QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Kyle Leslie Canisi**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2011/4364
DELIVERED ON:	17 December 2014
DELIVERED AT:	Brisbane
HEARING DATE(s):	26 November 2013; 19-20 February 2014. Further written submissions 2 June - 21 July 2014
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, prison assault, supervision of prisoners, associations between prisoners.

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Queensland Corrective Services:	Ms Jennifer Rosengren (Instructed by the Department of Justice and Attorney-General)
GEO Group Australia Pty Ltd and Mr G J Howden:	Mr Stephen Zillman (Instructed by Ashurst Lawyers)

Mr G Moody:	Mr Andrew Herbert (Instructed by AD Legal)
Mr Brendan Smith: Mr Darryl Siddons	Mr Luke Tiley Hall Payne Lawyers

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Introduction

After a lengthy stand-off with correctional officers in the exercise yard of the Detention Unit (DU) on Christmas Eve 2011, Scott O'Connor was returned to his cell at Arthur Gorrie Correctional Centre (AGCC).

The General Manager of AGCC, Greg Howden, had personally intervened in this stand off and walked Mr O'Connor back to his cell. Mr Howden says he gave a verbal order that Mr O'Connor was not to associate with any other prisoner until he returned from Christmas leave on 28 December 2011.

However, early on 27 December 2011, Mr O'Connor was allowed to associate with another DU prisoner, Kyle Canisi, to give Mr Canisi a haircut. Just before 8:00am O'Connor began a vicious and apparently unprovoked attack that left Mr Canisi with severe brain injuries and caused his death a short time later.

Due to the threat Mr O'Connor posed to the safety of corrective services officers, 20 minutes passed before they could access the exercise yard, restrain Mr O'Connor and commence first aid.

These findings:

- confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death;
- determine whether the authorities charged with providing for the prisoner's wellbeing adequately discharged that responsibility;
- consider the adequacy of policies and procedures in place at Arthur Gorrie Correctional Centre regarding the association of prisoners housed in the Detention Unit; and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The Investigation

An investigation into the circumstances leading to the death of Mr Canisi was conducted by Detective Senior Constable Rudi Knaggs from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). He submitted a report to my Office and this was tendered at the inquest.

Senior Constable Knaggs attended AGCC with several other CSIU officers. He inspected the Detention Unit and oversaw the forensic examination of all points of interest. Mr O'Connor had been isolated and AGCC staff had appropriately photographed him to record blood stains to his clothing and the injuries he had sustained to his hands during the assault.

CSIU officers commenced the process of taking statements from staff and inmates of the DU. They took steps to seize all relevant records and

interrogated the AGCC Information and Offender Management System (IOMS). Senior Constable Knaggs spoke to intelligence officers at AGCC and made arrangements for statements to be obtained from senior officials at the prison. He also seized CCTV footage of the exercise yard where Mr Canisi was assaulted.

Scenes of crime officers took a series of photographs of the scene and analysed a series of swabs and impressions for DNA and fingerprint matches.

The Chief Inspector, Queensland Corrective Services, appointed investigators to examine the incident under the powers conferred by s294 of the *Corrective Services Act* 2006. Those investigators prepared a detailed and thorough report which was submitted to the Office of the Chief Inspector (OCI Report). It examined matters within and beyond the scope of the coronial inquest. The report was tendered at the inquest and was of assistance in the preparation of these findings.

I also had access to two tendered reports compiled by an investigator appointed by the GEO Group Australia Pty Ltd, the private company which operates AGCC.

I am satisfied that the QPS investigation was thoroughly and professionally conducted and that all relevant material was accessed. I thank Senior Constable Knaggs for his assistance.

The Inquest

A pre-inquest conference was held in Brisbane on 26 November 2013. Mr Johns was appointed as counsel assisting and leave to appear was granted to Queensland Corrective Services, GEO Group Australia Pty Ltd, Mr Greg Howden who was General Manager of AGCC at the time of the death, and Mr Greg Moody who was employed as a Supervisor at the prison. Leave to appear was later granted to other corrective services officers employed at AGCC.

An inquest was held on 19 and 20 February 2014. All of the statements, records of interview, medical records, photographs and materials gathered during the investigations were tendered at the inquest. Written submissions were received from several of the represented parties in June and July 2014.

I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The evidence

Personal circumstances and correctional history

Kyle Canisi was 24 years of age at the time of his death. He was one of four children and had a partner and an infant son. He had maintained contact with his family while in prison. They would have been deeply distressed by his sudden and violent death. I offer them my sincere condolences.

Mr Canisi had a relatively minor criminal history until 2007, when he was imprisoned for the offence of grievous bodily harm. His second period of imprisonment was in 2011 for unlawful wounding. At the time of his death he was remanded in custody on further charges of grievous bodily harm.

The OCI Report noted that Mr Canisi was regarded as a violent and unpredictable prisoner and that Correctional Services Officers (CSOs) were cautious in his proximity. He was moved to the DU after being placed on a safety order when he was found in possession of a prohibited item (a syringe) on 19 November 2011.

On 21 November 2011 Mr Canisi activated a fire alarm and was detected with a prohibited item (a wick). He later assaulted three CSOs which resulted in further charges being laid against him by the CSIU.

Scott O'Connor

Scott O'Connor was 30 years of age at the time of his attack on Mr Canisi. He had an extensive criminal history and was serving his seventh period of imprisonment. The most recent episode had commenced when he was placed on remand on 21 December 2010 having been charged with armed robbery. The OCI report recorded that:

> "*Prisoner O'Connor has an extensive and complicated medical history involving mental health, substance abuse and withdrawals and a history of self-harming.*"

Mr O'Connor was charged with the murder of Mr Canisi but subsequently took his own life at the AGCC Maximum Security Unit. His death is the subject of a separate coronial investigation.

Mr O'Connor was held in the DU on consecutive safety orders. An order dated 5 December 2011 was to run until 2 January 2012. The reason for the safety order referred to an incident that occurred on 21 December 2010 involving a fire and damage to Mr O'Connor's cell, immediately after he was returned to custody. A condition of his safety order was that he was not to associate with any other prisoner without the General Manager's approval.

Mr O'Connor was an intermittent patient with the Prison Mental Health Service. However, he was not under any orders under the *Mental Health Act 2000* at the time of this incident. He had a history of non-compliance with respect to his medication and was regarded as an unpredictable, violent and physically imposing prisoner. He also had a history of self-harm.

