QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the deaths of Steven John PITTAWAY and Paul Allen COE**
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Bundaberg
FILE NO(s):	COR 3001/05(9) & COR 1428/05(5)
DELIVERED ON:	30 March 2007
DELIVERED AT:	Bundaberg
HEARING DATE(s):	22 February 2007, 26-28 March 2007
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	**CORONERS: Inquest, death in custody – watch house, inspection of prisoners, searching of prisoners, risk assessment of prisoners, elimination of hanging points**

REPRESENTATION:

Counsel Assisting: Senior Constable Daniel Lanzon, Senior Constable Christina Rinaldi, Senior Constable Darren Hume & Constable Owen Robertson (Pittaway) Constable Ricky Dodds & Senior Constable Andrew Webb (Coe):	Ms Kim Bryson Mr Adrian Braithwaite (Gilshenan & Luton Lawyers)
Queensland Police Service Commissioner:	Mr Wayne Kelly (QPS Solicitors)

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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, to 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 deaths of Steven John Pittaway and Paul Allen Coe. Their deaths were investigated in a joint inquest as provided for by section 33 of the Act because they happened in similar circumstances. The findings will be distributed in accordance with the requirements of the Act and placed on the website of the Office of the State Coroner.

Introduction

At the time of his death, Paul Allan Coe was a prisoner in the Bundaberg Watch house. He was discovered deceased in his cell on 11 June 2005.

At the time of his death, Steven John Pittaway was also a prisoner in the Bundaberg watch house. He was discovered deceased in his cell on 8 December 2005.

These findings explain how the deaths occurred and consider whether any changes to the policies and/or procedures of the Queensland Police Service would reduce the likelihood of similar deaths occurring in future.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

At the time of his death, Mr Coe was being held in custody as a result of his being charged with drug offences and being denied bail by the Acting Magistrate before whom he appeared earlier in the day. At the time of his death, Mr Pittaway was detained in the watch house following his conviction by a jury of two counts of assault occasioning bodily harm in the District Court at Bundaberg and being sentenced to a term of imprisonment. Accordingly, both deaths came within the definition of a "*death in custody*"[1] within the terms of the Act and they were therefore reported to the State Coroner for investigation and inquest.[2]

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

[1] Refer s10
[2] Section 8(3) defines "*reportable death*" to include deaths in custody and s 7(2) requires that such deaths be reported to the State Corner or Deputy State Coroner. Section 27 requires an inquest be held in relation to all deaths in custody.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [3]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[4] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.[5]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because section 37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.[9]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10]

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[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[4] s46
[5] s45(5) and 46(3)
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[10] (1990) 65 ALJR 167 at 168

makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

I will now say something about the investigations into these deaths.

The Investigations

The Coe investigation

Advice of Mr Coe's death was referred up the QPS chain of command and an investigation was commenced. The investigation was principally undertaken by Detective Senior Sergeant Terrance Borland of the Bundaberg District Criminal Investigation Branch. That was inappropriate. I have no basis to question that officer's investigative prowess. However, the fact that he worked in the same police division as the officers whose conduct would be the subject of scrutiny and no doubt had extensive professional contact with them, would inevitably diminish at least the perception of his being impartial and independent.

Of course it was not Senior Sergeant Borland's decision to undertake the investigation. He was detailed the responsibility by his superiors. That action would seem to be inconsistent with section 1.17 of the OPM which specifically states that "*police related incidents*" are to be investigated by the regional crime coordinator (RCC) or an independent senior investigator appointed by the RCC. Police related incidents are defined to include incidents resulting in death or serious injury that involve officers acting in the course of their duty and service property "*eg service firearms, vehicles, watch houses, stations or establishments."* The policy goes on to state:-

"In cases involving custody police related incidents, a regional crime co-ordinator should appoint an investigator from a police establishment other than from where the incident occurred, or where the officers or members directly involved in the incident are stationed."

Despite this apparent departure from proper policy, I accept that Senior Sergeant Borland conducted a rigorous and detailed investigation and I found no evidence that he allowed his association with the watch house staff to influence his conduct of the investigation.

The scene was secured and photographs taken. Statements were obtained and interviews conducted with relevant police officers. The closed circuit television recording of the watch house and other physical exhibits were seized.

Mr Coe's body was transported to the mortuary at the Bundaberg Base Hospital. A autopsy examination was performed by Dr Ashby, an experienced forensic pathologist, on 14 June 2005. During the course of the autopsy, tissue samples and blood were taken and sent to the John Tonge Centre for testing.

Staff of the Office of the State Coroner commissioned a report from Professor Olaf Drummer, a toxicologist at the Victorian Institute of Forensic Medicine. The purpose of this report was to obtain expert evidence on when the amphetamines found in Mr Coe's post mortem blood may have been ingested.

The Pittaway investigation

Following the discovery of Mr Pittaway deceased in his cell, an investigation was initially commenced by officers of the local Criminal Investigation Branch and then handed over to Inspector David Kolb of the Ethical Standards Command. The scene was preserved and scenes of crime officers were tasked to take a number of photos. Physical exhibits were seized and interviews were conducted with the relevant police officers and other prisoners detained at the Watch house at the time of Mr Pittaway's death.

An autopsy examination was performed by Dr Olumbe at the John Tonge Centre the next day. Dr Byron Collins, an independent pathologist also attended at the request of Mr Pittaway's family.

As can be readily appreciated, any death in custody may raise suspicions in the minds of those close to the deceased, that he/she has met with some foul play and/or that the authorities have failed in their duty to properly care for the prisoner. It is therefore essential that even when a death appears at the outset not to be suspicious, the investigation must be thorough, rigorous and impartial in fact and appearance. I am satisfied that as a result of the police investigation and the evidence obtained at inquest, the circumstances of these deaths have been sufficiently scrutinised to enable me to make findings on all relevant issues.

