TRANSCRIPT OF PROCEEDINGS

CORONER'S COURT

HALLIDAY, Coroner

Petr-Cor-00000585 of 1997

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF MICHAEL JAMES ADAMS

PETRIE

..DATE 13/04/2006

..DAY 1

FINDINGS

MR D J GREALY, Crown Law Office, appeared to assist the Coroner

MS M NEVILLE appeared on behalf of Corrective Services

YVONNE MARY MCDONALD, APPOINTED AS RECORDER

CORONER: The matter before the Court this afternoon, sitting in its coronial jurisdiction, is the continuation of the hearing of the inquest into the death and the circumstances of death of Michael James Adams.

MR GREALY: Your Honour, I might note that the solicitors who appeared for the next of kin of Mr Adams are aware of these proceedings but are unable to appear.

CORONER: Yes. They have been contacted and I will give a direction later on as regards a copy of this transcript.

The purpose of the proceeding this day is to deliver my findings following the holding of the inquest and to formally close the proceedings.

An inquiry and inquest has been held into the death of the deceased, Michael James Adams, and it is now incumbent upon me, pursuant to the provisions of the Coroner's Act 1958, to deliver requisite findings in open Court and I so do.

Pursuant to the provisions of section 24 of the Coroner's Act 1958 as amended, the purpose of this inquest, like any inquest, is to establish as far as is practicable the fact that a person has died, the identity of the deceased person, when, where and how the death occurred, and whether any person should be charged with any of those offences referred to in section 24 of the Act.

Throughout this inquiry I have been mindful, amongst other things, of the observations that had been made by Justice Toohey in Annetts and McCann, Volume 65, Australian Law Reports, especially at page 175, concerning the following dicta of Lord Lane:

> "Once again it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other.
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> In an inquest it should never be forgotten that there are no parties, there is no indictment, there is no Prosecution, there is no defence, there is no trial; simply an attempt to establish facts. It is an inquisitorial process, a process of investigation; unlike a trial where the Prosecutor accuses and the accused defends."

I refer to the foregoing dicta and to the foregoing statutory provisions, because there is a view held in some sections of the community that a coronial inquest is an ongoing Royal Commission with no terms of reference. It is my intention to refer, in more detail to the role and function of a coronial inquiry shortly.

Although a coronial inquiry is not a judicial proceeding in the traditional sense, the rules of natural justice and procedural fairness are applicable, the contents of such rules to be applied, depending upon the particular facts of the case in question.

In making my findings I am not permitted under the provisions of the legislation to express any opinion on any matter which

is outside the scope of this inquest, except in the form of a rider or recommendation, and I should also make it quite clear and abundantly clear that any findings that I do make in these proceedings are not and ought not to be framed in any way which may determine or influence any question of civil liability or any form of liability to be decided or to be determined in any other place, or which might suggest that any entity, body or person should be found guilty or otherwise in any other proceedings.

The family of the deceased have taken a most active part, both personally and through their solicitors, in the investigation of the death and the circumstances of the death of the deceased and for that they ought to be commended.

Various concerns are been expressed by the family and through their solicitors, and it is in the light of those concerns that I believe it incumbent that I ought to refer, in some little detail, to what is the role of the Coroner, and I see no better source than to refer to what was said by the Honourable, the Attorney-General for New South Wales, the then Honourable J A R Dowd. Where the Attorney said:

> "I think the basic function of coronial inquiries is to reassure the public that murders are not going undetected. It is also to reassure the public that people in positions of control over others, such as doctors in hospitals, or police holding people in custody, are not abusing their positions by neglecting

people in their care or actively causing them harm.

Reassuring the public is a basic function of coronial inquiries but it is not the only responsibility of coroners. Perhaps it is inevitable because of the emotional overtones of much of the workload of the coronial system, but it is clear many people have unrealistic expectations of the what the system can or should do and they fail to understand the constraints which surround the Coroner. However, there are real and necessary limits on coronial inquiries. Coroners are guardians of the public interest within the confines of their statutory responsibility. That public interest places demands on Coroners but it also imposes limitations on what Coroners should or should not do.

Coroners do not conduct criminal trials. If the Coroner forms the opinion that the evidence establishes a prima facie case it is not up to the Coroner to deal with that person for that offence.

