OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	Inquest into the death of **Tony John STANFORD**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2673/06(1)
DELIVERED ON:	03 July 2009
DELIVERED AT:	Brisbane
HEARING DATE(s):	25 June 2009
FINDINGS OF:	Ms Christine Clements, Acting State Coroner
CATCHWORDS:	CORONERS: Death in custody, hanging.

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
GEO Group Australia Pty Ltd:	Mr Alexander Horneman-Wren (instructed by Blake Dawson Lawyers)
Queensland Corrective Services:	Ms Kay Philipson
Queensland Health:	Mr Kevin Parrott (Crown Law)

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 organizations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system including the Attorney-General and the Minister for Police and Corrective Services. These are my findings in relation to the death of Tony John Stanford. They will be distributed in accordance with the requirements of the Act and posted on the website of the Office of the State Coroner.

Introduction

Tony John Stanford was an inmate at Arthur Gorrie Correctional Centre (AGCC), Wacol when he died there on 19 September 2006. At about 9pm that evening he was discovered hanging in his cell by prison officers. Despite attempts at resuscitation by prison nursing staff, Queensland Ambulance Service officers confirmed Mr Stanford had developed lividity and rigor mortis and further attempts at resuscitation were futile. He was 36 years of age.

At the time of his death Mr Stanford was on a risk management plan requiring him to be observed by staff on a two hourly basis as a result of concerns for his mental health. At the time he was discovered hanging in his cell he had not been checked for about 3½ hours.

Mr Stanford's death was a "*death in custody*"[1] within the terms of the Act and so it was reported to the State Coroner for investigation and inquest.[2]

These findings

- confirm the identity of the deceased man, the time, place and medical cause of his death;
- explain how he died and examine the events leading up to his death;
- examine the actions of AGCC staff in the hours prior to his death and in particular the adherence or otherwise to scheduled observations of the deceased; and
- consider whether the psychiatric and psychological treatment provided to him while in custody and the observation measures put in place as a result of his psychiatric history were adequate.

The investigation

Detectives from the Corrective Services Investigation Unit (CSIU) were advised of the death at 9.20pm and commenced investigation shortly after.

[1] See s10
[2] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state coroner or deputy state coroner. S27 requires an inquest be held in relation to all deaths in custody

Two detectives attended the scene at 10.10pm and coordinated scenes of crime officers and arranged the seizure of exhibits.

Registers, documents and other potential evidence relating to Mr Stanford were taken from the management of the AGCC.

All Corrective Services Officers (CSO's) and AGCC nursing staff having any involvement with Mr Stanford on the day of his death were interviewed and provided statements.

A police photographer attended the scene and a police scientific officer commenced an examination of Mr Stanford's cell; testing for the presence of blood and taking a number of samples. Fingerprint samples were taken from the body and at a later date confirmed to be identical to those held on record for Tony John Stanford.

CSIU detectives conducted interviews with all inmates in Unit W2 regarding their contact with Mr Stanford. CSIU detectives also took a detailed statement from the niece of Mr Stanford, Katrina Stanford, and obtained copies of correspondence between them.

A second investigation was conducted by Queensland Corrective Services. Three inspectors were appointed to investigate Mr Stanford's death pursuant to s294 *Corrective Services Act 2006*.[3] Nominated staff were interviewed and cell 39 was inspected. The inspectors met with the general manager and with the Investigations Manager for the prison operators, GEO Group Pty Ltd.

The third investigation was by GEO Group Australia Pty Ltd, who commenced an internal investigation which was carried out by their manager of investigations, Richard Laws.

I have found the police investigation in this matter to be extremely thorough and professionally conducted. I thank the members of the CSIU involved and in particular Detective Sergeant Williams for his considerable efforts.

The additional investigations have also been thorough and impartial and assisted the review of the circumstances of Mr Stanford's death.

Where a law enforcement agency is already conducting an investigation, s295(3) of the *Corrective Services Act 2006* provides that an internal investigation need not be carried out into such an incident. To that end it is notable that an internal investigation was nonetheless undertaken and considerable effort made by Mr Laws to identify systemic deficiencies and propose practical solutions. The Corrective Services investigation also identified issues of non compliance with some required procedures and identified actions required to remedy the situation.

[3] Exhibit C5

The inquest

An inquest was held at Brisbane on 26 June 2009. Mr Johns was appointed as counsel to assist me with the inquest. Leave to appear was granted to GEO Group Australia Pty Ltd (the operator of Arthur Gorrie Correctional Centre); the Department of Corrective Services and the Department of Health.

