CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Dane Benjamin Sloan**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2013/3596
DELIVERED ON:	10 February 2017
DELIVERED AT:	Brisbane
HEARING DATE(s):	19 December 2016; 30 January 2017
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	Death in custody; hanging; maximum security unit; supervision of prisoners

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Queensland Corrective Services:	Ms Ulrike Fortescue
West Moreton Hospital and Health Service:	Mr Aaron Suthers

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Introduction

1. Dane Benjamin Sloan was 24 years of age when he was found hanged in the exercise yard attached to the Maximum Security Unit (MSU) of Brisbane Correctional Centre (BCC) on 2 October 2013. He died in hospital four days later, on 6 October 2013.

2. On the afternoon of 2 October 2013, Mr Sloan was escorted into the exercise yard of the 'B' Wing of the Maximum Security Unit (MSU). At the time he was not the subject of a formal observations regime, and he was considered not to be at risk of self-harm.

3. At around 2:46pm, Mr Sloan approached the chin-up bar, and stood on a medicine ball to help him reach the bar. He then removed a piece of sheeting from the rear of his shorts. He then fashioned the sheeting into a ligature, which he placed over the bar and his head. He then stepped off the medicine ball.

4. Almost 15 minutes later, a Correctional Officer entered a nearby officers' station and saw Mr Sloan hanged from the chin-up bar. A Code Yellow and a Code Blue were called, and entry was gained to the exercise yard. Officers continued into the exercise yard where they observed that Mr Sloan was unresponsive. He was cut down and paramedics from the Queensland Ambulance Service (QAS) attended. Mr Sloan was then transferred to the Princess Alexandra Hospital (PAH) for further management. However, he did not regain consciousness, and died on 6 October 2013 at 2:02pm.

5. These findings:
   - confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death; and
   - consider the adequacy of CCTV monitoring facilities and procedures in place at the Brisbane Correctional Centre Maximum Security Unit.

The Investigation

6. The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) investigated the circumstances leading to Mr Sloan's death. Detective Senior Constable Donald Laird led the investigation. He submitted a report to my Office and this was tendered at the inquest.

7. Detective Senior Constable Laird attended BCC with several other CSIU officers. The scene had been secured and a crime scene log was commenced. He inspected the MSU and exercise yard and oversaw the forensic examination of all points of interest.

8. CSIU officers commenced the process of taking statements from staff of the MSU. Inmates declined to provide statements. Officers took steps to seize all relevant records and interrogated the BCC Information and Offender Management System (IOMS). Detective Senior Constable Laird spoke to intelligence officers at BCC and made arrangements for statements to be

obtained from senior officials at the prison. He also seized relevant CCTV footage. Scenes of crime officers took a series of photographs of the scene.

9. In addition to the QPS CSIU investigation, 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 that was submitted to the Office of the Chief Inspector (the OCI). 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.

10. I am satisfied that the QPS investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The Inquest

11. A pre-inquest conference was held in Brisbane on 19 December 2016. Mr Johns appeared as counsel assisting and leave to appear was granted to Queensland Corrective Services, and the West Moreton Hospital and Health Service.

12. An inquest was held on 30 January 2017, at which Miss Cooper appeared as counsel assisting. All of the statements, records of interview, medical records, photographs, CCTV footage and materials gathered during the investigations were tendered at the inquest. Oral submissions were heard from the represented parties following the conclusion of the evidence. QCS also provided written submissions.

13. 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

14. Dane Sloan had an extensive criminal history. At the time of his death he was on remand for an arson offence in which he was alleged to have set fire to his former partner's home, in addition to a number of other offences. As he was on parole at the time, the commission of these offences resulted in the parole order being suspended. He was returned to secure custody at BCC on 13 September 2013. This was his third period of imprisonment.

15. Mr Sloan's adult criminal history dated back to December 2006, when he was convicted of offences relating to burglary, robbery with actual violence and stealing. His commission of criminal offences continued over the years, leading to his final episode of incarceration.

