again attempted to kick Mr Challis but on this occasion missed.

Immediate response

CSO Janson immediately called a 'code blue' and directed Mr Richmond-Sinclair to go to his cell. He complied with this after obtaining some food and drink from the kitchen.

Broadcast of the 'code blue' resulted in prompt assistance from other CSO's and two registered nurses. After assessment by the nurses Queensland Ambulance were called with their records showing that this occurred at 1:58pm.

Supervisor Jeff Kajewski organised for preservation of the scene and directed that Mr Richmond-Sinclair be handcuffed and escorted to the health centre for examination. He complained of sore hands and feet and in his discussion with CSO's made comments to the effect of, '*I'm fucked now aren't I?*' He was strip searched and his clothes bagged as evidence. He was then taken to the detention unit, where, remarkably, he was allowed to shower.

Medical treatment at WCC

QAS officers arrived shortly after 2.00pm and found Mr Challis to be bleeding from the back of the skull, right ear and nose. He had a Glasgow Coma Scale rating of 7, was vomiting and had an obstructed airway. A request was made for a Careflight helicopter to attend for the purposes of an emergency medical evacuation. A cervical collar was applied and high flow oxygen administered.

The Careflight helicopter arrived at 2:38pm and Dr Michael Thompson gained intravenous access via the left external jugular vein. Previous attempts by other medical personnel had been unsuccessful, possibly due to Mr Challis' history of intravenous drug use. Mr Challis was intubated by a rapid sequence induction. This was done to control his airway and prevent secondary brain injury due to his being unconscious. He was then transported in a sedated, ventilated and paralysed state via ambulance and then helicopter to the PA Hospital; leaving WCC at 4:01pm.

Treatment at PA Hospital

On arrival at the PA Hospital an initial CT scan showed a left 6mm subdural haemorrhage with a smaller subdural haemorrhage and left arachnoid haemorrhage with fracture of the right petrous temporal bone. Mr Challis underwent an operation at which time his brain was observed to be contused, particularly in the temporal lobes. Post-operatively he had raised inter-cranial pressure and was managed in the ICU over the course of the next few days.

As early as 5 July CT scans showed the brain herniating through his craniotomy site and he continued to have refractory inter-cranial hypertension with high inter-cranial pressures. At that stage the neurosurgical opinion was that no further operative intervention was suitable.

Inter-cranial pressure remained at high levels through to 11 July at which time intensive care specialist, Dr David Cook, in consultation with colleagues, decided to remove the inter-cranial pressure monitor on the basis that its presence may be adding to the risk of brain infection. At this time his outlook remained very poor and this was made clear to Mr Challis' sisters.

Early on the morning of 12 July 2006 Mr Challis' pupils were found to be large and dilated. He developed sudden haemodynamic instability requiring adrenaline and noradrenaline. The neurosurgical team advised that only medical therapy was appropriate. It was determined by Dr Cook, again after consultation with his colleagues, including a full independent review, that the dilated pupils in combination with Mr Challis' history and brain scans represented a terminal event. Yet further reviews were conducted by two neurosurgeons and, after discussions with Mr Challis' family, ongoing therapy was ceased at 6.00pm on 12 July 2006 and Mr Challis declared dead at 6:30pm.

Autopsy results

An autopsy examination was carried out the following morning, 13 July 2006, by an experienced forensic pathologist, Dr Olumbe. After considering the results of a specialist neuropathologist examination of Mr Challis' brain he noted:

> *"The results confirmed presence of head injury consistent with assault and survival 12 days on ventilatory support, base of skull fracture and left subdural haematoma. Other findings including multiple cerebral (brain) cortical contusions, raised intra-cranial pressure due to the head injury and possible diffuse axonal injury."*

Dr Olumbe noted a bruise on the left side of the face being consistent with blunt trauma requiring a moderate amount of force. In his view, the fatal injury on the brain was the consequence of a primary blunt impact of severe force by one or more blows on the right temporal region (just above the right ear).
The presence of acute bronchopneumonia was consequent to the head injury and pro-longed loss of consciousness and was not pre-existing. Dr Olumbe found no evidence to suggest any shortcoming in the medical management of Mr Challis.