The inquest

A pre-hearing conference was held in Brisbane on 22 February 2007. Ms Bryson was appointed Counsel Assisting. Leave was granted to Mr Braithwaite of Gilshenan and Luton Solicitors, to appear on behalf of the officers working in the watch house at the time of each of the deaths. Mr Kelly of the Queensland Police Service Solicitor's Office was granted leave to appear on behalf of the Commissioner of Police. Neither the family of Mr Coe nor Mr Pittaway was separately represented however family members consulted with those assisting me before and throughout the inquest. The inquest then proceeded over three days commencing on 26 March 2007. Eighteen witnesses gave evidence and 135 exhibits were tendered.

The evidence

I turn now to the evidence. Of course I can not summarise 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.

The evidence in relation to Mr Coe's death

Family Background

Paul Allan Coe was born on 10 December 1966. He grew up on the Sunshine Coast and worked as a spanner crab fisherman.

At the time of his death, Paul was in a long term relationship with Anita Geisler. Paul was the father figure to Anita's daughter Nakita, now 4 years of age. They also had a son, Daniel who is now three years of age. Anita indicated that Paul was a devoted family man who loved his children dearly.

Criminal History

The record of Mr Coe's criminal offending commenced in Southport in 1984 and largely related to offences against the Drugs Misuse Act. He had been ordered to perform both probation and community service in the past and had fines imposed on a number of occasions. His last criminal conviction was in December 2002 and related to possessing a dangerous drug and contravening a police direction. For these offences, Mr Coe was ordered to pay a fine. He had never been sentenced to a period of imprisonment.

Mr Coe was arrested on 17 November 2004 in relation to a number of drug offences including producing a dangerous drug, namely methylamphetamine. He was granted bail in relation to these charges and was due to appear in the Magistrates Court at Bundaberg on 26 July 2005.

Mr Coe's arrest on 10 June 2005

At approximately 7.00am on the morning of 10 June 2005, police executed a search warrant on Mr Coe's residence at 124 Mount Perry Road Bundaberg. Police located Mr Coe at the residence along with his partner, Ms Geisler and Mr Luke Jacobson.

During a search of the residence and a detached shed, police located a quantity of equipment that they believed had been used to produce methylamphetamine. While other police officers searched the residence, Detective Senior Constable Craig Strohfeldt observed Mr Coe and the others at the dining room table. A strip search of Mr Coe was conducted by Detective Strohfeldt during which a small clip seal bag of methylamphetamine was found in Mr Coe's shirt pocket.

Detective Strohfeldt indicated in evidence that he had previously had a number of dealings with Mr Coe and that he had always found him to be co-operative and compliant. His opinion was that Mr Coe's behaviour on this occasion was no different to that he had observed on previous dealings with Mr Coe and that he displayed no indicia with either being affected by drugs or suffering from depression or emotional distress. Detective Strohfeldt is an experienced police officer who gave evidence that he could identify the indicia of illicit drug intoxication.

Mr Coe was transported to the Bundaberg Criminal Investigation Branch by Detective Strohfeldt. He there requested access to his legal representative and was allowed to make a phone call. He subsequently declined to be interviewed by police and was taken to the watch house.

Mr Coe is admitted to the watch house

Upon arrival, Mr Coe was formally charged with two offences; namely, possessing a dangerous drug and producing a dangerous drug. Detective Strohfeldt noticed nothing unusual about Mr Coe's behaviour and noted that he appeared calm. Detective Strohfeldt did not consider Mr Coe was at risk of self harm.

Mr Coe was received into custody by Constable Robert Darney at the watch house at about 12.30pm.[11] Constable Darney conducted an intake interview with Mr Coe and recalls observing Constable Andrew Webb conduct a pat down search of Mr Coe during which some of his clothing

[11] The times quoted for events that happen in the watch house are taken from the CCTV recording. They do not seem precise in relation to actual time but they are a good measure of the time that elapses between the various events described.

was removed and examined. Constable Darney asked Mr Coe a series of questions relating to his physical and mental health that are printed on the custody register. None of Mr Coe's answers gave the officer any cause for concern that Mr Coe might be at risk of self harm; nor was there anything in Mr Coe's demeanour to suggest this was likely. Mr Coe was then allocated to cell number 7.

Sergeant Raymond Moodie, the watch house manager, was also present. He observed Mr Coe to be a compliant prisoner who displayed no indicia of depression or of being drug affected.

The Queensland Police Service Operational Procedures Manual (QPS OPM) and the Bundaberg Watch House Standing Operating Procedures (SOP) stipulate that every prisoner must be personally inspected at intervals of not more than one hour. The results of these inspections must be recorded in an inspection register which, at the Bundaberg watch house is referred to as a *"Shift Log*." That log for the shift in which Mr Coe was first in custody indicates that inspections were undertaken at the required intervals. However, when questioned as to how these inspections were undertaken, Constable Darney was unable to recall whether the entries referred to physical inspections or merely the observing of the prisoners on the CCTV monitors above the charge counter. The other officer on duty, Senior Constable Gino Asnicar gave a similar account. He recalls none of the prisoners displaying any signs of being depressed or suicidal.

Nothing of moment is recorded as occurring during the night.

Events of 11 June 2005

At approximately 7.00am, the cell doors were unlocked to allow the prisoners access to the exercise yard and to shower. Constable Webb recalls observing Mr Coe to be awake and sitting on his bed when the doors were unlocked. Mr Coe was provided with breakfast at about 8.00am and upon request was also given two paracetamol tablets. Constable Webb recalls that Mr Coe's mood was unchanged from the previous day and he did not believe Mr Coe displayed any signs of being drug affected.