In 2009 the PMHS had assessed that Mr O'Connor demonstrated the "presence of a clear mental illness which appears to be cyclical in nature". He demonstrated bizarre behaviours with psychotic features that appeared to occur every few months.

There had been no recorded 'breaches' or incidents involving Mr O'Connor during the year of his most recent period of incarceration. There are indications that he had perhaps mellowed when compared to previous periods of imprisonment. This would have been a relevant consideration when approval was given for him to associate with Mr Canisi.

However, the OCI Report also found that there had been a failure to report incidents that might normally be considered worthy of note or even 'breach' during Mr O'Connor's most recent period of imprisonment. An example included the alleged assault of another prisoner in which hot water was thrown through a cell door, causing injuries to the prisoner's face.

This failure in reporting protocol was addressed in the findings and recommendations of the OCI Report and is referred to later in these findings.

Associations

Associations between prisoners accommodated in the DU had to be personally approved by Mr Howden in advance. Additional requirements identified in the GEO Group investigation report were that associations required the consent of both prisoners and were to occur in the main exercise yard.

The OCI report found that these requirements were not documented and that authorised associations were not limited to the exercise yard. Another protected prisoner in the DU, who I shall refer to as P1, and Mr O'Connor were permitted to associate freely for a period of some 3 ½ months prior to 27 December 2011. This included both prisoners undertaking cleaning duties together, access to the unit spine, kitchen, other prisoners' doors (where they were able to freely communicate) and each other's cells.

In practice, Mr Howden would personally attend at the DU each morning and speak with each of the prisoners located within the DU. A prisoner was able to make a request for an association during these visits as associations usually occurred on the same day. Mr Howden indicated that he would base his decision about an association on intelligence received by staff and case notes. On occasion Mr Howden would make an "on the spot" decision.

The OCI report records that Mr Howden would not approve an association involving short-term prisoners. Mr Canisi's request was outside the norm and occurred for a specific purpose – a haircut.

However, Mr O'Connor's case notes from 22 December 2010 indicate that he had extensive associations with a number of short-term prisoners within the DU. These increased in frequency from August 2011 and included associations with multiple prisoners on the same day. There was a view within the DU that most of Mr O'Connor's demands were acceded to in order to appease him.
The OCI Report found that associations that had been approved were noted on a whiteboard within the DU. Associations not approved were not documented. Associations were only noted within IOMS after the event but

this did not always happen. Handover notes were prepared and saved to a hard drive within the AGCC computer system which did not reflect the information contained within IOMS.

The lack of consistency between the notes saved on the G:drive and the material in IOMS was of particular relevance in Mr O'Connor's case as the PMHS placed reliance on the accuracy of IOMS in forming assessments of prisoners.

Significantly, the OCI report found there was no system in place within the DU to determine whether an approved association that had not taken place within a short period of time was still appropriate.

The absence of an appropriate system for the approval and documentation of associations is also addressed in the findings and recommendations of the OCI report referred to in these findings.

Events leading up to the assault

As noted above, Mr Canisi and Mr O'Connor were both detained in the AGCC DU. Mr Canisi was housed in cell 7 until shortly before his death and Mr O'Connor was in cell 2. There was no evidence that the two men knew or associated with each other outside of the correctional system.

The DU had 12 cells which are occupied by prisoners from other areas within AGCC, generally on a temporary basis, following a safety order or a breach of discipline. Prisoners on a safety order may stay for an extended period whereas prisoners placed in the DU following a breach of discipline usually stay for less than a week.

P1 reported that a verbal altercation had taken place between Mr Canisi and Mr O'Connor in late November 2011. It was alleged that this incident involved a dispute over loud rap music being played by Mr O'Connor.

P1 gave evidence at the inquest that he subsequently saw O'Connor go to Mr Canisi's cell door and he overheard O'Connor say to Mr Canisi that he would get association from the General Manager and "smash his skull". P1 was not aware of any animosity between O'Connor and Canisi prior to this incident.

P1 indicated that Canisi was worried following Mr O'Connor's threats. Mr Canisi had asked P1 to apologise to O'Connor on his behalf and he had done so.

On 7 December 2011, Mr Canisi assaulted CSO Brendan Smith by throwing hot water directly at his face. Following this incident he was placed on specific 'handling instructions' by Area Manager Len Lackey. The instructions were to remain in place until otherwise advised and were still in place at the time of Mr Canisi's death. The instructions were to the effect that he was to be treated as potentially hostile at all times, and that extreme caution was to be exercised. In addition when his cell was opened three custodial staff were to be present.

The instructions were placed in a plastic document holder next to the door of cell number seven.

At the inquest, P1 referred to the incident where Mr Canisi had thrown hot water at CSO Brendan Smith. P1 had reported this incident to O'Connor who became angry at Canisi because he interpreted this as an attempt by Mr Canisi to get a non-association order to avoid contact with O'Connor. While the incident involving hot water being thrown at CSO Smith is recorded in IOMS, no reference is made to the subsequent verbal altercation between O'Connor and Mr Canisi. However, it is possible that this incident was not witnessed by CSOs.

CSO Smith gave evidence at the inquest. He stated that Mr Canisi had thrown hot water at him after he had denied him a cigarette when he failed to clean his cell. He subsequently pressed charges against Mr Canisi with CSIU. CSO Smith initially said that he was unaware of any conflict between Mr O'Connor and Mr Canisi. He denied that P1 had drawn this to his attention.

Counsel Assisting drew CSO Smith's attention to a record of interview with GEO Group investigators in which he stated that he knew about an argument between O'Connor and Mr Canisi in November 2011 because P1 had drawn it to his attention. CSO Smith responded by saying "I totally forgot that".

CSO Smith stated that he thought it was a minor argument and that no specific threats were made. He agreed that he had failed to make a note of this incident. He was not present when Mr Howden approved the association but had no concerns about it.

Events of 24 December 2011

P1 informed OCI inspectors that on the morning of 24 December 2011 Mr O'Connor returned a number of items of property to P1's cell, including a digital television and other items. In evidence at the inquest P1 stated that he was aware that Mr O'Connor wanted to be returned to the maximum-security unit. Mr O'Connor handed his personal computer to CSO Smith with a request that it be sent to the maximum-security unit for prisoner Jason Nixon's use.

