QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Adam CARTLEDGE**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2010/3434
DELIVERED ON:	29 August 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	5 June 2012; 27-28 August 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: death in custody; hanging points

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Department of Community Safety:	Ms Kay Philipson
GEO Group Australia Pty Ltd:	Mr Sandy Horneman-Wren SC (instructed by Ashurst Lawyers)

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The *Coroners Act 2003* provides in s47 that when an inquest is held into a death in custody, the coroner's 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 Adam Cartledge. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

Adam Cartledge, 38, had been in custody on remand for almost three years at the Arthur Gorrie Correctional Centre (AGCC) when, on the evening of 5 October 2010 he was found hanging in his cell. Extensive attempts at resuscitation were unsuccessful and Mr Cartledge was declared dead.

These findings:

- confirm how he died and the identity of the deceased person, the time, place and medical cause of his death;
- consider whether any third party contributed to his death;
- consider the adequacy of the response by staff at the AGCC to notification that the deceased man was hanging;
- examine the policies in place at the AGCC regarding the accommodation of prisoners with an elevated base line risk of suicide or self harm;
- consider whether those policies were properly followed; and
- consider whether any changes to infrastructure, policies or procedures should be made with respect to the accommodation of prisoners at the AGCC.

The investigation

Detective Senior Constable Raelene Speers, then of the QPS Corrective Services Investigation Unit (CSIU) investigated the death and produced a report which was tendered at the inquest. She attended the AGCC and examined Mr Cartledge's cell; observing the body *in situ*. Detective Speers ordered a forensic examination and photographing of the cell and body. She then seized all relevant documentation from the AGCC relating to Mr Cartledge and the circumstances of the death.

Officers assisting Detective Speers conducted interviews with other prisoners in the unit housing Mr Cartledge and took statements from custodial corrections officers (CCO's) and medical staff at the AGCC. For reasons that

have not been explained the interview with the prisoner who first noticed Mr Cartledge hanging was not able to be found.

A separate investigation into the death was ordered by the Chief Inspector of Queensland Corrective Services. Two inspectors compiled a detailed report of their findings which was also tendered at the inquest. I found this investigation and report to thorough and most helpful in framing issues for consideration at the inquest. In aggregate I found the two investigations to have addressed all relevant issues and to have sourced all relevant information.

The Inquest

A pre-inquest conference was held in Brisbane on 5 June 2012. Mr Johns was appointed as counsel to assist me with the inquest. Leave to appear was granted to Queensland Corrective Services and GEO Group Australia Pty Ltd (the operator of the AGCC).

An inquest was held in Brisbane on 27 and 28 August 2012. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Seven witnesses gave oral evidence.

The evidence

Personal circumstances

Adam Cartledge was born on 25 October 1971 in Lithgow. He is survived by his parents and four children although had been estranged from the latter for many years prior to his death.

After separating from his wife in 1999, after more than seven years of marriage, he engaged in a number of other relationships while, from 1997 battling a work related back injury.

In November 2007 he was residing in Helensvale, sharing a house with his ex-girlfriend after the two had separated two months earlier. Mr Cartledge's ex-girlfriend was reported missing on 26 November 2007 and on 5 December 2007 Mr Cartledge confessed to police that he had killed her. He led police to where she was buried and on 7 December 2007 was charged with her murder. He was remanded in custody on that day pending a trial date that never came.

During his period of incarceration Mr Cartledge was visited on several occasions by his father who and had regular phone contact with his mother.

Medical history

In December 2001, and again in May 2002, Mr Cartledge presented to Albury Base Hospital with suicidal thoughts; in the first instance having apparently taken an overdose of his prescribed medication Zoloft and on the second, telling doctors he was thinking of driving his car intentionally into a tree. The

medical notes from the hospital indicate that even at that stage Mr Cartledge was considered to have had a long history of depression and of multiple overdose and self harm attempts.

Shortly after arrival Mr Cartledge told nursing staff at the AGCC that his most recent suicide attempt had been 8.5-9 years ago, although he also made reference to a threat to drive his car into the entrance of the Gold Coast mental health unit only 2-3 weeks earlier. He told medical staff that he had twice attempted overdose; on one occasion had attempted hanging and another had jumped in front of a moving car with suicidal intent. He also indicated a history of having slashed his arms.

The medical history also reveals Mr Cartledge having suffered chronic back pain since a work accident in 1997 in which he fell from a ladder.