Many people expect the coronial system to punish people who might be thought reasonably or unreasonably to be responsible for the death of somebody they knew. This expectation is often based on a combination of emotion and a misunderstanding of the Coroner's role. Coroner's cannot convict people but, and if I may add under the Queensland legislation, they may in appropriate circumstances commit them for trial.

Coroners do not punish people for what the evidence at an inquest indicates they may have been done. Responsibility for that falls to other bodies. It is important to remember that while the Coroner is an administrative office rather than a judicial one, being inquisitorial rather than adversarial, it has many of the responsibilities of judicial office.

They must perform their functions in an equitable manner, ensuring that proceedings are conducted with appropriate fairness dignity and care, and that the processes of the Court are not being abused.

Coroners are confronted by human tragedy every day. However, they must distance themselves from the emotional aspects of what they were dealing with. It is quite proper for a Coroner to feel sympathy for the family of the deceased. I would, in fact, be quite concerned if Coroners were not moved by some of the cases which come before them. However, the Coroner should not allow the parties a free hand to use the inquiry to make accusations or advance theories which do not relate to the circumstances of the death and which are not supported by available information.

Coroners are required to act in a public interest, difficult though it may often be to determine what the public interest requires. They are not the mouthpieces

> for particular pressure groups or lobbyists, nor should coronial inquiries be used as a means of conveying a partisan message to the public via the publicity often given to coronial hearings.
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> While Coroners are entitled to make statements or recommendations as part of their findings those statements and recommendations should be made as a consequence of evidence that has been presented in the course of the inquiry.
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> Considerable pressure is often exerted on Coroners to make recommendations or to offer criticisms which are not really justified by the available evidence. The fact that Coroners resist those pressures, where they feel it is not appropriate to comment beyond their formal finding, often causes disappointment as well as the occasional view that the system has in some way failed. However, the system has not failed; it has simply not met the perhaps unrealistic expectations placed upon it."

It has been further said in another context that an inquest is unique in that its purpose is not to name, blame or determine responsibility, but to allow the community to review the circumstances surrounding deaths that appear preventable.

An effort is made to obtain recommendations which might prevent a similar death in the future. The ultimate objective of each investigation is to gain knowledge to prevent similar

deaths occurring in the future.

Circumstances giving rise to these proceedings.

It is not my intention to refer in any great detail to the massive evidence that has been placed before this inquiry, as the relevant facts as they have evolved fall within a very small compass.

The deceased, Michael James Adams, was born on 28 December 1976 and on 11 September 1997 he was an inmate at the Sir David Longland Correctional Centre, Brisbane, where he was an occupant of cell number 14 which was contained within what has been referred to as the notorious unit 7B.

On 11 September 1997 at approximately 5:53 p.m. the deceased was found in his cell hanging from a plaited rope made from a prison sheet and which had been secured to bars above the door.

Following unsuccessful attempts at resuscitation the deceased was conveyed to the Princess Alexandra Hospital where at 1917 p.m. on 11 September 1997 life was certified extinct by Dr Devlin. Subsequently a post-mortem examination was performed by Dr Ansford at the John Tonge Centre Brisbane on 12 September 1997 following which a medical cause of death was described as "Hanging." (Vide Exhibit 2.)

Circumstances leading to and surrounding the death.

At the time of his death the deceased was serving a sentence imposed in October 1994 of 4 years 1 month and 18 days and which sentence commend on 6 October for various offences which included robbery, and he was on remand for an offence which was described as "Community riot" at the Woodford Correctional Centre on 1 April 1997. It would appear that the alleged involvement of the defendant in such riot involved the allegation that he had broken a window.

It would appear that as a result of the alleged involvement of the deceased in the alleged riot he was detained in isolation at the Woodford Correctional Centre maximum security unit.

During the course of such isolation Ms Fletcher a solicitor with the prisoner's legal service had occasion to visit the deceased and following that visitation she saw fit to write a letter, dated 16 May 1997, to the General Manager of the Woodford Correctional Centre in the following term:

> "Mr Adams instructs that he is 20 years old and serving a five year sentence with a recommendation for parole at 18 months. However, he told me he believes he may have been put in the NSU because he smashed his cell window to

get a cigarette in the days following the April first incident at Woodford because he was confined in his cell and unable to smoke. He is not sure about this.

He instructs that he has not been interviewed by police nor charged with any offence.