Dr Olumbe issued a certificate following the autopsy examination listing cause of death as:

1(a) Head injury

Conclusions

The immediate and proximate cause of Mr Challis' death was the assault on him by Mr Richmond-Sinclair; the criminality of which has been established. There is no evidence that any other person conspired, colluded or aided him in that cowardly, violent and criminal action.

The first aid and medical attention Mr Challis received after the attack was of an appropriately high standard. Once the injuries were sustained it is likely nothing could have been done that would have averted his death.

Findings required by s45

I am required to find, as far as is possible who the deceased person was, how, where, and when he died and the medical cause of the death. As a result of considering all of the material contained in the exhibits, the oral evidence and the submissions made by the lawyers who appeared at the inquests I am able to make the following findings.

Identity of the deceased – The deceased person was George Edgar Challis.

How he died - Mr Challis was a remand prisoner in custody at the Woodford Correctional Centre when he was unlawfully assaulted by another prisoner. He died 11 days later in hospital as a result of injuries sustained during that assault.

Place of death – He died at the Princess Alexandra Hospital in Brisbane.

Date of death – He died on 12 July 2006.

Cause of death – Mr Challis died from head injuries.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

The two issues in this case which warrant some comment from this perspective concern:-

- The adequacy of the response of the CSOs to the initial assault; and
- The preservation of evidence.

The response of the CSOs'

The primary responsibility for the death of Mr Challis undoubtedly lies with Mr Richmond-Sinclair: that has been established beyond reasonable doubt by the verdict of a criminal court. However, the authorities have a moral and legal responsibly to take all reasonable steps to preserve the safety of all prisoners. As Dostoyevsky famously observed; *"The degree of civilisation in a society can be judged by entering its prisons."*[1]

[1] Dostoyevsky, Fyodor - *The House of the Dead (1862)*

The failure of the corrective services officers to take actions which may have prevented the assault are concerning. It seems likely that had CSO Ruddock, or indeed either of the others entered the yard immediately on becoming aware of the first assault, they would have discouraged further conflict or been in a position to stop the second assault. It seems from the evidence of the prison managers and the other material tendered in evidence that there was an expectation by prison authorities that the CSOs would provide a physical presence on the floor of the unit much sooner than was actually provided by the officers in this case.

That raises the question whether the failure of the officers to intervene in a timely manner resulted from inadequate policy and procedures in place at the time or whether there was a failure to comply with those policy and procedures.

The detailed report compiled by Inspectors appointed pursuant to s.219 of the *Corrective Services Act* 2000 referred to earlier, made the following findings relevant to this issue:

- Officers in unit N12 and N13 failed to respond in a timely and appropriate manner after the fight between Richmond-Sinclair and Challis in the exercise yard. In particular there was a failure to call an emergency 'code yellow – officer needs assistance'.

- There is a culture of CSO's not reporting incidents between prisoners within units N12 and N13.

- There was an absence of dynamic security in unit N13 evidenced by officers managing the unit from the officers' station behind closed grills. The report noted that this may be indicative of a widespread practice at WCC.

The Code Yellow Policy in place at WCC during the relevant time set out its purpose as follows:

> *"To provide an immediate, effective and coordinated response to an officer requiring assistance while maintaining the safety of all persons and the security and integrity of the Centre."*

It set out a requirement for the first officer responding to the incident; requiring that person to raise the alarm by saying over the radio 'ALERT, ALERT, CODE YELLOW' followed by the location. The policy at this point provides the following as an example:

> *"November 17, inmates fighting"*

The inquest heard the opinions of various experienced corrections officials in addition to the CSO's involved in this incident as to when a code yellow was to be called. Opinions differed as to whether it was necessary to call a code

yellow on all occasions that two or more prisoners were observed to be fighting or whether there was an element of discretion on the part of the CSO involved.