Induction at the AGCC

Upon reception at the AGCC on 7 December 2007 Mr Cartledge underwent an Immediate Risk and Needs Assessment (IRNA). He told staff that he had been diagnosed with a depressive illness and with paranoid schizophrenia. He also reported a history of chronic back pain. It would have been apparent during this assessment that after his arrest, Mr Cartledge had advised QPS watch house staff that he was going to hang himself or cause himself brain damage or death by doing a handstand on his bed and then dropping head first to the floor. In any event, he was explicit in stating his current suicidal intent when asked about this by nursing staff during induction. He was accordingly determined to be at an elevated baseline risk (EBR) of suicide or self-harm. This meant he entered a regime of multi-disciplinary monitoring pursuant to a procedure in place at the AGCC.

As a result, Mr Cartledge was immediately placed on observations and housed in the medical centre. Mr Cartledge was referred to the Prison Mental Health Service (PMHS) and was seen regularly by psychologists employed by the AGCC. In all, Mr Cartledge would go on to have contact with PMHS staff on 68 occasions prior to his death. Although the meetings with the AGCC psychologists were predominantly for the purpose of risk-assessment, there was clearly a therapeutic element as well.

After a brief transfer to Woodford Correctional Centre he returned to the AGCC on 14 January 2008 at which time observations recommenced and continued through to 22 August 2008. Thereafter he remained classified as having an elevated baseline risk. Along with all other prisoners under this assessment Mr Cartledge's case was subject to regular multidisciplinary meetings aimed at assessing his needs and the risk he presented to himself.

Mr Cartledge was again placed under regular observation between 23 February 2009 and 4 March 2009 as a result of "*some suicidal ideation over a number of days*". He continued to be assessed as part of the EBR process. However, a little unusually for such a prisoner, he was housed in unit A1 from 4 March 2009.This is an older unit and does not contain cells which are

considered “suicide resistant”. Most EBR prisoners were placed in the newer Unit B5 which contained such cells.

Ongoing management and medical care at the AGCC

On 4 March 2010, the acting Principal Psychologist at the AGCC, Robert Harrison, wrote a memorandum to senior AGCC staff noting a directive from QCS that prisoners considered to have an elevated baseline risk of self harm or suicide should be housed in suicide resistant cells if at all possible. Mr Harrison listed eight prisoners who were so classified but were accommodated in older, less safe cells. He had concerns that for these prisoners the move required to adhere to the QCS directive would be detrimental. He noted that all these prisoners were relatively settled in their current units and “*removal from peer supports, in addition to their structured and identifiable environments may increase their levels of anxiety and potentially S/DSH risk*”.

On 25 March 2010 an AGCC counsellor, Jenny Hall, interviewed Mr Cartledge about a potential move to unit B5. Mr Cartledge seemed concerned about this news telling Ms Hall that he understood unit B5 to be a “*hectic*” unit. He said he did not believe he would cope if moved and made clear to Ms Hall that he did not wish to be transferred to that unit.

On 7 April 2010 Mr Cartledge was moved from unit A1 to unit B1 and on 11 April 2010 he was transferred to the medical unit (and subsequently unit W1) for observation. This followed a statement to staff that he was contemplating suicide. Mr Cartledge specifically referred to thought of hanging himself from the bars above the door of his cell. Regular assessments during this period indicated that by the end of April Mr Cartledge was denying any suicidal ideation and seeking re-integration into the general prison population.

He was reintegrated back into the mainstream population by spending days in unit B1 and nights at unit W1 from 7 May 2010. Records show that Mr Cartledge requested he be returned to unit B1 to undergo this process of re-integration.

There is also a reference in the EBR case notes for Mr Cartledge that he made a further request to be moved into unit B2. This request was granted and he was transferred to that older style accommodation on 22 May 2010.

On 9 June 2010 Mr Harrison interviewed Mr Cartledge. He found him to be “*calm of mood, future orientated and with nil S/DSH risk indicators*”. He recommended that Mr Cartledge be removed from the EBR review process. At a meeting on 24 June 2010 the other participants agreed with this recommendation and the removal took effect.

In the interim, on 18 June 2010, Mr Harrison issued another memorandum in similar terms to that of 4 March 2010. It again stated that the prisoners listed on the memorandum (which included Mr Cartledge) appear settled in their current units. Although it suggested that each had been within their respective units for “*relatively lengthy periods of time*” this was no longer the case for Mr

Cartledge, he having only been in unit B2 for four weeks. It was, though, open to Mr Harrison to reasonably take the view from his interview of 9 June 2010 with Mr Cartledge that he had settled well in unit B2 even at that early stage.