He instructs that he has been wearing the same clothes for 3 weeks and that all food he has received has been cold. He is distressed that his access to his family has been severely restricted, one phone call and one contact visit. He cannot read or write and so cannot communicate with them by mail.

The physical and psychological state of these inmates cause the writer significant concern."

The deceased was transferred to a unit which appears to be, from the evidence placed before the inquest, notorious for drug dealing and violent crime and suspicious deaths by violence.

By Friday 5 September the deceased was admitted to the Princess Alexandra Hospital following a drug overdose and it is said that when he was coming out of his coma in the intensive care ward he said to his stepmother, Dianne Maher, that he had taken heroin which was given to him by Spider, who has been referred to as Wayne Fife who is now himself a deceased.

The deceased was subsequently admitted to the Princess Alexandra Secure Unit, a unit maintained within the hospital structure for prisoners requiring hospitalisation. Whilst at the Princess Alexandra Hospital the deceased was attended by nurse Van der Pol who gave evidence that from what she had been told by the deceased she was concerned as to his safety should he be returned to unit 7B at the prison. She said that she discussed such concern with other nurses who shared her degree and extent of concern. Such nurses included registered nurse St Clair at the medical unit at SDL. There was also a concern expressed by officer Judith Malane who in the course of her evidence to the inquiry stated that she had similar concerns for the deceased's safety in the unit. Miss Malane's concern was apparently based on her observations of the conduct of prisoners within the unit, and upon conclusions drawn by her from conversation had by her with correctional officer Petarka.

As a consequence of that concern she submitted a report to the General Manager on 6 September 1997 which said in part:

"I'm submitting this report to inform you that if and when (the deceased) returns to cell 14 unit 7 there could be complications. It is highly possible that Adams could receive a touch up from one of the inmates because of what occurred on Friday the 5th. Inmates may take things into their own hands. This report is submitted for your information and immediate reaction."

Despite the concerns of medical and correctional staff the deceased maintained that he wanted to be returned to unit 7B and in the light of such expression of wish the deceased was required to provide a statement "authorising" and requesting his location back to that unit.

The deceased returned to the prison on Monday 8 September and he was placed in the medical unit overnight. A fellow prisoner, Alan Fisher, had conversation with the deceased and evidence was placed before the inquest of the content of that conversation. The deceased returned to unit 7B on 9 September.

There is no direct evidence, as far as I glean before the inquiry, that upon his return to the prison and prior to his reinstatement to the unit there was any appropriate or effective assessment of the deceased as to his suitability or of the appropriateness of the defendant being so placed back within unit 7B.

The evidence quite clearly, in my view, is supportive of a conclusion that the deceased was unsuitable to be so relocated, and further one might well ask why, having regard to his age, his prior history, and the notorious reputation of the occupants of the unit, he was permitted to be replaced back into such an environment. One might well ask but one may never receive any appropriate answer.

It is my determination on the available evidence that it was completely irresponsible and unreasonable and without foundation in all of the prevailing circumstances for him to be so replaced.

On 11 September 1997 the deceased was rostered to perform work in the bakery. Officer Evans said, in the course of his evidence, that he saw the deceased at about 4 p.m. and he formed the opinion that the deceased was in "fine spirits". Officer Bryson saw the deceased at approximately 5 p.m. when he had returned from the bakery and he "seemed himself".

Upon his return from the bakery the deceased spent some time in the common area. Prisoners Bayne, O'Laughlin and Drury, had contact with the deceased in the common area and there is nothing in their evidence which would indicate that there was any concern as to the welfare or the well-being of the deceased.

Devery says that he saw the deceased leave the common area at about 5:25 p.m. and walked down as what has been referred to as "The Spine" towards his, that is, the deceased's cell.

The deceased was the simple occupant of cell number 14, which was able to be locked from the inside by the occupant.

Prisoner O'Laughlin, after speaking with the deceased, went to the kitchen and then took some milk to prisoner Wayne Fife, who was at that stage in his cell in close proximity to that

of the deceased. In fact, it was directly opposite the cell occupied by the deceased.

It was observed by prisoner O'Laughlin that Fife was half asleep so he decided to offer the milk to the deceased.

The door to the cell of the deceased's was shut, but was not locked. He opened the door and saw that the deceased was hanging. He observed the presence of a towel, either the observation window area of the cell door. O'Laughlin then contacted prison officer Blume who was in the kitchen area and reported what he had seen.