It seems that this behaviour was interpreted by CSOs as preparation for a return to the MSU. However, this behaviour is also a possible sign that someone is planning to end their own life and should have been flagged with an appropriate professional to enable a self-harm/suicide risk assessment to be undertaken. [1]

After emptying his cell Mr O'Connor returned to it and locked his door. He was then visited by CSO Turner who had brought with him some 'hand

[1] http://www.health.qld.gov.au/mentalhealth/abt_mental/facts_suicide.asp

grippers', an exercise device. CSO Turner and Mr O'Connor then had a discussion inside his cell.

CSO Turner's evidence was that he had been asked to attend at the DU by CSO Smith as O'Connor was acting in an "unusual manner" and he had worked with him previously. CSO Turner was not aware of any conflict between Mr O'Connor and Mr Canisi.

After CSO Turner left, Mr O'Connor removed himself from his cell, went to the exercise yard, and locked himself in. Mr Turner was again contacted by CSO Smith to speak with O'Connor in an attempt to resolve the situation. He stated that he wanted to "box on" with the prison's Correctional Emergency Response Team (CERT) team at 5:00pm. He told CSO Turner that he had been training hard for 12 months and now wanted to test himself out. CSO Turner was asked by O'Connor to get the CERT crew so they could "have some hard training together".

After failed negotiations with Mr O'Connor, the acting Area Manager, Mr Moody, left the exercise yard and secured Mr O'Connor in it. He was aware that Mr O'Connor posed a risk to prison staff.

Mr Howden (who was not working on that day) was in attendance at the prison to resolve issues with the Arunta telephone system. Mr Howden has extensive experience as a correctional administrator including work within Pentridge, Darwin, Borallon, Sir David Longland, and Woodford prisons.

At approximately 3:30pm that day Mr Howden went to the DU with Mr Moody. They entered the exercise yard and spoke to Mr O'Connor. Mr Howden eventually persuaded Mr O'Connor to return to his cell on the basis that O'Connor would be able to choose some exercise equipment from a catalogue. Mr Howden and O'Connor left the exercise yard together at 3:54pm.

CSO Smith was on duty on 24 December 2011 when Mr O'Connor refused to leave the exercise yard. His evidence was that he remained in the officers' station while Area Manager Moody and Mr Howden tried to defuse the situation. He did not overhear any conversation between Mr Howden and Moody. He stated that Mr Howden had wished him a Merry Christmas and left the DU. He did not say anything to CSO Smith about associations involving O'Connor.

CSO Smith stated that Area Manager Moody was trailing behind Mr Howden and O'Connor. CSO Smith stated that he specifically asked Area Manager Moody if he required a report on the day's events. Area Manager Moody's response was that a report was not required in relation to Mr O'Connor's behaviour because it was not an "incident".

CSO Turner returned to the DU later on 24 December and collected a chess set that Mr O'Connor had offered to give him, which Mr O'Connor had hand crafted.

CSO Smith did not write a handover note because he did not "see the point" in drawing events of 24 December to CSO Siddons' attention when he had already verbally advised him of the incident on two occasions. At lunch time, he told Siddons that O'Connor was playing up and wanted to fight people. He later called him and told him that Mr Howden had returned him to his cell.

CSO Smith was subsequently disciplined for breaching the GEO Group Code of Conduct and Ethical Behaviour for failing to act with care and diligence in not making a case note of the incident that occurred on 24 December 2011. CSO Smith maintained that he held no animosity towards Canisi because abuse was part of the job when you were working in the DU.

Mr Moody's Evidence

Greg Moody was permanently appointed as a Supervisor of the mainstream side of the AGCC. He was the acting Area Manager at AGCC during the Christmas period in 2011. His evidence was that he was the only person on duty in a managerial capacity at the relevant time. There would otherwise be seven managers on duty.

Mr Moody was called to the DU by CSO Smith after Mr O'Connor refused to leave the exercise yard and wanted to confront the CERT team. He then spoke with Mr O'Connor and reported this to operations manager, Nigel McReaddie, who was not on duty at the prison on that day.

When Mr Howden arrived in the middle of the afternoon he went with Mr Moody to the exercise yard of the DU and had a conversation with O'Connor.

After they all walked with O'Connor to his cell Mr Howden had a discussion with O'Connor about the purchase of some exercise equipment. Mr Moody stated there was no conversation between him, Mr Howden and detention unit staff during this period.

They went to the MSU from the DU and spoke about the breakdown of the Arunta phone system. Mr Moody expressed that he was under considerable stress because 13 posts were unfilled. He had to negotiate with the union in relation to opening the prison and had to vacate "rover" posts to in order to open the prison.

He and Mr Howden spent 30 minutes in the MSU, an association between two other prisoners was approved and they returned to Mr Howden's office. Mr Howden produced a mobile phone and gave it to Mr Moody to facilitate contact between prisoners and their families in the event that the Arunta system was not operational on Christmas Day. Mr Moody stated that he had no contact with Mr Smith in the DU following the incident.

Mr Moody did not consider that it was unusual that no direction had been given to Mr Smith about how to manage Mr O'Connor as the situation had been resolved and O'Connor was calm. Mr Moody admitted that he had no

understanding of the association process within the DU as he had not spent much time there.

Even though he was acting Area Manager, Mr Moody did not consider that it was his role to provide directions to Mr Smith about the management of Mr O'Connor. Mr Moody recalled the discussions with CSO Smith and Mr Leckie on 25 December 2011 in relation to the management of Mr O'Connor. Mr Leckie advised that he should endeavour to keep Mr O'Connor in his cell, but he was not directed to do so. Mr Moody was confident that CSO Smith would call him should an incident arise. Mr Moody stated there was no discussion in that meeting about directions given by Mr Howden in relation to O'Connor.

The General Manager's Direction

Mr Howden's evidence was that when he arrived at the prison on 24 December 2011 he spoke with Mr Moody in his office and got a briefing on the telephone system, Mr O'Connor's behaviour in the DU and another issue in the maximum-security unit.

Mr Howden said that he spoke with Scott O'Connor for 15 to 20 minutes in order to convince him not to fight with the CERT team and to talk him down. After successfully negotiating with Mr O'Connor he walked him to his cell. Upon leaving the DU he told Mr Moody that he was to "stay in his cell until such time as I return from leave" with nil access to others. He recalled that this direction would have been given in the air lock or just outside the airlock en route to the maximum-security unit.