At 8.17am, Sergeant Peter Moloney and Senior Constable Puxty transported Mr Coe and two other inmates to the Magistrates Court. Senior Constable Puxty appeared in court as the prosecutor and it was Sergeant Moloney's responsibility to escort the prisoners from the holding cell to the court room. The vehicle used to transport the prisoners was a Hi-Lux twin cab four wheel drive. Mr Coe and Mr Jacobson were located in the caged area of the vehicle while a third prisoner was segregated in the back seat of the vehicle. Both Sergeant Moloney and Senior Constable Puxty gave evidence that the vehicle used to transport the prisoners to and from court was thoroughly searched before leaving the watch house and upon their return to the watch house from court. Nothing of interest was located.

Mr Coe appeared in court and was remanded in custody to re-appear on 20 June 2005. Sergeant Moloney and Senior Constable Puxty then transported the three prisoners back to the watch house arriving at 9.19am. Both officers were of the view that Mr Coe's demeanour remained unchanged during their dealings with him even in circumstances where he had been refused bail. Neither considered Mr Coe to be an at risk of self harm.

Once at the watch house, the three prisoners were put back into the exercise yards they had previously occupied. It was determined that an additional search of the prisoners was not required prior to them being returned to their cells.

Mr Jacobson says that when they were placed back in their cells, Mr Coe was obviously upset about not being granted bail and said words to the effect, *"I've just got to get out of here."* While in retrospect those words may seem prophetic, Mr Jacobson did not at the time interpret them to mean that Mr Coe was contemplating self harm and he had no reason, therefore, to relay them to the watch house staff.

At about 11.40am, lunch was provided. This was the last time Mr Coe was seen alive by police other than over the CCTV monitors. Constable Webb indicated that he observed Mr Coe on the monitors but did not undertake any physical inspections after this time. The shift log indicates all prisoners observed on the monitors at 12.30pm and at 1.05pm and all appeared to be "OK".

Constable Ricky Dodds also recalls viewing the monitors but did not see Mr Coe hanging nor did he see anything else out of the ordinary. He recalls that prior to attending Mr Coe's cell to collect the lunch plates, he was in the kitchen area of the watch house. At this time, it is his recollection that Constable Webb was absent from the watch house, in the main part of the police station. If this account is correct, no police officer was observing the monitors at the charge counter at this time.

Constable Dodds was questioned in relation to his knowledge of his obligations in relation to monitoring prisoners. His evidence was that at the time he did not know that officers were required to inspect prisoners by going to the cells rather than simply viewing them over the CCTV monitors. He said he only became aware of what was required on the morning he gave evidence as a result of reading a newspaper account of the evidence given by other witnesses earlier in these proceedings.

The death is discovered

At 1.49pm officers Webb and Dodds were collecting the lunch plates. As Constable Webb came to the exercise yard adjacent to Mr Coe's cell, he saw him hanging by a shirt secured in the space between the door and its jam. Constable Webb immediately alerted Constable Dodds and attempts were made by both officers to get Mr Coe down. Constable Webb attempted to lift Mr Coe and support his body weight while Constable Dodds removed the shirt from around his neck. He was lifted down and an ambulance was called while Constable Webb placed him in the recovery position and checked his vital signs. During the course of their actions, Mr Coe's forehead came into contact with the floor causing a laceration which bled. Constable Webb can be seen on the monitor to remove the shirt from the door and to throw it onto the floor. This was inappropriate in the circumstances.

Mr Jacobson was asleep in an adjacent cell. He was awoken and moved to another cell.

CPR was not commenced as Constables Webb and Dodds were of the view that Mr Coe was deceased. Reportedly, he was cold and no pulse could be found. Further, the colour had drained from his face. Ambulance officers attended the watch house at about 1.56pm. Mr Coe was examined by the ambulance offices and found to have fixed and dilated pupils. He was unresponsive and could not be revived. He was transported to the Bundaberg Hospital where a life extinct certificate was issued.

A search of Mr Coe's cell located a suicide note on the wall written in soap in which he apologised for his actions, expressed his love of his partner and children and said a sad goodbye.

As soon as Mr Coe's body was removed from the watch house the scene was secured and the investigation detailed above was commenced.

Investigation findings

The CCTV recordings were down loaded. It shows that at 1.08pm Mr Coe went into his cell and can be seen sitting close up against the perspex panel where the suicide note was subsequently found.

At 1.22 he can be seen to stand up, take off his long sleeved shirt and make a knot in the end of one of the sleeves. He then forces the sleeve into the gap between the inner edge of the cell door and the door jam. He slides the sleeve down the space until it comes to the hinge and tests the arrangement with his body weight by pulling on the shirt. The knot on the end of the sleeve stops it being pulled through the space. Mr Coe then loops the other sleeve around his neck and allows it to bear his weight. He can be seen struggling for some seconds. At 1.26pm he is still and does not move again. No one comes near him until officers Webb and Dodds arrive at 1.49pm.

Autopsy evidence

An autopsy was performed by Dr Rosemary Ashby at the Bundaberg Hospital on 14 June 2005. Dr Ashby had the opportunity to view the watch house CCTV recorded images prior to undertaking the autopsy examination.

Dr Ashby found a ligature mark around Mr Coe's neck which was consistent with it having been made by fabric that had been rolled. She also found congestion in the lungs, the trachea and the bronchi and petechial haemorrhages in the pleura of the lungs. No intravenous injection marks were located. Dr Ashby concluded that no third party was involved in Mr Coe's death. An injury found on his forehead was consistent with his head hitting the ground when the officers were getting him down. In her opinion Mr Coe died from hanging.

Samples were taken for histology and toxicology testing and forwarded to the John Tonge Centre. A toxicology certificate was issued on 7 September 2005 which detected amphetamine and methylamphetamine at levels of 0.3mg/kg and 1.2mg/kg respectively.

Once the toxicology results were conveyed to Dr Ashby, she issued an amended cause of death certificate which concluded methylamphetamine toxicity was a significant contributor to death. It was not however the principle cause of death which remained hanging. In evidence, Dr Ashby explained the amendment by saying that the level of methylamphetamine detected at autopsy may have had an impact of Mr Coe's mental state and his decision to take his own life.