Blume in his evidence stated that by the time he approached the deceased's cell other inmates were in the cell area. The door of the cell was open and he observed the body of the deceased hanging by a length of plaited sheet. Against the wall, between the cell door and the shelves at the end of the bed, the feet of the deceased he observed were on the floor but with its knees slightly bent. He called prison officer Malane and the relevant duress button was operated.

Blume re-entered the cell and attempted to lift the body. Prisoners Fife, Prassar and Krantz entered the cell. Prassar undid the knot on the noose and officer Nielson appeared and cut the plaited sheet with what has been referred to as the cut-down knife. The deceased was removed into the spine area and officer Nielson arrived with a resuscitation mask. Nurse St Clair arrived with oxygen and the oxy veda apparatus, but despite resuscitation attempts by all present such proved to be of no avail.

The body of the deceased was removed from the scene by ambulance.

The death of the deceased was and has been extensively investigated by officers of the Queensland Police Service, and in particularly Detective Sergeant Renwick and Detective Sergeant Tuttfield. Such investigation included what has been referred to as an operation under the Code name Operation Cash Box. Such operation including not only an investigation of the death of the deceased, Adams, but some 12 other deaths which occurred within the prison.

The investigation of the circumstances surrounding the death of the deceased continued during and as a consequence of certain requests and directions given by myself during the course of the coronial inquiry.

Such ongoing investigation was necessary because during the course of the inquest two witnesses, two prisoners gave evidence implicating Wayne Anthony Fife in the death of the deceased. Those witnesses have been identified as Donovan and Coombes. Both witnesses gave evidence as to the conversations that they had with Fife and what he has said in relation to his involvement in the cell of the deceased and of his putting a sleeper hold upon the deceased and of his subsequently hanging the deceased in the manner in which he was found.

Throughout the investigation, both initial and subsequent, the Queensland Police Service were of the view that there was no evidence of a reliable nature to implicate any third party in the death of the deceased and that the death of the deceased was at his own hand by self-hanging.

The medical evidence of Dr Ansford quite clearly indicates that the cause of death is consistent with hanging.

The conclusion, as expressed by Detective Sergeant Tuttfield, has been expressed in these terms:

> "It is my belief that there is insufficient evidence available to successfully prosecute any person from unit 7B in relation to the manner in which (the deceased) died on the 11th of September 1997."

And further:

> "There have been no statements obtained with any concrete evidence other than rumour to suggest that (the deceased's) death was anything other than suicide."

There has been placed before this inquest further material which indicates that on Sunday, the 29th of August 2004, one Andrew Thomas Kranz, a prisoner, had a conversation with a number of Correctional officers and, as a consequence of that conversation Sergeant Thomas, "a Queensland police officer", had a record of interview with such prisoner and in the course of that conversation he quite clearly admitted that he, in the company of others, wilfully murdered the deceased. He gave as his explanation for his "confession" the fact that he wanted to help the families of the deceased's victims and that, secondly, he had started reading the Bible; that he believed it was the right thing to do.

I read into the record the following portions of the record of interview so recorded and which contains a vivid description of what the prisoner Kranz says occurs:

> "Can you explain to me how you became involved in his death; that is, the death of Adams?-- Sometime in the morning of his death I was approached by another inmate that asked me to make a rope with a loop in the end out of sheets. I did make out of three strips of a sheet, I put a loop in the end and plaited the ends".

And later:

> "I believe Mickey was at work. He was working at the bakery at the time and it was, like, planned that when he got back from work it was going to happen and when he did get back from work those two inmates, they went down to get him in the cell, asked him to come down for a couple of cones. There was one inmate sitting on the bed or lying back on the bed. Mickey was lying back against him and there was another inmate sitting at the desk having cones. I came in. I believed that they'd already had some. I came in. The inmate that was sitting on the desk went and sat on the bed, then the inmate that was sitting behind me put him in a choke hold. He put his arms up to grab the other fellow's arms that were around his neck, and I grabbed his arms and pulled them down."

Later:

> "And then the other inmate joined in restraining him. I went and grabbed the rope that I had made out of my cell which was only - it was towards the end, so it was one or two cells away, came back. The other two inmates still had Mickey on the bed. I looped the rope around his neck and tightened it. I grabbed the end of it and started lugging him or trying to hoist him up to the bar on the window. Whilst the other inmates were dragging him, lifting him at the same time. I got the rope through the thing. They held him. I tied the rope. One of the inmates wiped the cell down for fingerprints with a T-shirt or something or other. I left straightaway. I went and had a shower."