> *It was a strategy to ensure that he was locked away safely in his cell, at which time I would have people back on station after the Christmas break, particularly psychiatrists, psychologists and others to confer with about what I'd confronted in the yard.*

Mr Howden's evidence was that after he had given the instruction to the acting Area Manager he expected that he would "case note that and he'd write a report after I'd left".

Mr Moody had originally informed the GEO Group investigator that he was instructed by Mr Howden to leave Mr O'Connor in his cell until Mr Howden returned from his Christmas break. He also told the investigators that he immediately told CSO Smith that he was to remain in his cell

> *"… that was a very obvious decision that one I mean it wasn't just a, I mean, no one in their right mind would have thought otherwise".*

At the inquest he stated that he gave that response to the GEO Group investigator "because that was what was expected" of him. Mr Moody denied that he had any conversations with Mr Howden in relation to the incident or the management of Mr O'Connor following O'Connor being returned to his cell on the afternoon of 24 December 2011. The situation had resolved and Mr O'Connor was back in his cell – "there was nothing more to discuss".

Mr Howden's evidence was that he also phoned Mr McReaddie on 24 December 2014 at about 6:00pm -

> *I briefed him on what I'd done and told him that I locked O'Connor in the cell and he has to stay there until I return from my leave. He got that message, I think, loud and clear.*

Mr Howden gave evidence that he called Mr Moody at home after Mr Canisi's death and asked for a report because he had given him an instruction to leave O'Connor in his cell and "clearly remembered that I'd given him that instruction and I wanted a report from him".

Mr Moody's evidence was that he was called by Mr Howden and asked whether he recalled Mr Howden telling him in the DU that O'Connor should be confined to his cell until he returned to work on 28 December 2011. Mr Moody responded to Mr Howden by saying "yes". Mr Howden told him that he should include that in the report and send it to him.

Mr Moody's evidence was that on the morning of 29 December 2011 he commenced to write the report but was asked to attend Mr Howden's office because the report had not been provided. He again asked him to prepare the report.

Mr Moody's evidence was that because he had no recollection of being given this direction by Mr Howden, he did not immediately finalise the report but spoke with two officers in Unit "Charlie 1" about the request. Mr Moody said that he then went to speak to Mr McReaddie, the Operations Manager, and told him that he had been asked to include information in his report.

Mr Moody's evidence was that he received a vague response from Mr McReaddie to the effect that it was necessary for staff to watch Mr Howden's back. Shortly afterwards, he was asked to go to Mr Howden's office where Mr Howden said to him "Have you got a problem writing this report".

His response to Mr Howden was "No, I don't have a problem and I will go and write it". He then returned to his office and wrote the report. Mr Moody agreed in evidence at the inquest that he had lied in his officer's report of 29 December 2011.

Mr Moody said he also spoke of his concerns about preparing the statement with other corrective services officers employed at AGCC, including Mr Waites, Mr Coolbride and Mr Carter.

Mr Moody produced a statement to the inquest in draft and final form that he asserted was prepared in 2012 in order to "set the record straight" in which he denied having been given the instruction. This statement had also been given to the GEO Group investigator.

The draft statement indicated that the General Manager, Mr Greg Howden, "to the best of my recollection, did not give me specific instructions" that prisoner O'Connor was to remain in his cell until interviewed by the General Manager on 28 December 2011.

The second document is in absolute terms that "the General Manager did not give me a specific instruction". He also informed the Chief Inspector in absolute terms that he had no recollection of the direction from Mr Howden.

Mr Moody confirmed in evidence at the inquest that at the time he was not fit for duty and had very high blood pressure and significant headaches. He was not certain of the impact of this on his memory. He had been granted a temporary demotion on ill health grounds from 23 September to 17 November 2011 when he was restored, at his request, to his supervisory position.

Mr Moody agreed that a direction to prevent O'Connor from associating with other prisoners would have been "the obvious and natural order to be given in the circumstances".

When interviewed by a GEO Group investigator on 6 January 2012, he reported that at the time of putting O'Connor in his cell he said to CSO Smith that he was to remain in his cell. He agreed at the inquest that "we were working out a way of trying to keep him in his cell". Mr Moody agreed in evidence that he also lied in his interview with the GEO Group investigator on 6 January 2012.

Under cross-examination he asserted that he had "no recollection" whatsoever of a direction being given by Mr Howden that Mr O'Connor was to be kept in his cell. He agreed that in a subsequent interview with Mr Lang he had also maintained that he had no recollection of a direction being given, not that he was not given the direction.

> *Might you have said that?---I - [indistinct] the line of questioning at the time, I don't remember, so I don't recall. I mean, you know, under the circumstances you'd expect that - that order to come forward, but it never did. You know, we were trying to - we were all trying to keep him in his cell.*
>
> *You were all trying to keep him in his cell?---[Indistinct] getting through?*
>
> *Why was that?---Well, only because we thought he was going to get more violent towards us.*
>
> *Right. Well, that would make good sense, wouldn't it?---Absolutely, sir. But I don't ever recall that being said, ever.*

Mr Howden's evidence was that he made contemporaneous notes of his direction to Mr Moody on or about the 24 December 2011 in his diary.

Mr Howden produced two diary entries to the inquest in relation to the events of 24 December 2011. The first was headed "GM Other Diary", and the other was headed "GM Prison Log". The entry in the first diary included the following entry written on 24 December 2011:

> *"Instructed that he stay there in his Peter[2] until Wednesday 29 when I return"*
>
> ….
>
> *"No access to others"*

The entry in the second diary included the following entry written on 24 December 2011:

> *A/M Greg Moody witnessed my conversation. I said to Mr Moody to leave him in his cell to settle. I would speak to him on the next duty day Wednesday 28 12 2011.*

The Operations Manager Nigel McReaddie also provided a statement in which he recalled a conversation with Mr Howden on the evening of 24 December 2011 in which Mr Howden said words to the effect:

> *"Prisoner O'Connor is to remain in his cell until I return to work. I have instructed staff that O'Connor is not to come out of this so until I return to work after Christmas"*.

Conclusion re the non-association direction

The inquest heard that two internal inquiries by the GEO Group found Mr Howden gave a verbal direction to Mr Moody on 24 December 2011 to the effect that Mr O'Connor was to remain in his cell until the return of Mr Howden from leave on 28 December 2011.