16. Mr Sloan's father, Raymond Sloan, was present at the PAH when Mr Sloan passed away. While Mr Sloan was reported to not have a close relationship with his family, it appears that he did have a close relationship with his

grandmother, Josephine Sloan. Arunta call logs from BCC confirm he stayed in contact with his grandmother consistently throughout his imprisonment, and particularly in the days before his death. Mr Sloan also received a letter from his former partner after his return to custody.

Mental Health History

17. On reception to BCC on 13 September 2013, Mr Sloan disclosed that he had no medical issues and no psychiatric history. He said that he was not on any medications, nor had he ever tried to harm himself or commit suicide. However, as he was on remand for an arson offence, a referral to the Prison Mental Health Service (PMHS) was required.

18. Just a day earlier, while at the watch house, Mr Sloan was recorded to have requested something to help him settle, as he was feeling very anxious. The notes indicate that a request was made for a mental health review. He was noted to have previously been open to the PMHS in 2012, and had been prescribed amitriptyline (Endep) while in prison.

19. During a previous episode in custody in 2012, Mr Sloan had reported feeling depressed and hearing an echo in his ears. He reported he was feeling sad, and had started thinking about his mother who died in 2003. Mr Sloan was subsequently prescribed Endep, and it was noted that this improved his mood considerably.

20. Despite his mandated referral to the PMHS relating to his arson offence, on 16 September 2013 Mr Sloan was specifically referred to the PMHS following an incident that had occurred on the prison roof involving Mr Sloan and another inmate. On 25 September 2013, QCS psychologist Michelle Perrin assessed Mr Sloan in the MSU non-contact room.[1]

21. Mr Sloan was noted to have a history of suicidal ideation from a young age, and most recently had experienced such ideation prior to his incarceration, due to the breakdown of a relationship. However, he denied any current suicidal ideation, intent, or plan. He was noted to be in a vulnerable position due to his placement in the MSU.

22. Mr Sloan presented to Ms Perrin with dysphoric mood and restricted affect. His speech was logical and coherent. He reported hearing multiple voices in an internal space that he believed were caused by the devil. He also reported sometimes hearing his name on the TV.

23. Ms Perrin's plan in relation to Mr Sloan was recorded in the notes as to keep him open to the PMHS for psychiatric assessment for diagnostic clarification and treatment as indicated.[2] Mr Sloan was noted to have participated in a brief intervention that included psychoeducation on mental illness, including risk and protective factors, and anxiety and the slow breathing technique.

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[1] Exhibit D5, from page 5.
[2] Exhibit D5, page 11.

24. An appointment was made with the prison Visiting Medical Officer (VMO) for consideration for resuming Endep. Mr Sloan's next court date was noted as being 4 November 2013.

25. On 27 September 2013, Dr William Lethbridge saw Mr Sloan during the doctor's routine round of prisoners in the MSU. The notes made by Dr Lethbridge confirm that Mr Sloan was re-started on 50mg of Endep, to then be titrated to 100mg. He told Dr Lethbridge that he had low mood, anxiety and a poor sleep pattern.

26. Mr Sloan was the subject of an observations regime in the weeks leading up to his death. The circumstances that led to that regime being put in place are outlined below.

Events leading up to the death

27. On 14 September 2013, Mr Sloan was involved in a major security incident involving himself and a fellow inmate, Daniel Grunberger. Both men climbed the exercise yard fence and continued onto the roof of a housing unit at BCC.

28. They then used a piece of timber to damage security cameras and air conditioning units. They moved about the roof tops of various buildings and remained there for approximately 10 hours. This resulted in BCC being locked down. When Mr Sloan and Mr Grunberger were removed from the roof, they both received six months in the MSU as punishment, pursuant to a formal 'Maximum Security Order'.