Other expert evidence

In an attempt to explain the toxicology results, in particular how Mr Coe could have such a high level of amphetamines in his body when he had been in custody for over 30 hours, staff of the Office of the State Coroner commissioned a report from Professor Olaf Drummer, a toxicologist at the Victorian Institute of Forensic Medicine.

Professor Drummer gave evidence that having regard to the effects of post mortem re-distribution it is difficult to be precise as to the level that would have been in Mr Coe's blood immediately prior to death. That obviously complicates any estimation of when he ingested the drug. However, if for the sake of the exercise it is assumed that he ingested the drugs prior to being taken into custody, it is clear that he would have to have had a very high level in his system when arrested and presented to the watch house. According to Professor Drummer, Mr Coe may have developed a tolerance for the drug through repeated use so that he could tolerate amounts of the drug that would otherwise be fatal. However, Mr Coe would still have been exhibiting obvious symptoms of being drug affected during the early stages of his incarceration. Professor Drummer indicated that a person who has consumed so much methylamphetamine would be in a hyperactive, anxious and/or sometimes violent state, regardless of their acquired tolerance. It will be recalled that none of the witnesses observed any such indicia.

This made it more likely, in Professor Drummer's view, that Mr Coe had ingested the drug while he was in the watch house. I am unable to explain how this could have occurred in view of the evidence of Detective Strohfled that he strip searched Mr Coe when he arrested him.

Senior Sergeant Borland suggested that Mr Coe may have somehow absorbed the drug while manufacturing it at his home prior to his arrest and that its affects were masked and/or its metabolism delayed. While the detective's creative inventiveness is admirable, I am aware of no scientific evidence supporting that hypothesis.

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 described above my findings in relation to this last aspect of the matter, the circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other particulars.

Identity of the deceased	The deceased person was Paul Allan Coe
Place of death	He died in the Bundaberg Watch house
Date of death	He died on 11 June 2005
Cause of death	He died from self inflicted hanging

The evidence in relation to Mr Pittaway's death

Family Background

Steven John Pittaway was born in Melbourne on 17 December 1958 making him 46 years of age at the time of his death.

Steven had two siblings, a sister Suzanne and a brother David. At the time of the inquest into Steven's death, his sister was residing in Switzerland. Steven's brother David travelled from Melbourne to Bundaberg to be present for the inquest.

Steven's father was a long serving member of the Victorian Police Service who attained the rank of Superintendent. The relationship between Steven's parents ended and Steven's father and new partner moved to the Hervey Bay area in about 1990.

Steven was a qualified plumber by trade undertaking an apprenticeship whilst residing in Melbourne. He spent a number of years travelling Australia and Europe and was a gifted didgeridoo player performing in Europe. When he returned to Australia, he decided to move to Biggenden to be closer to his father and buy a property.

He eventually settled in Gin Gin where he lived on a rural property of some twenty acres. He is described by his brother as a very spiritual man who enjoyed meditating.

He was a recluse who had no close friends. In the time prior to his death, he seemed to be increasingly out of touch with the rest of the world.

In 1997, Steven's father took his own life. Steven had a very close relationship with his father and this loss had a significant impact on him.

Criminal History

On 3 February 2004, police executed a search warrant on Mr Pittaway's residence at Gin Gin. They found a quantity of cannabis leaf, some 700 plants and numerous cannabis seeds. As a result, Mr Pittaway was charged with producing a dangerous drug and other drug offences.

Police allege that during the search Mr Pittaway resisted and obstructed their attempts to gain access to his motor vehicle and became violent. It was alleged that he punched at least two officers to the face causing them injury. As a result he was charged with a number of simple offences and with two counts of assault occasioning bodily harm.

The drugs were seized and lodged at the Gin Gin Police Station. Due to a shortage of suitable storage space the drugs were placed in the exercise yard of the disused watch house. In the early hours of 7 February 2004, someone entered the yard around the watch house and used a length of wire or something similar to drag some of the bags of cannabis over to the bars of the exercise yard. About 100 hundred of the 700 plants were taken.

Suspicion fell upon Mr Pittaway and police therefore again attended his residence. None of the missing cannabis plants were found there but Mr Pittaway was detained for questioning. During

this procedure he became very distraught and invited police to shoot him; he said that he was on a hunger strike and that his life was over. Police took Mr Pittaway to the Bundaberg Mental Health Unit. He was assessed but deemed not in need of treatment and released. Nevertheless, as a result of this incident, a warning was placed on the QPS POLARIS data base which indicated that Mr Pittaway may be suicidal.

On 1 November 2005, the charges relating to the drugs police found on 3 February 2004 came before the court and Mr Pittaway was convicted of producing a dangerous drug, namely cannabis. He was sentenced to three months imprisonment that was wholly suspended for a period of 12 months.

On 6 December 2005, the charge arising from the allegation that Mr Pittaway assaulted one of the officers involved in the search, went to trial in the District Court in Bundaberg. On 8 December 2005 the jury returned a verdict of guilty and Mr Pittway was remanded in custody for sentencing later in the afternoon.

Mr Pittaway is sentenced to imprisonment

After the verdict Mr Pittaway was taken from the dock and moved to a holding cell adjacent to the courtroom. One of the two police officers who was acting as a court orderly, Senior Constable Sajko, gave him a "*pat down*" search and removed his shoes and belt.

At about 5.00pm Mr Pittaway returned to court for sentencing. A four month custodial sentence was imposed. Mr Pittaway and two other prisoners were then taken to Bundaberg Watch house by the court orderlies Constable Blackwell and Senior Constable Sajko.

Constable Blackwell gave evidence that he had observed Mr Pittaway throughout the trial and sentencing and he did not see anything that would indicate Mr Pittaway was suicidal. In fact, Constable Blackwell was of the view that his demeanour was unchanged before, during and after the trial and before and after sentencing. This was also the view of the barrister who represented Mr Pittaway. He advised police that he had no basis to suspect that Mr Pittaway was suicidal at any stage during his dealings with him.