On 2 July 2010 Mr Cartledge declared a hunger strike until he was able to receive pain medication that he was seeking. He was again placed on observation which continued until 23 July 2010. A risk assessment team meeting on 23 July 2010, chaired by Mr Harrison, lead to this decision. Consideration was given at that time to reports of a psychologist, counsellor and nurse who had all made their own assessments of Mr Cartledge.

No further concerns were raised in relation to Mr Cartledge's conduct or disposition in the months thereafter leading to his death. As he had throughout much of his stay at the AGCC, Mr Cartledge, remained dissatisfied with the adequacy of the analgesic medication he had been prescribed for his chronic back pain. Medical records tendered at the inquest show that a variety of different medications were tried and that Mr Cartledge was referred for specialist diagnostic and therapeutic treatment in relation to this complaint.

A similar theme is evident in Mr Cartledge's consultations with his psychiatrist. A constant in his interaction with the PMHS was a desire to change the type or dosage of his prescribed medication. In the months prior to his death he had sought and obtained an increase in the dosage of his prescribed antidepressant medication Effexor and of Gabapentin.

As at 4 October 2010 Mr Cartledge was on the following medications for treatment of his physical and psychiatric conditions:

Chlorpromazine
Olanzapine
Diazepam
Lipitor
Effexor
Gabapentin

On 3 September 2010 Mr Cartledge was seen for the last time by a psychiatrist from PMHS. In the notes of the consultation it states:

> "*Although denying suicide plan/intent did state he had experienced some suicidal thoughts 'if I got that bad I asked for help'"*.

The psychiatrist discussed with Mr Cartledge the need to continue the techniques he had developed through work with the AGCC psychologist. The psychiatrist noted:

> "*Wants to give the increased gabapentin another 2-3/52. Adam satisfied with his plan 'the support would be good… If I can restart the largactil as well it will help. For clinic review 1/52"*

This is a reference to an increase in this medication which had occurred at the previous consultation on 6 August 2010 following a request by Mr Cartledge.

It appears from previous entries in the psychiatry records that there were sometimes delays from one appointment to the next when compared to the intended review date.

At the time of his death more than four weeks had passed since his last psychiatric review. The clinical review scheduled for one week after his last consultation on 3 September appears to have taken place on 25 September. Mr Cartledge told the registered nurse who conducted the assessment that he did not have any suicidal ideation. He returned voluntarily to see that nurse the following day at which time he reported feeling "*much less stressed, much calmer today"*. It appears that by this stage his request for Largactil had been partly satisfied as he reported to the nurse "*largactil has started to kick in"*. He did though state that he wanted an increase in the dosage to a more "*effective*" level.

Evening of 5 October 2010

Antony Maranic was a prisoner in Unit B2 who had befriended Mr Cartledge. He told the inquest he had noticed a deterioration in Mr Cartledge's mood in the weeks leading to his death. He claimed he was aware of Mr Cartledge's frustrations in relation to the prescription of psychiatric and analgesic medications but considered this particular deterioration in mood was due to news Mr Cartledge had received of further delays to his court proceedings. No such delays in fact seem to have arisen around this time. In any event, as at 5 October 2010 Mr Maranic did not consider Mr Cartledge was in imminent risk of suicide and he did not raise concerns about Mr Cartledge's mental state with any prison staff member.

At 8:18pm on the evening of 5 October, CCO's conducted a routine headcount in unit B2. Nothing unusual was observed.

Mr Maranic was housed in a cell directly opposite that occupied by Mr Cartledge. Mr Maranic told the inquest that he had been asleep in his cell earlier in the evening and after waking he had spent some time cutting strips to light a cigarette. During this process he did not notice any sounds coming from the cell of Mr Cartledge, although he did not consider this unusual as it was his experience that Mr Cartledge usually went to sleep at around 7:00pm.

At what Mr Maranic thought was around 9:10 or 9:20, (although it seems clear that it was closer to 9:50) he looked through the window in the door of his cell and saw Mr Cartledge, apparently standing near the door of his own cell. The desk light and television in Mr Cartledge unit provided enough light for Mr Maranic to make out a cord around the louvers in Mr Cartledge's cell and around his neck.