29. When Mr Sloan entered the MSU, he was initially placed on an observations regime requiring him to be observed by correctional officers every 15 minutes. This regime was put in place as while Mr Sloan was on the rooftop, he was heard making threats of self-harm, and also experienced auditory hallucinations. However, Mr Sloan later told Clinical Nurse Steven Hoban that he had made the threats of suicide and reported hallucinations in an attempt to avoid being placed in the Detention Unit.

30. During Mr Sloan's stay in the MSU he was assessed by the Risk Assessment Team (RAT) every four days, and over a period of time his formal observations regime was adjusted and reduced to a point where they were ceased entirely. The purpose of the RAT is to assess prisoners at risk to themselves. It is a multidisciplinary team, involving contributions from a mental health nurse, psychologist and corrections officers.

31. The records relating to the RAT meetings and the gradual reduction of Mr Sloan's observations regime were tendered at the inquest. Those records confirm that, at least initially, Mr Sloan was unwilling to engage in the RAT process. On 16 September 2013, he was noted to display an arrogant attitude, and was rude and uncooperative with staff. He did not participate in any assessment. The recommendation at that initial stage, was that Mr Sloan remain on 15 minutes observations.

32. Over the assessments that followed, Mr Sloan’s attitude had markedly improved. He was noted to have perhaps come to understand the gravity of his situation, and appreciated why he had been placed in the MSU. He was polite and cooperative towards staff, and repeatedly denied any current suicidal intent or ideation. He reported that he was coping, and denied any issues or concerns within his current unit. His observations regime was gradually reduced from 15 minutes observations, to 60 minute observations, and by 23 September 2013 it had been reduced to 120 minute observations.

33. On 27 September 2013, Mr Sloan was noted to be affable and spontaneous when interacting with medical staff.[3] He denied feeling depressed or anxious, nor was he feeling hopeless. He spoke of the future and the external support measures he had access to. Mr Sloan denied any current suicidal or self-harm ideation, plan, or intention. The RAT unanimously agreed that the formal observations regime could cease, and the General Manager’s nominee for approving the termination of At Risk Management Plans confirmed this.

34. Arunta call records relating to Mr Sloan’s external telephone calls were obtained and analysed as part of the police investigation. Those calls confirm that, from 19 September 2013 to 23 September 2013, Mr Sloan spoke to his grandmother, Josephine Sloan, every day. Mr Sloan had informed her that he was in the MSU, and during the initial calls he told her that he was not feeling very good. During the calls, Mr Sloan would ask his grandmother about his ex-partner, and he asked his grandmother to tell his ex-partner that he was sorry. Mr Sloan was noted to be emotional during some of the calls.

35. During the call on 23 September 2013, Josephine told Mr Sloan that she had spoken to his ex-partner, and informed him that his ex-partner was pregnant. Josephine passed on that his ex-partner loved him, but that she needed space and did not want to feel pressured. His ex-partner had written to him in similar terms.

36. Mr Sloan spoke to his grandmother again on 1 October 2013. He was told his ex-partner was going to keep their baby. She had also asked for her phone number to be added to Mr Sloan’s phone list at the prison. Analysis of this call revealed that Mr Sloan was quite distressed and crying. He professed his love for his ex-partner and his grandmother. He also told his grandmother that he thought it would get easier in prison, but it had not. His grandmother told him to “keep his chin up”. This was the last time he spoke with his grandmother.

Events of 2 October 2013

37. Just after 1:15pm on 2 October 2013, Mr Sloan was escorted into the exercise yard of the ‘B' Wing of the MSU. The MSU Register tendered at the inquest

[3] Exhibit C16, from page 5.

indicates he was last sighted at 1:30pm.[4] The MSU contains four wings, 'A' Wing, 'B' Wing, and 'C' Wing and 'D' Wing. The 'B' Wing consists of five cells and has an exercise yard attached for the use of 'B' Wing inmates. Access to this exercise area is via a cell door that is electronically operated from the officers' station.