The inquest heard in particular from Mr Scott Collins, General Manager of Custodial Operations for DCS and a former General Manager of WCC. He was very clear in his view that the calling of a code yellow retained an element of discretion on the part of the CSO involved. He said that CSO's are trained that in the case of prisoners seen to be fighting that the overarching objective is to do something to ensure that this is stopped as soon as possible. That may, in the first instance, be the imposition of a physical presence or even a physical intervention into the fight should the CSO feel it is safe to do so. If it is the case that the CSO involved is not of the view that a situation can be resolved without imposing on their safety the option is then clearly to call a code yellow.

It is on this basis I believe that the failure of the officers involved in this case was not simply failing to call a code yellow immediately (or indeed at all) but in failing to take any action in a way that could reasonably be expected to resolve the situation when it came to their attention that Mr Challis and Mr Richmond-Sinclair had been fighting.

I adopt the findings of the QCS report that it was naïve to believe that the two prisoners would remain separated once they had been spoken to by CSO Ruddock.

I am satisfied the officers involved were trained and instructed to physically intervene in situations such as those on the afternoon of 1 July 2006 rather than remain passive. If they did not feel safe in doing so; and I can understand why they may not have, then it was incumbent on them to have called a code yellow. They did neither.

Changes in procedure

The inquest heard from various senior officers at WCC in relation to changes in procedures at the prison. It is clear that CSO's at WCC are now expected to call a code yellow in circumstances where two prisoners are seen to be fighting. CSO Ruddock's evidence confirmed that the frequency of code yellows has increased significantly since this incident.

This approach appears to withdraw from individual CSO's the option of applying their discretion as to whether physical intervention may alone be sufficient to resolve matters. The obvious downside to the new approach is the imposition on prison staff and the potential to reduce security in other areas of the prison. The inquest heard that the current hierarchy at WCC did not consider the current frequency with which code yellows are being called compromised safety or security and I accept that evidence.

Mr Collins gave evidence about the training regime put in place since this incident as it concerns the response to 'contingencies'. He held the role of General Manager at WCC for a period shortly after Mr Challis' death and

personally oversaw an increase in the level of code yellow practice drills for staff at the prison. The records show a marked increase in such drills immediately after the death of Mr Challis before once again tailing off. In any event it appears that such training included little if no focus on when code yellows were to be called (the issue in the case of Mr Challis), rather they were concerned with the response to such a call. This issue may be overcome by the adoption of the policy outlined above imposing a mandatory requirement to call code yellows in certain situations.

The evidence given by Mr Collins also highlighted an increased focus in the training of CSO's on 'dynamic security'. Daily inspection reports aim to provide a level of oversight on the extent to which officers are interacting with the prisoners.

I am of the view no useful recommendations could be made by me in relation to the issue.

Preservation of evidence

As mentioned earlier, there is a basis for concern about aspects of the evidence preservation procedures adopted in this case.

The inspectors report also dealt with that issue and found:

- There was poor communication between supervisors who acted independently of each other in the aftermath of the incident.

- There was a failure to preserve evidence by allowing Mr Richmond-Sinclair to shower and place his clothing in a single bag.

- Mr Richmond-Sinclair was placed in a detention unit without supervision and without officers considering self-harm/suicide indicators.

- No evidence was found that the CSO's had been trained to a competent level in responding to 'contingencies'. There was a lack of recent training in such matters. This was evidenced in their lack of crime scene and evidence preservation skills and the poor first officer response to an 'offender on offender' assault.

Changes in procedure

Mr Collins acknowledged the management of the crime scene in this case was 'less than ideal'. He explained the current regime of training for CSO's and those in supervisory roles as to crime scene management and the preservation of evidence. This involves a localised training package for each correctional facility being devised by intelligence officers from the prison and members of the QPS CSIU. Training for prison staff is then conducted by the intelligence officers several times a year.

I am satisfied that training program is adequate. The ongoing consultation with officers from the CSIU is to be encouraged. Accordingly I have no recommendations to make in relation to this issue.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
17 June 2010