At the inquest Mr Maranic claimed he had looked in Mr Cartledge's direction after hearing the louvers above his cell door slam shut. He had not said this before and I do not believe it.

Mr Maranic said he initially tried to get a reaction from Mr Cartledge by kicking on his own door. When this failed he made a call from the intercom in his cell

to the master control room where CCO Chris Parslow took the call. That conversation commenced at 9:53:45 and went as follows:

Parslow: Yes?
Maranic: Get the fuck down here now.
P: Say that again.
M: Get the fuck down here now.
P: What is the problem?
M: Fucking now:
P: What is your name?
M: It's very Code Blue. Hurry the fuck up.
P: What is the problem?
M: My fucking cell mate has just killed himself. Hurry the fuck up.
P: You do not have a cell mate.
M· Next to me ... opposite me .. don't ... hurry the fuck up.
P: Ok, what's the name of the bloke opposite you?
M· Hurry up. .. .fuck

CCO Parslow told the inquest that he initially thought the call was a "*gee up*" as he was aware there were no double cells and as such no prisoners in that unit had a "cellmate". He told the inquest that he had experienced such prank calls previously. The area manager, John Hafner, happened to be in the control room at the time the call was made. CCO Parslow explained to Mr Hafner what had been said leading to the area manager speaking directly to Mr Maranic as follows:

Hafner:It's the [indecipherable] manager here. What's your problem?
Maranic:Get medical down here now.
H: Is this for you?
M: No. Fuck what's taking so long? Shouldn't there be someone fucking here by now?
H:I want to know what's going on.
M: My cell mate is hanging from the fucking louvers. Hurry the fuck up and get here. The cunt is opposite me.
H: Is that in cell 9?
M: No cell5.
H: Cell 5. Alright, we'll get down there.

The duration of the call from Mr Maranic to the control room (encompassing both of these conversations) was 1 min 30 seconds.

At the time this call was made the CCO's responsible for unit B were on a break in the meal room. Mr Hafner instructed CCO Parslow to make urgent contact with those officers and tell them to attend unit B2 to see what was going on. Mr Hafner set off to attend that unit himself.

At 9:57:05 Mr Maranic made this further call to CCO Parslow:

P: Yeah we have officers coming down there now
M· Yeah it would be a good idea if they did.
P: Say again?
M· It'd be a good idea if they did.
P: Yes, the corrections manager is coming down there with him

Mr Maranic says that on entering the unit a CCO initially came to his cell and asked him what the problem was. However, cctv recorded vision shows the officers going directly to Mr Cartledge's cell which was accessed at 9:59:32pm.

Mr Cartledge was cut down and placed on the landing just outside his cell door. A towel was placed under his head while CCO Richard Bugeya cut the noose from his neck. A "code blue", medical emergency, call was made over the internal communication system at about this time. Mr Hafner arrived in the unit just as the cell was being opened

Resuscitation attempts

CCO Raymond Barrett commenced CPR while another CCO contacted the Queensland Ambulance Service (QAS). Two nursing staff arrived at 10:01pm and assisted with CPR by using a bag and defibrillator. When attached to Mr Cartledge the defibrillator issued an instruction to continue resuscitation attempts but that no shock should be given. Three CCO's took turn to administer chest compressions with nursing staff providing air.

The QAS received a call from the AGCC at 10:01pm according to that organisation's computerised records. The first paramedic arrived to assess Mr Cartledge at 10:17pm by which time there was evidence of rigor mortis. That paramedic, Simon Bennett, issued a life extinct certificate at 10:22pm. The cell and areas around it were appropriately cordoned off until the arrival of police.

Autopsy results

An autopsy examination was carried out on 7 October 2010 by an experienced forensic pathologist, Dr Nathan Milne. After considering toxicology and histology results Dr Milne issued a report in which he stated:

> "*External post mortem examination showed abrased and pale compressed skin on the science and front of the neck. The appearance was typical of hanging and is consistent with having been produced by the segment of towels seen in the police photographs. There was also an injury to the right hand near the knuckles.*
>
> *Internal post mortem examination confirmed a haemorrhage of the right side of the hyoid bone. There was also haemorrhage in the muscles at the base of the neck on the left side, an injury that is recognised to occur in hanging. Bleeding on the back of the right hand was confirmed. There were no other internal injuries. There was no significant pre-existing natural disease."*

Toxicology results showed higher than therapeutic but less than lethal levels of tramadol and venlafaxine. Otherwise the results were considered to be unremarkable.