Mr Stanford's sister and niece were provided with a copy of the police investigation report prior to the inquest and both were advised of the date of the inquest. Neither attended the inquest.

All of the statements, records of interview, photographs and materials gathered during the investigation were tendered at the inquest. The General Manager of Arthur Gorrie Correctional Centre, Mr Greg Howden, gave evidence at the inquest.

I determined that the evidence contained in these materials and the oral evidence heard from Mr Howden were sufficient to enable me to make the findings required by the Act and there was no other purpose which would warrant any further witnesses being called to give oral evidence.

The evidence

I turn now to the evidence. I do not refer to all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Social history

Tony John Stanford was born on 2 August 1970 in Narrabri, New South Wales. He had an older brother and sister, who were twins named Shane and Roslyn. He was thirteen years younger than his siblings.

In recent years he had lived an itinerant lifestyle in northern New South Wales and southern Queensland, in particular, around the Chinchilla region. He had not been involved in any long term relationships and had no children.

The material available to me shows he had a good relationship with his niece, Katrina, however, had difficult ongoing relationships with his siblings.

Imprisonment

Mr Stanford had no criminal history in Queensland and none of any note in other States or Territories.

He was arrested on 26 May 2006 for the alleged murder of his brother on 23 May 2006 and the alleged attempted murder of his sister on 16 May 2006. He was remanded in custody and arrived at AGCC on 1 June 2006.

Health Risk Assessment at time of death

On arrival at AGCC on 1 June 2006, medical staff interviewed Mr Stanford and referred him for an assessment by a psychiatrist. This was his first period of imprisonment and he had been treated in the past for depression. On arrival at AGCC, his depressed clinical presentation and his history meant he was identified immediately as being at potential risk for suicide or self-harm.

A High Risk Assessment Team (HRAT) consisting of various mental health and medical personnel was responsible for monitoring and assessing Mr Stanford's mental health needs from this time until the time of his death.

A history of his assessments is outlined later in these findings. At all times during the period of custody from 1 June 2006 to 19 September 2006, Mr Stanford was subject to a risk plan that required him to be observed at certain intervals.

Prisoners, the subject of these risk plans, were categorised as either "A", "B" or "C". "A" and "B" category prisoners required observation at least every 60 minutes. These prisoners were subject to 24 hour CCTV monitoring and were usually located in Unit W1.

Category "C" prisoners were those requiring observation every two hours. In relation to these prisoners Mr Laws notes in the GEO report:

> "*Two hourly observations were not intended to detect suicide attempts but rather note any deterioration or development of at risk indicators that might warrant review of an at risk management plan".*

The subsequently appointed General Manager, Mr Greg Howden, interpreted this differently saying two hourly observations were to detect if there was any self harm ideation. It was at the low end of the scale of risk, but still to be considered significant.

As a Category "C" prisoner Mr Stanford was accommodated in Unit W2. This Unit housed prisoners who were predominantly not under observation. Part of the rationale for accommodating Mr Stanford in this Unit was to assist in his reintegration with the general prison population.

Mr Stanford had been a Category "A", "B" and "C" prisoner at different times during his imprisonment. He had been a Category "C" prisoner since 18 August 2006 through until the date of his death.

Events leading up to discovery of the deceased

On 19 September 2006 Mr Stanford was observed by CSO's at two hourly intervals through the day until 4.30pm. Between 5 and 5.30pm the day shift CSO's commenced "lock-down". During this process, at 5.30pm, CSO

Raaymaakers saw Mr Stanford lying, awake, on his bed. This was the last time he was seen alive. The lock-down was completed at 5.45pm.

The nightshift commenced at 6.30pm and six CSO's commenced "rover" duties, which include assisting with movement of prisoners, responding to any incidents, conducting headcounts and conducting "at risk" observations. As a result of various factors examined later in these findings, the first headcount of Unit W2 did not occur until shortly before 9.00pm. The "at risk" observations had been combined as a matter of practice.

At this time CSO Bachmann commenced his headcount on the upper landing of the Unit. On looking into cell 39, where Mr Stanford was accommodated, he observed Mr Stanford against the wall beside the front door. He was in a slumped position that indicated he was hanging. A piece of material could be seen extending from the television shelf to his neck. CSO Bachmann notified CSO Ward who was assisting him in Unit W2. CSO Ward immediately notified a medical emergency via radio and obtained permission from the Corrections Manager to open the cell.