Mr Moody's evidence was that he did not recall any such direction being given and he failed to mention anything about such a direction when he was discussing the plan for prisoner O'Connor at the meeting with CSO Smith on 25 December 2011. There was no reason for him to withhold such information at this time.

Evidence which could be construed as supporting the GEO Group internal review findings includes:

- The evidence of Mr Howden that he gave the direction;
- The inherent likelihood that, having just dealt with such a tense incident as he had, Mr Howden would give some direction with regard to the management of O'Connor;
- The acknowledgement by Mr Moody that it was an obvious direction;

[2] A reference to his cell

- The contemporaneous diary entries made by Mr Howden on 24 December 2011; and
- The evidence of Operations Manager Nigel McReaddie.

Mr Moody was not an impressive witness. Many of his answers were evasive. It is clear that this incident has weighed heavily upon him. The credibility of Mr Moody's evidence suffered from the knowingly false initial account he gave to the internal investigator appointed by the GEO Group. He had also knowingly suggested that CSO Smith had failed to follow his direction to keep O'Connor in his cell.

In his disciplinary interviews and again, when pressed at the inquest, Mr Moody was unable to discount entirely the possibility that Mr Howden gave the direction.

On his own account, he was suffering significant health problems on 24 December 2011 and was under a great deal of stress. He acknowledged this may have affected his memory.

On balance, the evidence supports the version of events set out in the report prepared for the GEO Group; namely, that the direction was given and owing to the stressful events of the day involving the management of the Arunta system, prisoners in the MSU, and his own health issues, Mr Moody failed to remember it.

It is also clear that Mr Moody failed to document and pass on the General Manager's direction to other officers within the AGCC.

Mr Moody was also authorised to independently give a direction that Mr O'Connor was not to associate with any other prisoner but failed to do so.

Management of Canisi and O'Connor on 24-26 December 2011

IOMS records that Mr Canisi was moved from cell 7 to a powered cell (cell 10) on 25 December 2011 for 'operational reasons'. This enabled him to have access to a television which was reported to have moderated his mood.

The OCI report notes that following this move Mr Canisi's handling instructions were no longer located adjacent to his cell door, and may have led to an assumption on the part of CSOs that they no longer applied. However, this was not documented in IOMS.

CSO Smith's evidence was that he was on duty on 25 and 26 December 2011. On 25 December 2011 he spoke to Area Manager Leonard Lackey and Area Manager Moody with respect to the management of Mr O'Connor. (Lackey was on leave but attended at the prison to drop his partner at work).

Lackey's advice to him was to "use your instincts and play it by ear." Moody gave him no advice. There was no discussion about Mr Howden's directions on 24 December 2011.

CSO Smith was annoyed that this was the only advice he received and he subsequently decided to keep Mr O'Connor confined to his cell on 25 and 26 December.

He wrote a handover note for Siddons' use on 27 December 2011:

> *"O'Connor- hasn't had his yard door opened the last two days and has just spent all day in his cell smoking and sleeping. He has said that he will not be bought by Mr Howden so we need to watch him when Mr Howden comes in the morning. If he is going to use the yard I think we need to def lock him out there and limit his out of cell time because I think it is messing with his head."*

CSO Smith made the following entries in the IOMS system on 25 and 26 December 2011:

25/12/2011 *The prisoner has spent most of the day sleeping. The prisoner had an officer initiated call today to his mother. This appeared to lift his spirits, which had been very down today.*

26/12/2011 *The prisoner appears to be in a sullen state today again spending most of the day sleeping. He is polite when interacting with staff but is still withdrawn. Extreme caution should be used with this prisoner when he is in these moods.*

Mr Lackey gave evidence at the inquest. He recalls having a conversation with Mr Moody and Mr Smith on Christmas Day about the incident of 24 December 2011. The discussion was in relation to how Mr O'Connor would be managed over the Christmas break. As he was not on duty that day he "recommended" that Mr O'Connor should not be allowed to have association with anyone else. In his view, Mr Moody was acting Area Manager and he had the capacity to make such a direction.

While Mr Lackey was aware of the approved association between Mr O'Connor and P1, he was not aware of the association between Mr O'Connor and Canisi.

Mr Moody was Area Manager over the Christmas period in 2011. Even if he did not recall a direction being given about Mr O'Connor's management, he could have directed that he be kept in his cell. He acknowledged in evidence that this was the order he would have expected to have been made in the circumstances, and that the objective was to keep Mr O'Connor in his cell.

It was incumbent on Mr Moody or Mr Lackey to give clear directions to CSO Smith when they met on 25 December 2011 to discuss Mr O'Connor's management. However, this did not occur.

Events of 27 December 2011

Mr Howden informed OCI investigators that Mr Canisi had requested an association with another prisoner for a haircut on 19 December 2011.

Mr Howden had limited the range of prisoners who could cut Mr Canisi's hair because he was considered to be aggressive and having a violent disposition. In his opinion, Mr O'Connor was the most settled prisoner within the DU (up to 24 December 2011) and the risk of contact between the two could be managed provided sufficient staff were present.

Mr Howden was not aware of any animosity between Mr Canisi and Mr O'Connor at the time he approved the association.

P1's evidence was that Mr Canisi had asked on three separate occasions for P1 to cut his hair but this was refused by Mr Howden because P1 was a protection prisoner. P1 was told Mr O'Connor would perform the hair cut.

In evidence at the inquest, Mr Howden noted that Mr Canisi was not a long-term prisoner in the DU. He described him as "anti-authority, anti-prison officer, anti-police" and there was a risk that he "vent his anger" on P1. Mr Howden also stated that at any time, if Mr Canisi was not comfortable with Mr O'Connor cutting his hair cut, he simply could have stated "I don't want the haircut".

P1 stated that he was told by Mr O'Connor that morning that Mr O'Connor was cutting Kyle's hair, based on the approval given on 19 December 2011. Mr Canisi and Mr O'Connor collected coffee and were escorted to the exercise yard. P1 stated that CSO Siddons had told him that Mr Howden had approved the association between Mr Canisi and Mr O'Connor. P1 told Siddons that he did not think that was a good idea.

CSO Darryl Siddons was rostered to work in the DU unit between 6:30am and 6:30pm on 27 December 2011. He was the sole officer rostered to work in the DU on that day but was able to obtain assistance from other CSOs if it was necessary to move prisoners within the unit. Two other officers attended at the DU to assist with the morning unlock at about 7:00am.