38. The exercise yard contains a chin-up bar, dip bar and exercise bike. All items are fixed so they cannot be moved by any means. The exercise yard also contained a yoga mat and a medicine ball.

39. Mr Sloan's actions in the exercise yard were clearly captured on camera, and the footage from two different camera angles was tendered at the inquest.[5] The footage from the camera angled directly in front of the chin-up bar, depicts Mr Sloan approach the chin-up bar, and use the medicine ball to aid him in reaching the chin-up bar. Between 1:29pm and 2:47pm, Mr Sloan repeated this action some eight times.

40. Between 2:44 and 2:46pm, Mr Sloan can be seen removing a piece of sheeting from the back his shorts, and making several attempts to attach the ligature to the chin-up bar. At 2:46pm he can be seen preparing the sheeting into a sling, which he finally attaches to the bar and places over his head. He then steps off the medicine ball and, while his feet were still touching the ground, appears to choke himself with the sling in a standing position.

41. At 3:02pm, Custodial Corrections Officer, Ahmed Mohamud, entered the officer's station in the B wing of the MSU for the purpose of facilitating the weekly buy-up. He saw Mr Sloan hanged from the chin-up bar, and activated a Code Blue and Code Yellow. Other correctional staff then entered the exercise yard at 3:03pm. Mr Sloan was cut down and resuscitation efforts were commenced with the aid of BCC medical staff. Queensland Ambulance Service paramedics attended and were able to detect a pulse, however, Mr Sloan did not appear to be breathing.

42. Mr Sloan was transferred to the PAH by the QAS. He never regained consciousness, and on 6 October 2013 at 2:02pm all life support measures were ceased. Mr Sloan was subsequently declared deceased.

Autopsy results

43. Forensic pathologist Dr Rohan Samarasinghe conducted a full internal autopsy examination on 9 October 2013. The autopsy report was tendered at the inquest.

44. Examination confirmed a prominent ligature mark on the mid to lower section of the front of the neck inclining towards the back of the head. Dr Samarasinghe considered the pattern of the ligature mark was consistent with being hanged. There was also some bruising noted to the upper and lower lips, and this was attributed to resuscitation attempts.

[4] Exhibit C6.
[5] Exhibit E12; camera angle 8031.

45. Histology of the brain showed acute neuronal degeneration consistent with the clinical diagnosis of hypoxic ischaemic encephalopathy.

46. Toxicology testing confirmed low levels of midazolam and its metabolite. A level of Propofol was also detected. Dr Samarasinghe considered the levels of drugs to be consistent with therapeutic management.

47. Dr Samarasinghe confirmed the cause of death as being from "hypoxic ischaemic encephalopathy due to or as a consequence of hanging".

Adequacy of the CCTV surveillance in the MSU

48. Two fixed cameras that are located inside the yard monitor the exercise yard. A single operator monitors the two cameras located in the MSU from the control room. The cameras are covered by convex screen to protect them from damage. The covering screen also distorts the image.

49. The operator has four computer screens that are monitored, three of which display nine fixed camera positions. Thus, there are a total of 27 smaller images. The fourth screen is used to enhance any of the particular cameras to enable better vision. Another screen depicts the Detention Unit and has four small images.

50. The control room operator is not only responsible for monitoring these screens. They also open and close security doors from the control panel, and complete a log of events. The control room operator at the time of Mr Sloan's death was correctional officer James Finn. I heard evidence from Mr Finn at the inquest.

51. Mr Finn explained the dynamics within the BCC MSU at the time of Mr Sloan's death. The MSU at the Arthur Gorrie Correctional Centre (AGCC) had been closed down after the death of prisoner Scott O'Connor in January 2013. Due to that closure, the prisoners from the AGCC MSU were moved to BCC MSU.