Admitted to the Bundaberg Watch house

Upon arrival at the watch house at approximately 5.40pm, Mr Pittaway and the two other prisoners were initially placed in the holding cell. One of the other prisoners claims that during this time Mr Pittaway was demonstrating distress by punching the walls and crying but a viewing of the watch house security vision does not support these claims.

The officers acting as court orderlies presented Mr Pittaway to the watch house staff. Constable Hume asked Mr Pittaway the standard questions outlined in the watch house custody register. These included questions relating to his mental health such as "*Do you suffer any mental problems?*" to which Mr Pittaway answered "*Yes, depression*". He was also asked "*Are you currently seeing or have you ever seen a psychiatrist?*" to which Mr Pittaway answered "*Yes, in Bundy years ago*". He denied ever attempting suicide, self harming or having suicidal thoughts in the previous three months.

As a result of observing his demeanour and having regard to the answers detailed above, Senior Constable Lanzon concluded that no special precautions needed to be taken in relation to Mr Pittaway.

The QPS OPM requires an arresting or detaining officer to search the QPS data base, POLARIS, during the process of charging a prisoner. This is to allow information about threats the prisoner may pose or risks he/she may face when in the watch house that have previously been identified, to be brought to the attention of the watch house staff. On this occasion, neither the officers who brought Mr Pittaway to the watch house, nor the officers on duty there interrogated the system and so they were not aware of the entry referred to earlier. Both watch house officers gave evidence that had they been aware of the entry indicating that Mr Pittaway may be at risk of suicide they may have more closely questioned him in relation to this.

While at the counter, Mr Pittaway was the subject of a second pat down search by Senior Constable Sajko. All of the officers involved in Mr Pittaway's reception into the watch house considered that he did not meet the criteria for a more intrusive search such as unclothed search given they had no basis to suspect Mr Pittaway had secreted any contraband on his person.

As Mr Pittway was a sentenced prisoner who would be transferred to a correctional centre in coming days, he was given prison issue clothes to change into. He went with Constable Blackwell to a cell adjacent to the charge counter to do this. His own clothes were then taken from him.

When being processed at the charge counter, Mr Pittaway was also asked if he had any problems or concerns about mixing with other prisoners. He indicated that he wished to be placed in a cell by himself saying he would prefer to be alone for a while. Initially, he was told that this might not be possible due to the high occupancy rate on the night in question. It was explained that his cell would open onto an exercise yard that would be shared with other prisoners but he could lock himself in his cell if he wished.

Mr Pittaway was then taken to cell 6 in which he was to be housed. This cell like many others in the Bundaberg Watch house is located in a cluster of three opening onto a common exercise yard. Senior Constable Lanzon and Constable Blackwell escorted Mr Pittaway to the exercise yard. There were already two other prisoners in there when they arrived. When Mr Pittaway became aware of the configuration of the cells he again asked to be given a cell to himself and one of the other prisoners was moved to accommodate Mr Pittaway's request.

Senior Constable Lanzon gave evidence that in his experience, prisoners sometimes have difficulty in locating toilet paper in the cell. He says he therefore showed Mr Pittaway that it was located in a recess in the side of the cistern. Mr Pittaway declined an offer of an evening meal or a cup of coffee. On his own request, he was locked in his cell at about 5.56pm.

Thereafter, no prisoner or police officer had any direct contact with Mr Pittaway until he was found dead at 10.44pm. In the intervening period, the only interaction between Mr Pittaway and the other prisoners occurred when he came to the door of his cell and asked one of them who was upset by being in custody whether he was alright. The only contact with police occurred at about 8.50 pm when the two other prisoners in the exercise yard were locked in their cells by Senior Constable Lanzon. At this time, the officer looked through the perspex door panel into Mr Pittaway's cell and saw that he appeared to be asleep.

The prisoner inspection log indicated that inspections were undertaken at 6.00pm, 7.00pm, 7.20pm 8.00pm 8.15pm, 9.00pm and 9.50pm. However Senior Constable Lanzon and Constable Hume conceded that unless one of them had reason to visit a cell, the inspections were in fact done by

looking at the prisoners over the video monitors that were located behind the charge counter. They contended that their signing of the search log was not an attempt to give the false impression that physical inspections had been undertaken; rather the log simply showed prisoner numbers and movements. I find their explanation untenable; I shall return to the issue in the recommendation section of these findings.

The death is discovered

At 10.30pm, when Senior Constable Rinaldi and Constable Robertson commenced duty in the watch house they received a "*hand over*" from officers Lanzon and Hume who informed them of prisoner numbers and distribution. The incoming officers said that they were advised that one prisoner required some close attention on account of his emotional state. Nothing was said of Mr Pittaway.

Senior Constable Rinaldi said that in accordance with her usual practice, before making an initial physical inspection of all of the cells, she first observed the prisoners on the monitors. She almost immediately noticed that the prisoner in cell 6 was lying on the floor of his cell. She said in evidence that on viewing Mr Pittaway's cell on the monitor she considered he appeared to be sleeping. In my view, the quality of the picture would not allow her to make such an assessment. Having seen the same footage, I consider it unlikely that the officer was able to conclude that Mr Pittaway was asleep. In any event, what ever the reason, she decided to start the inspection with his cell and asked Constable Robertson to accompany her.

The officers arrived at the cell and on looking through the perspex panels in the door and wall could still not satisfy themselves of the prisoner's condition. They therefore entered the cell. The CCTV records this as occurring at 10.44pm.