CSO Siddons unlocked Mr O'Connor's cell at about 7:00am at which time O'Connor asked whether he could cut Mr Canisi's hair. His evidence was that O'Connor appeared to be calm and in a good mood.

Contrary to CSO Smith's evidence, Mr Siddons' evidence was that he was unaware of the details of the incident that had occurred in the exercise yard on 24 December 2011 until after Mr Canisi's death. He had not been informed of the incident by Area Manager Moody even though he considered that it was a reasonably significant incident which he would expect to be told about. Mr Siddons indicated that he would have expected Area Manager Moody to provide this advice by email.

Mr Siddons did not attend a staff briefing at the commencement of his shift on 27 December 2011. Neither did he log in to either the IOMS or the AGCC G:Drive to read case notes or handover notes left by CSO Smith at the commencement of the shift. CSO Siddons denied that P1 had drawn any concerns about the association to his attention on the day.

CSO Siddons stated he spoke with Mr Canisi about the haircut from Mr O'Connor on 27 December 2011. He had agreed to it proceeding because he thought the association was still in place. It was still recorded on the whiteboard in the officers' station. If Mr Howden had cancelled the association it should have been recorded in the handover notes and wiped off the whiteboard.

CSO Siddons was aware of the incident involving hot water being thrown by Mr Canisi at CSO Smith but asserted that he held no animosity towards him. He was present when Mr Howden had approved the haircut for Mr Canisi and aware that no specific time had been allocated for it to occur. If he had been aware of the incident of 24 December 2014 he would have conducted a risk assessment and not facilitated contact between Canisi and O'Connor.

CSO Siddons evidence was that Mr O'Connor was moved to the main exercise yard shortly after 7:00am and then Mr Canisi was placed in the yard a short time later.

At approximately 7:30am a registered nurse and another CSO attended at the unit for the morning "medication run". The medication was delivered to the exercise yard for prisoners Canisi and O'Connor, but O'Connor declined to take his medication.

At 7:46am the breakfast trolley was brought into the DU and CSO Siddons assumed responsibility for its distribution.

No one was supervising the prisoners in the exercise yard during this period. In his interview with the GEO Group investigator CSO Siddons stated that this was "common practice" in the DU provided the General Manager had approved the association. It was clearly unnecessary for the association to occur at this time. It could have been deferred until after the breakfasts had been served and CSO Siddons was in a position to monitor the exercise yard from the officers' station.

After being left in the exercise yard largely unsupervised for almost one hour, CCTV records that at 7:58am, Mr Canisi took a seat in a chair with Mr O'Connor standing behind him.

CSO Siddons at this time was still serving breakfast in the unit spine. Shortly after commencing to cut Mr Canisi's hair Mr O'Connor struck the back of his head with the electric hair clippers. A struggle ensued, with Mr O'Connor eventually straddling Mr Canisi and delivering a stream of punches to his head.

After being alerted by P1, CSO Siddons called a code yellow in response to the incident at 8:00am.

Up to three other CSOs arrived at the DU shortly afterwards. Mr O'Connor was pacing around. He was enraged and covered with blood. The CSOs were warned by P1 not to go into the exercise yard as O'Connor would attack them as well.

O'Connor was overheard by CSOs to say to Mr Canisi who was lying prone on the ground "that will teach you to be a mouthy cunt" and "this is what happens when they bring lippy fucks like you into the DU".

These statements by O'Connor indicate that the attack was at least partially motivated by the earlier verbal altercation, and that he had intended on that morning to assault Mr Canisi when the opportunity arose, waiting for CSO Siddons to move away from the exercise yard and out of visual line of site before beginning his attack. He had loud music playing to mask the sounds of the disturbance.

By 8:03am there were seven or eight CSOs present within the DU in response to the incident including a number of CERT team leaders. Mr O'Connor threatened to kill any CSO who tried to enter the exercise yard.

The CSOs decided not to enter the yard because of the threat posed by O'Connor's known physical capabilities, including the presence of a large amount of property which could be used as weapons by him in the exercise yard.

Mr Howden was contacted and directed that the dog squad be sent to the exercise yard. He also authorised the use of gas. After the dog squad arrived at the DU Mr O'Connor armed himself with a metal pole from a large industrial fan located in the corner of the exercise yard. Mr O'Connor threatened to kill the dog. The dog handler CSO McKay made the decision not to enter the yard because O'Connor had the means to take both CSOs and the dog out.

At 8:20am Mr O'Connor adopted a position along the wall with his hands behind his head. This is the position that a prisoner is asked to assume when CSOs enter their cells. By this time 14 CSOs were in attendance at the DU. Mr O'Connor was handcuffed and led away to the AGCC Medical Centre for examination.

At 8:21am medical staff entered the exercise yard and attended to Mr Canisi. Life extinct was pronounced at 8:23am.

Autopsy results

A full autopsy examination was carried out on 29 December 2011 by experienced forensic pathologist, Dr Nathan Milne.

A post mortem CT scan was conducted and samples were taken for histological and neuropathological examination. Blood samples were subjected to toxicological analysis.

Dr Milne had access to a police summary of events, Mr Canisi's medical records and CCTV footage of the assault. In his autopsy report Dr Milne stated:

> "*Neuropathology examination of the brain showed signs of severe brain injury, complicated by raised intracranial pressure. These findings are consistent with the history, including what can be seen on the CCTV……*
>
> *The injuries are the result of blunt force trauma. For example, this could include blows from a hand/fist, knee or foot, or the body coming into contact with a hard object/surface such as the ground*."

Nothing in the toxicology findings was considered to have contributed to the death nor were they remarkable in any event.

As a result of the information available to him and his own observations during the examination Dr Milne issued an autopsy certificate listing the cause of death as:

> *1(a) Head injuries*

Conclusions

Mr Canisi died from an unprovoked and vicious physical attack perpetrated by Scott O'Connor. I find that none of the correctional officers or other inmates at AGCC had any direct involvement in his death.

There is no evidence to suggest that the attack was orchestrated by officers as a way of "getting square" with Mr Canisi.

It is clear that once the two men were permitted to associate in the exercise yard with limited supervision nothing could be done to stop the assault by Mr O'Connor after he commenced the attack.

Mr Canisi's death could have been prevented if Mr O'Connor was maintained in his cell in accordance with the General Manager's direction that he not be permitted to leave his cell.