Actions of CSO's and medical attention given to deceased

On entering the cell the CSO's observed Mr Stanford hanging by brown cloth material that had been secured through a hole in the television shelf. CSO Bachmann supported Mr Stanford and raised him while CSO Ward cut him down. CSO Bachmann immediately felt Mr Stanford to be cold and rigid. He was placed on the floor, initially on his knees and then on his back.

At 9.06pm, two registered nurses attended the scene along with the Corrections Manager. The nurses observed that rigor mortis had set in, that Mr Stanford's skin was an ashen colour and that there was a deep impression, about half-an-inch wide, around his neck. A "life pack" monitor was attached and the nurses performed CPR until 9.16pm when QAS officers arrived. At no time during this process did Mr Stanford display any signs of life. QAS officers declared an obvious death within minutes of arrival and resuscitation attempts ceased.

The top floor of Unit W2 in the vicinity of cell 39 was immediately cordoned off and a running sheet kept in relation to all activity around the scene.

The investigation findings

The investigating officer concluded that sometime after 5.30pm on 19 September 2006 Mr Stanford had utilised a homemade noose which had been made by tearing his prison issued sweatshirt into strips. This was attached to the television shelf through a hole with a 2cm diameter. A thorough search of the cell revealed no instrument that had obviously been used to create the hole. The cell was last searched on 10 September according to a register of cell searches.

It was established that no other persons could enter Mr Stanford's cell after lockdown without the Master cell door key.

There was no evidence at all to suggest the involvement of another person in the death of Mr Stanford. The issue of the apparent failure to comply with the "at risk" observation schedule is properly identified by the investigating officers and I will deal with this later in these findings.

It is suggested by the investigating officer that "*there were no concerns raised by either Stanford or any other inmate to correctional staff at AGCC regarding Stanford's demeanour on the date of his death".* I accept that this was so in relation to other inmates however, do not accept that the demeanour of Mr Stanford on the day presented 'no concerns'. The evidence shows the observation made that morning was - "poor clinical presentation, withdrawn and depressed".

The psychologist Julia Smith who saw him that day noted:

> *"Reported feeling 8/10, (where "1" equals depressed and 10 is not depressed.."*

However, the report went on to state;

> *"Presents as calm and quiet. Denied current suicide or deliberate self harm ideation and denied current concerns. Reports adequate support and reports adequate future orientation. Maintain due to poor clinical presentation – withdrawn and limited in range of disclosure."*

To put this in context, this assessment was not new or unusual but rather a continuing assessment consistent with previous observations which continued the requirement for two hourly observations. There were no signs recorded of elevated risk on the day he died.

The autopsy

On 20 September 2006 an autopsy examination was carried out on the body of Mr Stanford by Dr Olumbe, an experienced forensic pathologist.

Dr Olumbe found injuries consistent with hanging namely:-

> *'…a furrowed abrasion around the neck, congestion of the skin on the face and neck, and bilateral fractures of the superior horns of the hyoid bone (U-shaped bone in the upper part of the front of the neck).'*

He found evidence of coronary atherosclerosis, however, formed the opinion that this did not contribute to the death given the severity of the neck injury.

Minor healing bruises on the skin of the chest were identified; these being consistent with the application of mild to moderate blunt trauma. He found no other injuries that may have contributed to the death and consequently listed hanging as the cause of death.

Analysis of blood samples taken from the deceased during the examination did not reveal the presence of any drugs or alcohol.

Findings required by s45

I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last issue, the manner and circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by witnesses at the inquest I am able to make the following findings in relation to the other aspects of the death.

Identity of the deceased – The deceased person was Tony John Stanford.

Place of death – He died at Arthur Gorrie Correctional Centre at Wacol in Queensland.

Date of death – Mr Stanford died on 19 September 2006

How Mr Stanford Died – At an unknown time presumed to be after 10 September 2006 Mr Stanford gouged a hole through the shelf unit in his cell. The tool he used was not identified or discovered.
Mr Stanford created a noose by ripping prison issue clothing and threaded this material through the hole to secure the noose. On 19 September 2006 he used this noose to deliberately hang himself causing his own death.

The Cause of Death – Hanging

Concerns, comments and recommendations

Section 46 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.