As a consequence of that admission of involvement with the death of the deceased, an ex officio indictment was presented in the Supreme Court of Queensland against Andrew Thomas Kranz charging him, amongst other offences, with two counts of murder, one count involving the deceased Michael James Adams and the other David Edward Smith. The defendant pleaded guilty to the indictment so presented, and, in the course of

her sentencing remarks, Justice Mullins on the 16th of June 2005 said the following:

> "Michael James Adams was only 20 years old when you killed him. He also was an inmate at Sir David Longland Correctional Centre. He was found hung inside his cell on the 11th of September 1997. His body was suspended by a series of bed sheets that had been plaited together and were wrapped around his neck. His death certificate stated that the cause of death was hanging. The authorities were unsure whether he committed suicide or was killed.
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> When you made your confession to police, you did not disclose the names of the other inmates who were involved, but you told police that you had been approached by another inmate to prepare a noose. You prepared the noose and hid it. That same person then told you later in the day that he and another were going to kill Adams.
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> When Adams was in his cell the other two inmates offered him a couple of cones. You then entered the cell and the four of you were smoking the cones together. One of the other inmates then placed Adams in a sleeper hold with one arm around the front of his neck and one behind it. Adams lifted his arms up to the arm that was around his throat. You grabbed Adams by the arms and held him to stop him from struggling. You then went and got the rope that you had made earlier and returned to the cell. You put the noose around Adams' neck and tightened it and the other inmates assisted you. You thought that Adams was dead as a result of what was done at that stage. The other inmates lifted Adams up to allow you to place the noose through the window and tie the knot to suspend Adams in the air. You then left the cell with the other inmates.
>
> This charge could not have been pursued against you but for your admissions.
>
> The reasons that were expressed by you to the police for making those confessions were that you wanted to let the families of each deceased know the truth, that you had been reading the Bible and that you realised that it was the right thing to do."

In relation to the death of the deceased and of the plea of guilty to murder in that regard the defendant, it would appear, was sentenced to a period of life imprisonment.

It was further directed that the defendant not be released from imprisonment until he had served a minimum of 22 years' imprisonment unless released sooner under exceptional circumstances parole pursuant to the provisions of the Corrective Services Act 2000.

It is clear on the evidence which has been placed before me, or before this inquiry, that there were others involved in the death of the deceased other than the defendant Kranz. It would appear that those individuals may well have been prisoners described as Prasser and Barlow and Pfeiff. Pfeiff is deceased and so therefore there remains prisoners Glen Patrick Prasser and Wayne Barlow.

In the course of his report Detective Sergeant Tuffield discounted any consideration being given as to the Queensland Crime Commission conducting investigative hearings into the circumstances of the death of the deceased as it was his then view that any such hearing would be ineffective as the inmates of Unit 7B are all hardened criminals and have shown on previous occasions their disregard for authority, and that the Commission's powers to compel witnesses would be ineffective against such inmates without the support of any circumstance or physical evidence due to their already lengthy sentences and that any inquiries by Commission staff would tend to suggest that it would be pointless attempting to cross-examine an inmate without having any areas of contradictory evidence to attack.

It is clear also on the evidence presently before me that there is insufficient evidence, as the evidence presently stands, upon which any jury properly instructed as to the law could arrive at a verdict involving either of the prisoners Prasser or Barlow, and, for that reason, it is not recommended that either of such persons be charged with any offence arising out of the death of the deceased. It is clear, however, that Kranz did not act alone and that there are others, and it would appear three in number, including Pfeiff, who were directly involved in the death and the murder of the deceased.

Having regard to the change in circumstances since the report of Detective Sergeant Tuffield, namely, the plea of guilty by Kranz, it is recommended in the interests of justice for the Queensland Crime Commission to consider the holding of investigative hearings with its coercive power in order to finalise and to bring to justice all those involved in the death of the deceased.

I make the following formal findings as required pursuant to the provisions of the Coroner's Act 1958:-

1. The name and identity of the deceased is Michael James Adams and that his occupation as at the date of his death was that of a prisoner.

2. The deceased was born on the 28th of December 1976.

3. The deceased at the time of his death was an inmate at Sir David Longland's Correctional Centre, Brisbane and that he was an occupant of cell 14 contained within Unit 7B at such Correctional centre.