Constable Robertson entered the cell followed by Senior Constable Rinaldi. Senior Constable Rinaldi noticed a cord around the foot of Mr Pittaway. She observed the cord was tight and leading from his foot towards his head. She and Constable Robertson therefore ran back to the charge counter to get the "*noose knife'* which she used to cut the cord. Senior Constable Rinaldi then went back to the charge counter to summon assistance. She told Constable Robertson to help Mr Pittaway. He ascertained that a ligature was still affixed around Mr Pittaway's neck. He was unable to free it with his hand and so went to the charge counter to retrieve the noose knife from the other officer. Constable Robertson recalls that Mr Pittaway was cold to touch, his face was purple is colour and a pulse could not be detected.

While Constable Robertson was retrieving the knife, one of the offices from the police station who responded to the call for assistance, attended and entered the cell. He noticed the prisoner lying on his back with a length of rope tied around his right foot. He further noticed that prisoner was purple in his face and that there was blood pooling next to his head. This officer commenced first aid but then noticed the noose tied around the prisoner's neck. He attempted to remove it with his fingers but it was too tight. He therefore took out a pocket knife and was in the process of attempting to cut the ligature when Constable Robertson returned to the cell with the noose knife. This was used to cut the rope from Mr Pittaway's neck.

Other officers arrived and Mr Pittaway was carried out into the exercise yard. One of the officers had brought with him a resuscitation mask. This was immediately applied to Mr Pittaway while another officer commenced cardiac compressions.

When Senior Constable Rinaldi returned to the watch house charge counter after cutting the cord, she called the ambulance. Accordingly, a few minutes later, two ambulance offices entered the watch house. They observed police performing cardiac compressions and artificial ventilation on Mr Pittaway. The ambulance offices attached a cardiograph which indicated no mechanical or electrical activity in Mr Pittaway's heart.

Additional ambulance officers arrived at the scene and after examining Mr Pittaway it was agreed that further resuscitation attempts would be futile and treatment was terminated at 10.52pm.[12]

When it was apparent that Mr Pittaway was deceased, the scene was secured and advice of the death was passed up the Queensland Police Service chain of command. The officer in charge of the local criminal investigation branch initially took charge of the investigation until an inspector from the Ethical Standards Command arrived the next morning. The investigation detailed earlier in these findings then proceeded.

The next day, Mr Pittaway's body was then transported to the John Tonge Centre where he was identified by his sister, Suzanne Pittaway.

Autopsy evidence

An autopsy was performed by Dr Olumbe, an experienced forensic pathologist, at the John Tonge Centre on 11 December 2005. At the request of the family an independent pathologist from Melbourne also attended. Deep grooves consistent with being caused by a ligature were found around Mr Pittaway's neck and right foot. Diffuse petechial haemorrhages were found in the face and ears. The neck and lungs were heavily congested. Both pathologists agreed that the cause of death was neck compression. No other significant injuries were found and no evidence of any third party involvement in the death was discovered.

Dr Olumbe also found dried blood and mucus in Mr Pittaway's nostrils and noticed that it tracked down his cheek. He explained in evidence that this was most likely the result of an agonal event involving the rupture of capillary blood vessels in the lungs issuing blood into the airway which was then expelled through the nose. It explained the blood seen pooling near Mr Pittaway's head when he was found in the cell.

Investigation findings

During the course of the investigation, the digital recording equipment at the watch house was downloaded. It showed the following events of significance[13]:

- 17.56pm – Mr Pittaway is locked in cell 6 by Senior Constables Lanzon and Sajko;
- 20.47pm - Senior Constable Lanzon looks through the window into the cell;
- 21.15pm – Mr Pittaway stands up and sits on the toilet;
- 21.19pm – Mr Pittaway lies down on the bed and pulls the blanket over his head. Movement is then detected and Mr Pittaway is seen to be in a foetal position before straightening his right leg;

[12] This time was provided by the QAS officers and does not coincide with the other times which are taken from the CCTV recording

[13] As mentioned previously the time shown beside each event may not be completely accurate but it is likely be a good record of the time that transpired between each of the events.

- 21.22pm – Mr Pittaway sits upright and moves his hands to his throat and then rolls on his side. He rolls over and falls from the bench onto the floor. His legs appear to move momentarily but then remain motionless;
- 22.43pm – Two police officers appear at the doorway to cell 6, look through it and the window and then enter the cell.

An examination of the noose that was cut from around Mr Pittaway's neck revealed a complex knot that tightened as the free end was pulled and which was difficult to release.

An unwrapped condom was found in the alcove where the toilet paper was kept in cell 6. It was tested for identifiable bodily residue however the results were inconclusive.

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 described above my findings in relation to this last aspect of the matter, the circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other particulars.

Identity of the deceased	The deceased person was Steven John Pittaway
Place of death	He died in the Bundaberg Watch house
Date of death	Mr Pittaway died on 8 December 2005
Cause of death	He died from neck compression due to self inflicted strangulation

Concerns, comments and recommendations

Section 46 of the Act 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 have found that no person other than the two deceased men were directly responsible for or involved in the deaths. However, the circumstances of the deaths of Mr Pittaway and Mr Coe raise similar issues from a prevention perspective and for this reason the deaths were investigated by way of a joint inquest as provided for in s33 of the Act.

Both deaths, in my view, raise the following issues for consideration:-

- Was the risk of self harm adequately assessed?

- Were the deceased men adequately searched when they came into custody?

- Were the men adequately monitored while in custody?

- The adequacy of the management of the watch house and the supervision and training of watch house staff.

The circumstances of Mr Coe's death, in addition, raises the issue of hanging points in the cells.

Assessing a prisoner risk of self harm

The requirement to make a risk assessment of a prisoner being lodged in a watch house is contained in section 16.9 and section 16.13 of the OPM. In so far as is relevant to this case, those provisions provide that where a prisoner is accepted into custody at a watch house, the charging officer should assess the prisoner to determine:

- whether the prisoner should be confined alone or with other prisoners; and
- the frequency of prisoner inspections.

The officer must continue to inspect and assess the prisoner at regular intervals.