I find that staff at the AGCC followed death in custody and medical emergency protocols on finding Mr Stanford hanging in his cell. I accept the finding of the investigating officers that they did all in their power to provide assistance to and attempt resuscitation of the deceased. I find that QAS officers acted appropriately and professionally albeit in their limited role. As such I make no comments in relation to this aspect of the incident.

There are two main areas of concern arising from the events surrounding Mr Stanford's death. These are:

1. **Mental Health treatment:**

   Whether the decision by the Health Risk Assessment Team, to decrease observations of Mr Stanford to two hour intervals, was appropriate given his history and presentation. In particular whether the decision not to accommodate him in a cell under 24hr CCTV (for prisoners on one hourly observations or less) was one no reasonable professional could have made in the circumstances; and

2. **Monitoring by AGCC staff:**

   The failure of Corrective Service Officers to ensure that these observations were in fact made; Mr Stanford not having been observed between 1730hrs and 2100hrs on the day in question.

Psychiatric Treatment

I will briefly outline a history of the assessments and risk management strategies put in place for Mr Stanford.

Initial Assessment and Psychiatric History

Mr Stanford was initially assessed as an 'At Risk' inmate and as such was assigned a High Risk Assessment Team. Shortly after an initial assessment, and the failure of Mr Stanford to attend a psychiatrist appointment, he was placed on 15 minute observations. After failing to attend a second appointment on 14 June 2006 he was placed on 10 minute observations.

Records note that his poor clinical presentation (to other medical and mental health staff that had seen him), an apparent history of depression and the fact it was his first time in custody, all weighed in favour of regular observations.

Over the following months Mr Stanford disclosed a history that included the prescription of anti-depressant medication and an attempted suicide in 1995 or 1996.

Health Risk Assessments

Mr Stanford was assessed on a regular basis by psychologists, psychiatrists and nursing staff. Over the following months his demeanour was constantly noted as being withdrawn or depressed although he consistently denied any suicidal or deliberate self harm ideations.

On 23 June 2006 his observations were reduced in regularity to 60 minute intervals. This time interval remained in place through a series of further assessments over the following four weeks.

Attempted Suicide

At 8:30am on 18 July 2006 Mr Stanford was escorted to the AGCC medical centre following what was reported to be an attempted suicide.

Mr Stanford told CSO's he had made a noose from his shirt and placed it around his neck, however, the noose snapped before it could take effect. The incident was not witnessed; however, a superficial red mark was visible on Mr Stanford's neck. He told staff the reason for the attempt was boredom and being 'sick of it all'.

According to the review by Queensland Corrective Services a QCS Incident Report should have been submitted concerning this incident but was not submitted. It is also of significant concern there was apparently no search of his cell conducted after this incident.

Further Health Risk Assessments

As a result of this incident Mr Stanford was kept in the medical centre and placed under observation every 10 minutes for three days.

On 21 July 2006 these observations were reduced to intervals of 15 minutes and Mr Stanford allowed to return to Unit W1 during the day.

A further assessment was carried out on 27 July 2006 and 15 minute observations were maintained.

On 3 August 2006 the HRAT approved a recommendation to change observations back to 60 minute intervals. Mr Stanford told staff he was feeling '*pretty good*' and he had no thoughts of suicide or self harm.

On 17 August Mr Stanford had a consultation with a psychiatrist who noted there were, in his view, '*no identifiable risk concerns*'.

On 18 August 2006 Mr Stanford was re-categorised as a 'C' risk and observations were reduced in regularity to once every two hours. He moved thereafter to Unit W2 where there was no facility to monitor him via CCTV.

On 5 September 2006 Mr Stanford was assessed by a psychologist and it was recorded Mr Stanford commented that he wished his suicide attempt 6 weeks earlier had been successful.

Final interview with psychiatrist and psychologist

The following day, 6 September 2006, Mr Stanford saw a psychiatrist and presented as having '*no obvious risk for deliberate self harm or homicide*'. Mr Stanford made it clear he did not wish to continue with psychiatric treatment and did not arrange to see a psychiatrist again before his death. The notes from this consultation refer to Mr Stanford having no '*identifiable or treatable condition*'.

On the morning of 19 September 2006 Mr Stanford was questioned by a nurse in regard to his general health status. During this routine check it is noted Mr Stanford exhibited a depressed demeanour.

A psychologist Julia Smith then saw him and recorded the comments outlined earlier in these findings.

A recommendation was made to continue 2 hour observations.