4. That the deceased died on the 11th of September 1997 at the aforesaid Sir David Longland's Correctional Centre.

5. That the medical cause of death of the deceased is that described as by "hanging".

6. I find that the deceased was wilfully murdered by Andrew Thomas Kranz within cell 14 of Unit 7B of the Sir David Longland Correctional Centre whilst in the company of other persons whose identity is presently unknown.

As indicated earlier this Court has a statutory obligation and duty at the conclusion of the taking of evidence in any Coronial inquiry to commit for trial any person or persons who in the view of the court ought to be charged with any of the offences referred to in section 24 of the Act.

For reasons indicated earlier it is the determination of this inquiry that as the evidence presently stands there is no sufficient evidence upon which any person ought to be so charged apart from the person Kranz who has been already so dealt with.

This court also has a statutory duty to make recommendations in an appropriate case with a view to the prevention of death in the future or death recurring from a given set of circumstances.

It has been said that it is the paramount duty of any State to protect the lives of its citizens and to that end it is important that the coronial system monitor all deaths and particularly that it provide to the community a review of the circumstances surrounding deaths that appear to be

preventable. Every effort should therefore be made to obtain recommendations which might prevent similar deaths in the future.

Having regard to the whole of the circumstances of this unfortunate incident, the court is of the view that it is apposite for the following recommendations to be made, and they are so made in general terms.

1. That there be provided in all custodial facilities provision for the taking of a formal interview or statements from a prisoner in a private secure area in relation to any prison related investigation.

   Such a facility would assist investigators gain the confidence of prisoners as to their privacy and amenity and to provide security to both prisoners and investigators.

2. That prison cells be designed and/or rectified so as to provide a self locking device to the closing device of a cell so as to permit upon the entry of a prisoner to a cell the cell being secured against the entry of a fellow prisoner.

In the circumstances of this particular case it is clearly apparent that fellow prisoners were permitted because of the facility provided to wander in and out of a cell. Such a facility would prevent a cell door remaining open and/or a cell being assessable to a fellow prisoner once a prisoner has entered his cell and has closed it.

3. That protocols be established and practices put in place to prohibit and/or to remove any object which prevents the clear unobstructed observation of the interior of a cell. Such a provision would prohibit the placing of an object over the observation window and thus prevent clear unobstructed view into the cell.

4. That there be developed, introduced and strictly monitored protocols as to the securing of cells and the scenes of any death occurring in custody.

It is clear from the evidence in this particular inquiry that fellow prisoners were permitted to wander at will into the cell of the deceased and, therefore, possibly contaminate a potential and appropriate scene of crime. Such a protocol would declare a scene of crime and with appropriate care and control of the scene prevent interference, intentional or otherwise, with relevant evidence thus preventing other prisoners access to such scene and thereby contaminating the value of any evidence that may be obtained from subsequent forensic research.

Further, it would prevent a prisoner being able to rely upon any forensic evidence implicating himself from the occurrence by referring to his presence at the scene upon his entry to the cell.

5. That each and every cell in which a prisoner is detained, and all places within a Correctional centre in which a prisoner is reasonably likely to be located, be viewed by in-house recorded video device.

Such a provision would ensure the ongoing safety of each and every prisoner and would provide evidence as to the occurrence of any incident occurring within the confines of the Correctional institution.

The inquiry is conscious of the concerns as to the rights to privacy of individual prisoners. However, the stage must surely be reached where it is in the public interest and in the rights of prisoners generally for their welfare to be protected in such a way.

6. That there be undertaken as a matter of urgency a proactive regiment of removing "all" possible hanging points in all prisons irrespective of their age.

The inquest is cognisant of the steps that have been taken to date with the construction of more recent custodial institutions and the attempt to eliminate all potential hazards. However, it is essential that all such hazards be removed from all established prisons.

7. That prisoners be permitted reasonable access at all nominated times by the Correctional institution to telephone access to next of kin and other support persons, and that such be monitored and/or recorded by reliable mechanical devices.

Such a provision would ensure that prisoners have relevant support and solace from relevant family members and to provide them with solace in times of need.

In this particular inquiry, evidence has been given of a conversation said to have been had with the deceased and with his father shortly prior to his unfortunate death. However, the recording device normally in use was not operable due to some mechanical failure and, therefore, there is no evidence which may be called upon to show either the content of that conversation or of the state of mind of the deceased.