As a result of his findings, Dr Milne issued a certificate listing the cause of death as:

1(a) Hanging

Investigation findings

Nothing from the forensic examination of Mr Cartledge's cell was indicative of the involvement of another person in his death.

Two notes in Mr Cartledge's handwriting found in his cell indicated an intention to take his life.

The ligature around his neck appears to have been made from a shredded towel. It was fastened to the exposed bars above the cell door.

Former Detective Senior Constable Speers told the inquest she was satisfied there was no evidence of the involvement of another person in the death either by foul play or by rendering assistance to Mr Cartledge.

Conclusions as to cause of death

I conclude that Mr Cartledge intentionally took his own life without assistance from or with the knowledge of any other person. It is apparent he was at chronic risk of self harm but it is unclear when that risk became acute.

There is no reliable evidence that points to an obvious deterioration in his mental state in the days or weeks leading to his suicide. Accordingly, I do not consider the staff at the AGCC who had contact with Mr Cartledge in this period could reasonably have been expected to have been aware of his increased risk and to have to prevented the death.

I am satisfied that the officers who became aware of Mr Cartledge's situation acted appropriately in responding to it by summoning assistance and administering first aid. There was nothing more they could have done to try and save him.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering the oral evidence given at the inquest and all of the material contained in the exhibits, I am able to make the following findings in relation to those matters:

Identity of the deceased – The deceased person was Adam Cartledge.

How he died - Mr Cartledge intentionally took his own life by hanging himself from exposed bars in his cell in the Arthur Gorrie Correctional Centre where he was being held on remand.

Place of death – He died at Wacol in Queensland.

Date of death – He died on 5 October 2010.

Cause of death – Mr Cartledge died from hanging.

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.

In this case, the following issues warrant consideration from that perspective.

- Adequacy of medical care;
- Appropriateness of cell allocation;
- Adequacy of the emergency response; and
- Adequacy of infrastructure at the AGCC for prisoners at risk of suicide.

Adequacy of medical care

The medical care provided to Mr Cartledge was reviewed by Dr Alun Richards, then executive director of Offender Health Services; a central unit in Queensland Health, the functions of which have now been divested to individual administrative regions. As the health staff at the AGCC are employed by GEO Group Australia Pty Ltd and Queensland Health does not administer the medical care in that prison, I am satisfied that this was an appropriately independent assessment.

Dr Richards, while noting the difficulty of assessing the severity of chronic pain, made the following findings:

> "*Mr Cartledge's medical file reveals that he has been reviewed by an orthopaedic surgeon, had received physiotherapy on at least 8 occasions this year and had been referred to a pain management specialist. It is noted that there is a significant waiting list for pain management services in the public sector. Mr Cartledge's back had been investigated by X-Ray, which showed degenerative changes, but not evidence of spinal compression.*
>
> *.*
>
> *Mr Cartledge had been prescribed a variety of different medications to assist with his pain by a variety of doctors including simple analgesics, compound analgesics, opioid analgesics, antidepressants, muscle relaxants and nerve stabilising agents.*
>
> *While it is impossible to ascertain Mr Cartledge's level of pain in retrospect, Mr Cartledge's pain appeared to have been taken seriously and investigated appropriately."*

Although I do not discount the possibility that Mr Cartledge's chronic back pain contributed to his suicide, I am satisfied that there is no evidence of mismanagement of his condition by health care staff at the AGCC.

I have also given consideration to Mr Cartledge's apparent concern in relation to the prescription of medication for his psychiatric conditions. In one of the notes found in his cell Mr Cartledge ascribed blame for his suicide to changes in this medication. Notwithstanding this, I am satisfied his access to psychiatric and psychological services was adequate when compared to that which is likely to have been available to him outside prison.

Accordingly, there is no basis for any preventative comments in relation to this issue.

Appropriateness of cell allocation

Despite having an extensive history of psychiatric illness and suicide attempts Mr Cartledge was housed in one of the 380 old style, non suicide resistant cells still in use at the AGCC. He killed himself by utilising one of the numerous easily accessible hanging points in the cell. This naturally brings into question the appropriateness of decisions concerning his housing at the Centre.

The report prepared for the QCS Chief Inspector recommended:

> *When allocating prisoners to secure accommodation at AGCC, prisoners who have a self harm flag are placed in modern suicide resistant cells unless other reasonable factors warrant against it; and where such prisoners are not allocated to a modern cell, the reason(s) for the individual decision be recorded*.