Conclusion

I am of the view the handling of Mr Stanford's condition and the safety measures put in place up until at least 4 September 2006 were not only reasonable but entirely appropriate, and even cautious.

There was concern when Mr Stanford expressed on 5 September that he wished his earlier attempt to suicide had been successful. He was, referred to a psychiatrist the following day and on both days denied thoughts of suicide or self harm.

It is also clear Mr Stanford presented as depressed on the morning of his death. I accept though this had often been the case throughout his period of custody.

Mental health professionals have a difficult task in assessing a patient's risk of suicide, particularly if the person is trying to conceal his intention. A meaningful assessment of risk cannot merely rely on a patient's denial of thoughts or plans of suicide. Indeed the psychologist's decision to persist with the two hourly observations reflects a level of concern noted due to the disparity between Mr Stanford's stated mood at 8/10 and his physical presentation and ability to interact. The assessment indicated he was withdrawn and limited in his range of disclosure.

The issue to be determined is whether a properly qualified mental health professional could reasonably have decided it was appropriate to maintain observation intervals of 120 minutes given all the information available from 5 September to 19 September 2006. In my view this was a reasonable decision.

The history of suicide attempts, demeanour and references to wishing the attempt on 18 July 2006 had been successful would clearly point towards more regular observations. Against this, however, is the fact Mr Stanford's presentation appears to have been consistent over his period of custody; he consistently denied suicidal ideations, and by 19 September 2006 he had been on two hour observations for over a month without incident. The two people known to have had conversations or corresponded on a personal level with Mr Stanford, Katrina Stanford and Ricky Lee Van Zwieten picked up no suggestion or hint of suicidal intention.

The assessments carried out on Mr Stanford were extremely regular and in my view the mental health care available to him was satisfactory. I am satisfied the risk analysis systems in place at the time of Mr Stanford's death were appropriate. It was reasonable for the staff on Mr Stanford's HRAT to have taken the decisions they did and as such I do not make any recommendations under s46 of the Act on this issue. I also note the regime of supervision of those considered at risk of self harm has been reviewed and evolved since the time of Mr Stanford's' death. A multi disciplinary Risk Assessment Team with greater involvement of psychologists has replaced the previous High Risk Assessment Team.

Those prisoners with the highest assessment of risk are housed in the medical unit and are subject to continuous or 15 minute observations. Those requiring 30 minute or 60 minute observations are located in W1. Low risk prisoners requiring two hourly observations are housed in Unit W1 overnight but can be integrated within other areas of the prison during the day, while still being subject to two hourly observations by officers tasked with this responsibility.

Monitoring of the deceased

It is clear the observation watch logs completed in relation to Mr Stanford did not comply with the two hourly requirement set by his HRAT; this was accepted by the AGCC's own internal report, the Qld Corrective Services Report and the Corrective Services Investigation Unit report.

Following the death of Mr Stanford a detailed audit was carried out on all observation logs. These found strict compliance for Category "A" and "B" prisoners and compliance for Category "C" prisoners during the day shift. The audit showed non-compliance for night shift which: -

> "*was not isolated to observations conducted on the deceased. In particular the audit confirmed that it was not uncommon for the first observation to be conducted between 2 and 3 hours after lock-away*".

The evidence reveals at the time of Mr Stanford's death there was a systemic defect in the adherence to observation schedules for Category "C" prisoners. This was limited to the period from lock-down (carried out by the day shift) to the first headcount performed by officers on night shift.

I accept that observations at other times were carried out appropriately. There is documentary evidence to show that, for instance, the observation requirements for Mr Stanford were diligently passed on to relevant court and watch house staff when Mr Stanford was to be transported for court appearances.

There were 4 reasons identified by the various investigators as to why the problem had developed:-

1. **Timing of lock-down** – day shift officers had commenced the practice of locking down prisoners at around 5.30pm each day which was earlier than envisioned by those setting observation schedules. One of the reasons for this was the requirement that the Correctional Manager certify that all accommodation unit and cell doors were secure. This involved a time consuming amount of reporting from each unit. As a result this naturally extended the time between lock-down and the first observation of nightshift.

2. **Identification of Category "C" prisoners** – the location of Category "C" inmates was not communicated to the oncoming night shift personnel as part of their shift briefing. There was, therefore, no capacity for those officers to know the whereabouts of such prisoners until the first headcount was carried out. This meant the first observation of the Category "C" prisoners in the evening occurred during the course of the first headcount rather than as a prioritised specific observation of a prisoner identified to be at elevated risk of self harm..