In making this assessment the officer should:

- observe the prisoner's physical appearance and demeanour;
- seek from the prisoner, police and watch house staff information that will assist in the management of the prisoner; and
- administer the health questions in the watch house custody register

When Mr Coe was initially brought to the watch house, all of the information about his mental health including the answers to the relevant questions did not cause concern. The information would not reasonably have required him to be inspected at any greater intervals than should normally occur, namely hourly.

However, when he returned from court on Saturday morning after having been denied bail, he was not reassessed despite there being a significant change in his circumstances. His co-accused reports that it was during this period he noticed Mr Coe was distressed and made remarks that can be seen in hindsight to be indicative of an intention to self harm. I understand that Bundaberg watch house staff have now been made aware of the need to have particular regard to such changes of circumstances. I consider this approach should be incorporated into the OPM and all watch house standing orders.

Recommendation 1 – Reassessment after change of circumstances

A prisoner's emotional state may change very significantly as a result of decisions made as part of the criminal justice processes. I recommend that watch house staff be directed to have regard to the likely impact of such decisions and to re-assess a prisoners risk of self harm whenever a negative impact can be anticipated.

When Mr Pittaway was brought to the watch house he too showed no signs of emotional distress according to the officers who transported him and the officers who received him. Their assessment in that regard was consistent with that made by his defence counsel.

Mr Pittaway did disclose some mental health history but he denied any history of self harm or any current suicidal ideation. His assurance that these problems had been resolved was not incongruous with his presentation. However, watch house staff did not access a source of information relevant to the assessment they were making, namely that contained on the POLARIS database.

The POLARIS index is an integrated computer system which is used to record and store information about prisoners and others with whom officers have contact. Any specific warnings in relation to individuals are also entered. For example, if a person has suicidal tendencies or is considered dangerous to police, that information is entered onto the POLARIS database.

As is detailed earlier there was such an entry on the system in relation to Mr Pittaway indicating that in February 2004 he was thought to be at heightened risk of suicide. It was not accessed by any of the officers who dealt with him. The watch house officer who processed Mr Pittaway said that had they been aware of this entry, they may have questioned him more closely about his risk of self harm rather than simply accepting his assurances that his mental health issues had been resolved. I am of the view that had this occurred it is unlikely that Mr Pittaway would have disclosed any information that would have enabled a person without specialist mental health training to come to a different conclusion about his level of risk. Therefore, the failure of any of the officers to check the data base was not a contributing factor to Mr Pittaway's death. However, in other circumstances it could be crucial.

Arresting/detaining officers are required to interrogate the system when they charge a person and bring him/her to a watch house. Watch house staff are required to do this when a prisoner is brought from a correctional centre to attend court. However, the OPM is silent about whose responsibility it is to interrogate the system when a prisoner is not arrested or detained and has not been transferred from a correctional centre to the watch house. This should be addressed.

Recommendation 2 - Checking of computer indices for sentenced prisoners

I recommend that the OPM be amended to make clear the responsibility of watch house staff to check all relevant indices when a prisoner is sentenced and comes into the watch house after having been on bail.

Searching of prisoners

Generally, all persons detained or arrested should be subjected to at least a pat-down search on initial arrival at a watch house. Only if an officer has reason to suspect that a prisoner may have items secreted under his/her clothes is the officer justified in requiring all clothing to be removed. Internal body searches can only be undertaken by a medical practitioner after an order has been made by a magistrate.

The Standing Orders particular to the Bundaberg Watch house provide that a prisoner should be searched following arrest and again on reception at the watch house, if in the opinion of the responsible officer, the need exists. Watch house staff should search a prisoner after the arresting officer has searched the prisoner and the prisoner should be advised as to the reason the search is being undertaken.

Mr Coe was apparently strip searched at his residence when he was arrested and drugs found on him were seized. It is possible that he nonetheless smuggled drugs into the watch house and these may have been in the clothes he changed into after the search. However the evidence is insufficient for me to make a finding in this regard. Watch house staff were aware that he had the shirt that was used as a ligature to end his life but I accept that they did not at the time he was admitted to the watch house have any basis for suspecting that he would use the shirt in that manner.

The evidence indicates that Mr Pittaway smuggled into the watch house a ligature that would have been taken from him had it been found. However, I accept that staff had no basis to consider there was a need for an internal search that would have been needed to discover the cord.

The inspection of watch house prisoners

The requirement to inspect prisoners while they are being held in a watch house is contained in para 16.13 of the OPM. It specifically provides that inspections of prisoners must occur at intervals no greater than one hour and should be conducted personally irrespective of whether video monitoring equipment is installed.

In so far as it is relevant to these deaths, the OPM directs that officers should:-

- observe the prisoners physical appearance or demeanour;
- ask prisoners who are awake if they are well;
- ensure that a sleeping prisoner is breathing comfortably and appears well; and
- wake a sleeping prisoner when the officer is unsure or is concerned about the condition of that prisoner.

The officer monitoring the prisoner is required to record in the inspection register details of the date and time of the inspection as well as a brief comment in relation to each prisoner inspected.

The Standing Orders particular to the Bundaberg Watch house provide that inspections are to be carried out in accordance with the relevant OPM and that a watch house inspection register is to be kept for the purpose of recording such inspections.

The evidence indicates than none of the officers who were on duty when Mr Coe or Mr Pittaway were in custody consistently complied with the requirements of the OPM and the Bundaberg watch house SOP to personally inspect each prisoner at intervals of not greater than one hour. Some of them seemed to be aware of their responsibilities in this regard but said that they were too busy to carry out the necessary checks. Those who used this excuse admitted that they had not brought this situation to the attention of their superiors nor sought assistance to enable them to comply with the requirement. Other officers gave evidence that they believed that prisoner inspections could be carried out either by attending the cell or looking at the prisoners on the CCTV monitors situated above the charge counter. These officers seemed surprised to be informed that the OPM explicitly prohibited this method of inspection.