When he was interviewed by the QCS Chief Inspector and again at the inquest, the General Manager of the AGCC, Greg Howden, questioned the appropriateness of self harm flags as the primary tool for determining cell allocation. In particular he noted that once a prisoner was "flagged" they retained this status indefinitely, even if the risk had long passed. This had the propensity, he said, to result in the unnecessary placement of prisoners who are at low risk of suicide in suicide resistant cells.

Apparently, there are enough suicide resistant cells at the AGCC to cater for all "flagged" prisoners. However the need to separate prisoners who pose a risk to each other - protection prisoners from the general population; members of different outlaw motorcycle gangs from each other; prisoners with drug debts from those who collect such debts; and sexual predators from vulnerable prisoners, etc - means that the all of the cells can not be utilised this way.

The inquest heard that the AGCC has changed its procedures to ensure that all prisoners who arrive at that prison and are flagged as either a current risk of suicide or who have a history of attempted suicide are now housed initially in suicide resistant cells. There is now a subdivision of "flags" on the

integrated offender management system (IOMS) to differentiate those with a current risk of suicide or self harm from those who have a historical incidence of attempted suicide but are not considered to be at imminent risk. Arrangements are now in place such that the first group are always housed in new suicide resistant cells. At any one time the second group; those with a "historical" flag, number around 300. These prisoners will also be housed in suicide resistant cells unless there is some "*significant operational impediment to achieving this*."

After the initial placement of the flagged prisoner, a panel, chaired by the operations manager, and including operational supervisors, intelligence operatives and a psychologist, meet to assess the status of the prisoner and decide on the most appropriate accommodation for him. Reasons for the decision as to where a prisoner will be accommodated are now captured by a form which is uploaded into IOMS.

The investigators appointed by the Chief Inspector also recommended that "*representatives from QCS and GEO Australia Pty Ltd meet to examine and progress the necessary changes at AGCC with a view to increasing the number of prisoners were self harm flags accommodated in one cells*". Consistent with this recommendation such meetings have resulted in the QCS Incident Oversight Committee endorsing the new placement process at the AGCC as at 10 July 2012.

It is apparent that the decision to house Mr Cartledge in a cell which gave him ready access to a hanging point facilitated his death. However, I accept that it was a carefully considered and justifiable decision, even if retrospectively it can be seen to have been wrong.

I am satisfied that the process for making such decisions has developed further since this sad death. As a result of implementing recommendations made in the chief inspector's report, progress has been made in addressing this issue and there is nothing that I could contribute as result of any evidence gathered during this inquest.

Adequacy of the emergency response

The door to Mr Cartledge's cell was opened a little less than six minutes after the alarm was first raised. Some delay was occasioned by scepticism from the officer first contacted as to whether there was an actual emergency. I accept the evidence that this was based on experience of false alarms in similar circumstnces. There was also some delay in summoning medical assistance until an officer had attended at the cell to ascertain whether that was necessary.

When medical assistance was called for, nurses from the medial centre and QAS paramedics were quickly on scene.

In all of the circumstances, I am of the view the response to the call for assistance was reasonable, as was the provision of medical attention when the emergency was discovered. In my view, Mr Cartledge was almost

certainly already dead when he was first seen by the prisoner who summoned assistance and nothing could have been done to save him.

Adequacy of infrastructure at the AGCC

As mentioned earlier there are still 380 cells in use at the AGCC with exposed hanging points. This is contrary to the recommendations of the Royal Commission into Aboriginal Deaths in Custody, made 20 years ago and to numerous recommendations made by coroners.

The prison operators and QCS say this is unavoidable: that all safer cells that have been built more recently are full and that the system could not function adequately without the unsafe cells being utilised. QCS also says that many millions of dollars have been spent and will continue to be spent incrementally addressing the issue.

I acknowledge that progress has been made and that the proportion of unsafe cells has decreased. Of course, I readily accept that there is on-going competition for public funds and that it is the role of governments to balance those competing needs. Conversely, it is the role of coroners to point out the consequences of these decisions when they result in reportable deaths. Accordingly, I observe that preventable fatalities will continue to occur in Queensland correctional centres while prisoners continue to be housed in cells with readily accessible hanging points. There is no recommendation to reduce this risk that I could make that has not been already made.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
29 August 2012