3. **Impact of late reception returns** – The "creep" in lock-down times referred to in issue 1 exacerbated the problem of late arrivals at reception. Any prisoner arriving after lock-down was unable to be transferred to their cell by reception staff. Instead a practice developed of transferring them to the medical unit regardless of whether they required medical assessment. They would then be taken from there by staff on roving duties. On 19 September 2006 there were 15 such prisoners even though only 8 required medical processing. This delayed the first headcount of the evening.

4. **Other incidents** – On the evening of 19 September 2006 an altercation took place between two prisoners in the medical unit. This was properly reported and documented. The attendance of CSO's to deal with this incident was another reason delaying the first headcount by the night shift.

Procedures adopted to address monitoring problem

I am advised and accept that measures have been put in place to address each of these issues. These are as follows:

1. Responsibility for certifying units as being secure has now returned to unit officers. Routine orders have been amended to ensure that no unit lock-down commences before 5.45pm.

2. Written instructions were issued requiring all prisoners subject to HRAT (now RAT) observation requirements be listed and the list be handed to the Correctional Manager Operations by 4pm daily.

3. From 21 – 25 September 2006 intensive compliance monitoring was carried out in relation to Category "C" prisoners. The result of this was it was felt necessary that such prisoners be located in one area. All prisoners subject to two-hourly observations were, therefore, returned to Unit W1 where they were able to be effectively observed.

   This practice is at odds with the reintegration rationale for placing prisoners in Category "C". I am advised the current situation in regards to prisoners under two-hourly observations is they integrate in other accommodation units during the day but return to Unit W1 to facilitate observations overnight. If Unit W1 is full, then prisoners categorised as requiring two hourly observations will be accommodated overnight in the medical unit where there is constant CCTV surveillance.

4. Arrangements were made for reception to be open where necessary on night shift and extra staff deployed in the reception area. This allows more prisoners to be held in that area and only escorted to the medical unit when necessary for medical assessment. This in turn reduces the operational requirements on "roving" CSO's in the initial stages of the night shift.

5 Dedicated staff is assigned to perform the required observations as their primary role. These observations are enforced and reviewed by management. Variation of assessment levels other than by the RAT can only be exercised by the General Manager or similar level. CCTV monitoring occurs in Unit W1 with an officer tasked to constantly monitor the split screen footage of the block.

6 Inspection of cells previously occurred on a random basis so that each cell was inspected at least once per month. The General Manager Mr Howden confirmed cells occupied by prisoners assessed as being at risk of self harm or suicide are searched daily as are the prisoners. The manner of the search is specified by orders to ensure thoroughness.

7 Inspection of shelf units was organised by a special audit to ensure there were no other shelves in W Block with holes in them or defects which could be utilised by a prisoner to create a hanging point.[4]

It is noted when a prisoner is deemed in need of protection as well as being at risk of self harm then particular arrangements are made to accommodate these issues.

[4] Exhibit C6

Conclusion

At the time of Mr Stanford's death there was evidence a practice had developed which meant lockdown was commencing earlier and the first headcount of the night shift was not necessarily occurring within a two hour period of lockdown. Some prisoners, such as Mr Stanford, who had been assessed as requiring two hourly observations due to a low risk of self harm, were not being observed as stipulated due to this practice. On 19 September 2006 there was a period between about 5.30pm and 9.00pm during which Mr Stanford was not observed, despite being designated as a prisoner at low risk of suicide who required two hourly observations.

At some time between 10 September 2006 and 19 September 2006 Mr Stanford had created a hole in the shelf unit. The mechanism and tool used were never identified.

I am unable to reach a finding that the failure to comply with the HRAT observation schedule contributed to Mr Stanford's death. It is, though, clearly a matter of concern and one on which I am entitled to comment. What can be inferred from the manner of Mr Stanford's death is he planned his death. In the absence of locating any tool used to make the hole on the day of his death, it can be assumed he did this at an earlier time with a plan in mind.

The General Manager of the facility has provided evidence of new procedures, staffing and accommodation arrangements which it is hoped will reduce the likelihood of a similar death occurring at the Arthur Gorrie Corrections Centre in the future..

I thank all those who have assisted in the inquest into the death of Tony John Stanford.

This inquest is closed.

Christine Clements
Acting State Coroner
Brisbane
3 July 2009