His death could also have been prevented if Area Manager Moody had given an appropriate direction in relation to Mr O'Connor's management after witnessing the events of 24 December 2011. Mr Moody should not have been in a managerial role at this time. It was incumbent upon him to not have voluntarily assumed what he knew would be a stressful role. He should have

relinquished it when it was apparent that he was unable to handle the position because of the impact on his health.

Without needing to rely on the evidence of P1, it is clear that both CSO Smith and CSO Siddons were aware of the animosity between Mr O'Connor and Mr Canisi. They were both known to be prone to violence and the possibility of a physical confrontation between them during any association was real.

If CSO Siddons had accessed CSO Smith's handover notes or IOMS to assess the current level of concern about both prisoners he should have conducted a risk assessment to determine whether the association should proceed. Instead, his first act after he commenced duty on 27 December 2011 was to facilitate the association.

I do not consider that it was unreasonable for the CSOs to delay entry into the exercise yard until the CERT team arrived given Mr O'Connor's demeanour, size and his access to weapons.

The first aid Mr Canisi received after the attack was of a suitably high standard. Once he had sustained his injuries it is doubtful anything could have been done that would have prevented his death.

I concur with counsel assisting's submission that I should adopt (where relevant) the findings of the investigation conducted on behalf of the QCS Chief Inspector ("OCI Report"). These are set out below and numbered as per that Report.

> ***Finding 1***
> *Inspectors find a significant failure within the AGCC DU concerning the 'accurate' reporting of incidents, and prisoner behaviours and compliance within IOMS Case Notes system and the furnishing of timely intelligence information notices/reports. The failures include not reporting matters at all (although noted on hand-over notes) and inconsistent entries. Further, Inspectors find that officers, in order to save time and effort, are often 'copying and pasting' prior case note entries for a prisoner and inserting this information at the commencement of the shift to record the prisoner's behaviour and compliance for that relevant day. Officers may have the intent to modify the entry at the conclusion of the shift to reflect actual occurrences, however, due to time constraints, this is either forgotten or neglected resulting in case notes that do not accord with actual events and or behaviours.*

Finding 2

The association process adopted by AGCC in regards to prisoner associations within the DU was lacking. The AGCC DU had no written procedures, such as 'Standing Operating Procedures' (SOPs), 'Post Orders' or 'Guidelines' stipulating the process for: an association request; risk assessment; subsequent approval; implementation (including supervision); and a requirement to document the various steps of the process.

Finding 3

Although prisoners are at times placed on 'specific handling instructions', those instructions are not always entered onto the relevant prisoner's IOMS Case Notes. Additionally, any changes to the handling instructions are also not recorded on IOMS.

Finding 4

Not all staff posted to special accommodation units such as the DU receive sufficient familiarisation training to ensure compliance with unit specific procedures and requirements.

Finding 5

A high degree of officer complacency existed within the DU that resulted in compromising the safety of AGCC personnel and prisoners.

Finding 6

There were no adequate procedures within the DU that monitored, controlled and authorised the movement of items of property into the main exercise yard, foyer and kitchenette areas.

Finding 7

AGCC management failed to supervise the movement of items of property into the main exercise yard, foyer and kitchenette areas and failed to identify and rectify risks associated with such property.

Finding 8

AGCC does not have an adequate system to record specific instructions and directions given by senior management to subordinate staff concerning specific incidents or prisoners.

Reliance is placed on subordinate personnel to enter IOMS case notes, Incident Reports and Officer Reports, however, there is inadequate supervision and auditing to ensure information is recorded and accurate, in particular where senior management is personally involved in protracted or significant incidents.

Finding 9

A number of supervisory and management personnel use 'personal diaries' to record daily events, incidents and specific verbal instructions relevant to prisoners and personnel within the AGCC. AGCC does not have a formal record retention system to store and retain these diaries

and other similar documents. Some diaries are immediately destroyed at the end of the calendar year (thereby losing the information therein contained) whilst others are retained ad hoc by individuals.

…..

Finding 11
Specific warnings concerning DU prisoners, such as 'extreme caution when dealing with this prisoner', were not relayed to all other persons that may come in contact with the relevant prisoner. Additionally, staff that attended the DU to assist the unit officers were not briefed as to any specific risks, concerns or handling instructions regarding individual prisoners that they may have to physically interact with.

Finding 12
Inadequacies with the procedures concerning the medication rounds within the AGCC DU were identified that exposed AGCC personnel and prisoners to unnecessary risks.

Finding 13
The CCTV within the DU main exercise yard is inadequate due to significant sun glare and contrast issues.

Finding 14
A distinct lack of command and control occurred in response to the incident which resulted in the absence of appropriate leadership and direction.

It was submitted on behalf of Mr Howden and the GEO Group that findings 1, 5, 8, 10 and 11 should not be adopted en bloc.

In relation to findings 1 and 5 it was submitted that there is no evidence that the failures identified in these findings extended to all officers in the DU. I accept that the evidence does not disclose that all officers in the DU should be the subject of finding 1. However, Mr Ittensohn's evidence accepted that there were significant failures by some corrective services officers in the DU in relation to record keeping and that some officers exhibited complacent behaviour.
It is clear that Mr O'Connor was afforded a significant amount of latitude within the DU in terms of his associations with other prisoners and access to the exercise yard and unit spine. It was also clear that not all significant or concerning behaviour was documented. The exercise yard contained a large amount of property that could be used as weapons and this was visible to all officers. Although not all officers may have engaged in these practices finding 5 is an accurate reflection on the culture in place in the DU at the relevant time.

It was also submitted on behalf of Mr Howden and the GEO Group that I should not find that the system for recording directions given by managers

was inadequate (finding 8). It was suggested that it was impractical for senior managers to follow up on the implementation of their directions.

However, I do not consider it unreasonable for senior managers to diarise significant directions given by them in relation to the management of incidents or prisoners, or to ensure that these directions are recorded in IOMS and accessible to other staff, and capable of being audited. Mr Ittensohn's evidence was that a more robust process for capturing verbal instructions and directions has been implemented.

Finding 10 was "There are no specific instructions for DU staff to attend morning briefings at the commencement of their shift." I accept the submission on behalf of the GEO Group that CSO Siddons' failure to attend the morning briefing on 27 December 2011 did not impact on the subject incident, and that the General Manager attended at the DU each day after the morning briefing. I accept that it is impractical for the lone DU officer to attend morning briefings, and note that the relevant recommendation (10) has been implemented in a modified form which ensures that DU officers receive relevant information from the morning briefing and that this is documented.