8. That there be established a protocol developing a meaningful relationship between any hospital to which a prisoner may be admitted and the prison hospital or medical establishment to which a prisoner is discharged upon leaving such hospital, and the bureaucracy of the prison Correctional establishment so that there may be put in place appropriate guidelines to determine the then physical, mental and psychological status of the relevant prisoner so as to ensure that there is sufficient material upon which to determine a prisoner's preferable place of confinement.

Such a protocol would ensure that a prisoner returned to a prison after confinement in a public hospital would be professionally assessed by an in-house nurse or social worker, or the like, and who would then be in a position to furnish an appropriate report with appropriate recommendation to the relevant authority within the prison as to the placement of a prisoner within the Correctional centre.

Any such placement of a prisoner ought to be based upon appropriate and relevant professional advice, not relying upon the wishes of a prisoner, but having regard to the legal obligations of the Correctional authority and to the best interests of the prisoner in the light thereof.

9. That there be introduced protocols involving the taking by prisoners of unprescribed drugs so as to ensure their proper future management of such persons within the Correctional institute.

Such a protocol would ensure that all prisoners were not only properly supervised, but they would not be placed in a situation where they would be tempted and/or provided with further drugs having regard to the environment in which they had been placed.

It is apparent from the evidence in this particular case that the deceased ought not to have been replaced in an environment which was well-known to be associated with illicit drug taking and for him to be returned to such an environment after he had experienced an overdose of illicit drugs.

10. That there be introduced a more timely practice concerning the attendance and provision of Emergency Services at an emergent incident.

Such provision would ensure that upon notification of a relevant life threatening incident there would be immediate attendance at the scene of relevant personnel and relevant medical apparatus so that emergency services such as the provision of oxygen or cardiorespiratory equipment would be carried out at the first available opportunity.

It is clear from the evidence in the present case that there was delay in the "cutting down" of the deceased and of the

availability and the presence of emergent medical apparatus.

11. That there be introduced as a matter of urgency an active and proactive regiment to rid places of Correctional service of illicit drugs.

The court is aware of the program presently in place concerning the screening of visitors to Correctional centres for the possession of illicit drugs. The cold uncontradictable fact is that drugs are freely available to prisoners within the prison, and this is clearly shown by the facts in this case.

Drugs can only be used in the prison, one would reasonably presume, by lawful prescription, by the introduction by visitors to the prison, by introduction by employees of the prison, by the introduction by mail, by the introduction by trespass such as "throwing" of drugs contained within tennis balls and the like over the walls of the prison, or by the introduction by new prisoners.

It is a nonsense to suggest that drugs can suddenly appear within the confines of a prison without them being introduced unlawfully. It is suggested that there be introduced in every prison a proactive constant and random inspection of prisoners and cells occupied by prisoners by relevantly trained personnel and by appropriately trained drug detection dogs. It is a nonsense to suggest, as might be argued, that the cost of such procedures is exorbitant.

There is already in place, as understood, a system whereby especially trained dogs at random inspect visitors to the prison with a view to the detection of the illicit drugs. There can be no reasonable explanation offered for such a procedure not to be extended to the random inspection of prisoners and prison cells.

The only argument that can be advanced is that it is an invasion of a prisoner's privacy. However, the public interest and the general welfare of a prisoner is far outweighed by any consideration of the invasion of any such suggested right to privacy.

The death the subject of this inquest is one that should never have occurred. The State and a custodial institution has a duty to protect a prisoner and to ensure the welfare of a prisoner during the course of such prisoner's confinement.

Whether a death occurs by the acts of a third person or by suicide, such deaths ought not to be permitted to occur in this modern day and age.

Before I formally close the inquest, I wish to express my personal sympathy to the relatives of the deceased in their sad and tragic loss. With the delivery of my formal findings that brings a close to the inquest.

Is there anything further, Mr Grealy?

MR GREALY: No, your Honour. I think it covers the matter. I imagine the matter, of course your findings and

recommendations, will be forwarded to the appropriate authorities.

BENCH: Is there anything else that you'd like to-----

MS NEVILLE: No, your Honour.

BENCH: I formally direct that a copy of the findings in this proceeding, once transcribed and revised by myself should the need arise, that a copy of those findings be delivered to each of the relevant parties.

I formally close the inquest.

THE COURT ADJOURNED