I viewed the CCTV recording of the cell. At night the picture is grainy, monochrome and indistinct. It is barely possible to make out Mr Pittaway's form after he falls to the floor in what we now know was an agonal event. It is preposterous for the watch house staff to claim that they could exercise any supervision or protective observation of a prisoner via the CCTV monitors at night.

To suggest that the purposes of cell inspections can be achieved by a method that does not even enable a watch house staff member to tell whether a prisoner is alive or dead is ludicrous. This is amply demonstrated by the fact that Mr Pittaway lay dead in his cell for an hour and 20 minutes before an officer coming on duty at a change of shift did the right thing and went to his cell. Similarly with Mr Coe: he was almost certainly dead for 25 minutes before an officer coming to collect meal plates chanced to find him.

I accept that on the days on which Mr Pittaway and Mr Coe died, the watch house was busy and the officers were occupied. I have no evidence to suggest that they failed to adequately discharge their duties because of indolence or laziness. Further, it can not be shown that had they done what the OPM requires either man would necessarily have been saved: it is clear that the events that caused the death in each case occupied only a few minutes and it is well known that death by asphyxiation is irreversible after a few minutes.

Nevertheless, compliance with the obligation to regularly inspect all prisoners is crucial to the safety of the watch house: there are many circumstances in which timely intervention could be life saving.

The evidence indicates that there was at the time of both deaths an entrenched practice of not complying with the requirements of the OPM to physically inspect prisoners. That practice was epitomized by the evidence of an officer who had worked in the watch house for four years who said, "*I don't go to the cells unless there is a need to.*" Strangely, no one apparently thought that prisoner inspections was a sufficient reason. There was little evidence that practice has improved since that time. The reasons for this continuing non compliance will be dealt with in the following section concerning the question of watch house management.

The watch house manager's role

The obligations discussed in the preceding sections fall upon individual officers performing duty in a watch house. It is the role of the watch house manager to ensure that those obligations are carried out. The OPM in paragraph 16.22 provides that the officer in charge of the watch house is responsible for the efficient and effective management of a watch house. This includes the development of appropriate systems for the:

- safety of people in the watch house;
- health care of prisoners and members;
- security of prisoners and their property; and
- the performance of staff.

In his role as watch house manager, Sergeant Moodie is responsible for the compilation and maintenance of the watch house standing operating procedures. He gave evidence that he reviews these procedures on a yearly basis at a minimum but in practice, as frequently as two to three times per year, or at such time that an additional risk factor is identified.

Sergeant Moodie was questioned about the steps he takes to ensure police officers working in the watch house are familiar with the standing operating procedures. He advised the court that he personally advises new staff in the watch house as to the availability of the procedures both

electronically and in hard copy. He conceded that new staff are not given any allotted time to review the procedures however they are encouraged to do so when practical.

Sergeant Moodie gave evidence that compliance with the OPM is not always possible or necessary in relation to inspections of prisoners. He believed that in some circumstances, adequate monitoring can be conducted by utilising the close circuit television monitors in conjunction with the intercom. He accepted however that this conduct was in breach of the specific OPM requirements.

The evidence in this case overwhelming demonstrates that watch house staff are not complying with the OPM requirements in relation to the inspection of prisoners and the recording of the results of those inspections. This is to some extent condoned by the watch house manager. While he considers that the departures he countenances do not negatively impact on safety, it is clear that other staff have taken a lead from him and depart from their duty to inspect prisoners in ways that are clearly dangerous.

If Sergeant Moodie is correct when he says that the current OPM requirements are unnecessary, those requirements should be changed. If he is not right he should be required to comply with them.

Recommendation 3 – Review of the OPM requirement to physically inspect prisoners

I recommend that the requirement to inspect prisoners contained in the OPM be reviewed in light of the Bundaberg Watch House Managers concerns to determine whether they should be amended or enforced. If it is determined that the policy should be maintained all other watch house managers should also be reminded of the requirements.

The elimination of hanging points

The Royal Commission into Aboriginal Deaths in Custody, in its final report recommended hanging points be eliminated from watch houses and prison cells. The State Government accepted that recommendation and committed to implementing it. Whilst attempts have been made to minimise access to hanging at police watch houses, they have not been completely removed.

The Bundaberg watch house and police station was built 1996. The watch house was constructed in accordance with the service design standards at the time which were thought to be compliant with the relevant recommendations of the Royal Commission. However, within all of the exercise areas, potential suspension points exist on the exercise area side of the cell doors particularly when the doors are open.

Research undertaken by staff at Bundaberg indicates that the problem can largely be addressed by converting the door locks on the cells so that that they can be electronically operated. This will enable the doors to be kept closed except when a prisoner wants access to the cell for toilet facilities or to be let out into the exercise area. The addition of material to the upper side of the hinge where it protrudes past the outer side of the door will eliminate it being used as a hanging point when the door is closed and prisoners are in the exercise yard. Finally, an intercom would need to be added to the exercise yard so that prisoners can request access to the cells.

A quotation dated 19 August 2005 relating to the modification of the cell doors and implementation of the additional intercom system was obtained. It costed this work at $46,259.00.

Official statistics uncontrovertibly prove that the prisoners as a group are at far greater risk of suicide than the general population. As this case demonstrates, mechanisms for assessing the degree of risk for individual prisoners are far from fool proof. It is therefore incumbent on authorities who have a duty to care for prisoners to do all that is reasonable to reduce the risk of prisoners self harming.

In this case, a prisoner hung himself from the door hinge on the cell door. Research has repeatedly shown that any interference with an opportunity to commit suicide can deter and prevent other attempts succeeding.

Recommendation 4 – Elimination of hanging points in the Bundaberg Watch House

I recommend that the QPS make the necessary modifications to eliminate the hanging points from the cell doors in the Bundaberg Watch House.

This inquest is closed

Michael Barnes
State Coroner
Bundaberg
30 March 2007