Findings required by s45

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

Identity of the deceased – The deceased person was Kyle Canisi

How he died - Mr Canisi died as a result of being assaulted by another prisoner while he was an inmate at Arthur Gorrie Correctional Centre.

Place of death – He died at Wacol in Queensland.

Date of death – He died on 27 December 2011.

Cause of death – Mr Canisi died from head injuries.

Comments and recommendations

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

I adopt the following recommendations related to the death of Mr Canisi that were initially made as part of the OCI Report (*numbered as per that report*).

These recommendations are comprehensive and are likely to prevent a death from happening in similar circumstances at AGCC.

I am satisfied from the evidence of Troy Ittensohn, General Manager, AGCC that adequate steps have been taken to implement these recommendations.

Mr Ittensohn's evidence was that AGCC no longer manages a Maximum-Security Unit. This means that it no longer requires prisoners to spend long periods in a Detention Unit. This enables the Detention Unit to be used for its intended purpose - short periods of accommodation for defined purposes. Detailed procedures have been developed in relation to associations between prisoners which include guidelines in relation to risk assessment, approval processes and documentation.

Recommendation 13 is the responsibility of Queensland Corrective Services and I am satisfied that it has been addressed by the placement of smoked polycarbonate sheeting above the exercise yard to reduce glare.

Recommendation 1:
a) That AGCC ensure that Supervisors and Area Managers cross check IOMS Case Notes with handover notes to ensure consistency and accuracy during any auditing.
b) AGCC reminds all staff about the importance and reasons for completing intelligence information notices/reports.
c) QCS consider removing the copy and paste functionality in IOMS concerning case noting.
d) AGCC ought to remind staff of the requirement for timely and accurate IOMS reporting and the relevance and significance thereof to the risk assessment.
e) AGCC reminds staff of the importance of case noting corrective behaviour directions to accurately record prisoner behaviour and compliance.
f) AGCC ought to develop and use a formal and consistent handover note that requires specific details to be entered to ensure timely and accurate exchange of information for incoming personnel for the unit. The documents ought to be retained and archived in compliance with accurate record keeping practices.

Recommendation 2:
a) That AGCC implement a robust and documented procedure for the DU concerning the association process between prisoners.
b) The procedures ought to give clear and unambiguous instructions to document fully: all requests for associations from prisoners (written request form); the authorisation process including a robust risk assessment process; the outcome concerning authorisation (such as declined or authorised and the reasoning why); the authorised duration of any association or any other restriction/s; specific handling or supervision requirements; whether the authorisation stands until completed or whether it requires daily renewal (complemented by a

robust risk assessment that documents the process); and the outcome of any association in fact completed.

Recommendation 3:
a) That AGCC implement procedures for the DU that requires all 'specific handling instructions' for prisoners within the DU that may be issued by Supervisors or Managers to be immediately (or as soon as is reasonably practicable operational requirements permitting) entered onto IOMS.
b) IOMS ought to record: the specific details; the officer who gave the instructions, duration of the instructions who is authorised to alter or rescind the specific instructions.

Recommendation 4:
That AGCC develop and implement specific unit induction training or an information training package for all staff that perform duties in the DU on either a permanent, part-time or casual basis to ensure officer awareness of the specific requirements relevant to the DU environment.

Recommendation 5:
That AGCC implement a robust 'situational awareness training program' or similar to minimise officer complacency for staff attached to special units such as the DU, and take such other reasonable measures to minimise officer complacency.

Recommendation 6:
That AGCC implement a robust and documented procedure for all property within common areas of the DU that specifically identifies the approval process for any property and the officer authorising it. The procedure ought to assist all AGCC personnel attending the DU to identify unauthorised property and to provide guidance for immediate rectification.

Recommendation 7:
That AGCC ensures all Supervisors, Area Managers and other Senior Management Personnel are reminded of, and receive further training on, proactively identifying risks involving items of property when conducting unit checks and to implement immediate rectification once risks are identified.

Recommendation 8:
That AGCC implement a process/procedure to ensure that any verbal handling instructions or directions concerning a prisoner that is given by a supervisor or manager is immediately relayed to the relevant unit officer and to direct for those instructions and or directions to be immediately entered onto IOMS. The relevant supervisor or manager ought to be responsible for ensure that those instructions are carried out and that IOMS accurately records their verbal instructions as given.

Recommendation 9:
That AGCC review and consider the use of diaries by supervisors and managers and implement a formal diary system that includes the annual allocation of a numbered diary to senior personnel. The diary ought to be checked and audited throughout the year for compliance and accuracy and collected at the conclusion of each calendar year for record retention and stored in compliance with the relevant Standards.

Recommendation 10:
That AGCC earlier ensure adequate procedures are implemented to ensure DU Officers attend relevant shift briefings unless operational requirements excuse their attendance.

Recommendation 11:
That AGCC ensure adequate procedures are implemented in the DU to ensure that outside personnel attending the unit are briefed on specific risks or handling instructions for particular prisoners (where relevant) prior to those persons interacting with the particular prisoners. This procedure ought to ensure that outside personnel are fully informed of any risks or concerns to ensure appropriate levels of prisoner awareness.

Recommendation 12:
That AGCC ensure adequate procedures are implemented in the DU concerning the process for the medication rounds to ensure that nursing staff and escort officers are not exposed to the risk of insecure prisoners within the unit or multiple prisoners within one location (such as the main exercise yard). The procedure ought to minimise the opportunity for prisoners to share prescription medications.

Recommendation 13:
That DCS take immediate steps to correct the CCTV defect within the DU main exercise yard.

Recommendation 14:
That AGCC ensure that personnel relieving in the roles of Supervisor and Area Manager receive appropriate training on incident command and control

Section 48

Section 48 of the *Coroners Act 2003* provides that a coroner must report offences if, from information obtained while investigating a death, a coroner reasonably suspects a person has committed an offence. A coroner may also give information about corrupt conduct or police misconduct to the Crime and Corruption Commission.

I am satisfied that where there has been a failure or a departure from procedures on the part of an employee at AGCC this has been dealt with

adequately through internal disciplinary processes undertaken by the GEO Group.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
17 December 2014