52. Mr Finn described the prisoners transferred to the BCC as highly dangerous and volatile. At the time one such prisoner was on remand for the violent murder of another prisoner at the Maryborough Correctional Centre, which occurred in October 2012.

53. Mr Finn explained that a second BCC MSU team was formed to assist with the structured day in the MSU. Mr Finn confirmed that the MSU was at full capacity at the time of Mr Sloan's death.

54. During his interview with the OCI inspectors, Mr Finn said that he did not think he could (or should) have noticed Mr Sloan hanged from the chin-up bar between the time he placed his head in the noose and the time he was discovered. This was because from the perspective available to him, it looked as though Mr Sloan was simply standing there. He recalled seeing on the monitors an image of Mr Sloan while he was in the exercise yard. He recalled

seeing Mr Sloan rolling a cigarette and standing with his back to the camera, near to where a cigarette lighter was located on a wall.

55. In his evidence at the inquest Mr Finn said that his approach when monitoring via CCTV was to be on the lookout for "unusual behaviours", such as damaging property. However, he also said that he had few dealings with Mr Sloan prior to his death. Mr Finn also said, in his report written on the day of the incident[6], that:

> *I also observed prisoner Sloan standing in the corner of the exercise yard on a brief scan of the monitors, I didn't see anything suspicious or out of place as I remember thinking he must be rolling a cigarette and just standing quietly.*
>
> *Most of my attention was focused during this time on Prisoners Toalei D78911, Small B30449, Drake C89168, and prisoner Glebow B06430 who were arguing with each other from their cells and the small exercise yard.*

56. There was no requirement that Mr Sloan be physically or virtually observed at regular intervals at the relevant time, as the formal observations regime had been ceased some five days before his death.

57. During the course of the OCI investigation, the inspectors visited the MSU control room to observe for themselves the size of the monitor, which displayed the CCTV footage of the 'B' Wing exercise yard. A re-enactment (of sorts) was conducted by the inspectors, so they could understand exactly what could be seen on the monitors. In this regard, an officer stood beneath the chin-up bar, so that the inspectors could then observe from the control room what was capable of being seen on the CCTV.

58. In the OCI report, the Inspectors conceded that the ligature itself was difficult to observe on the CCTV footage, even with the benefit of hindsight and knowing it to be present. The inspectors conceded that if Mr Finn had not actually witnessed Mr Sloan tie the ligature to the chin-up bar; it very well could have been missed.

59. Mr Finn helpfully provided a number of printouts of various camera angles to the 'B' wing exercise yard. These printouts were tendered.[7] The first printout depicts the control room desk, with each monitor and the various camera angles able to be depicted on each monitor. The only camera angle that Mr Finn had access to on the day of Mr Sloan's death is depicted at exhibit B3.11 in the top right hand corner. That angle looks at the chin-up bar from a side on view, such that the actual chin-up bar cannot be easily seen.

60. There is an additional camera in the 'B' wing exercise yard, which looks at the chin-up bar from a 'front-on' view, thus making the chin-up bar easy to view in its entirety. Mr Finn explained in his evidence that this particular camera angle was not available for him to display on his monitors. Mr Finn's understanding was that this particular camera was only activated when the door to the exercise yard was opened for prisoner movements.

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[6] Exhibit B3.

[7] Exhibits B3.10 – B3.12.

61. Mr Finn's evidence was the MSU was staffed by four officers and a supervisor on a normal day shift. Officers spend 2-4 hours per shift in the movement control room. He said that the role is demanding because of the nature of the prisoners in the MSU, and the "constant vigilance" required causes fatigue.[8] Officers not working the control room are occupied with matters such as prisoner movements, musters and headcounts.

62. Mr Finn's evidence was that the control room operator would benefit from a second officer within the room to assist with the range of monitoring tasks and other activities. However, Mr Shaddock noted that more staff within the control room would not necessarily improve safety within the prison, and the presence of other persons may cause distractions.

Conclusions

63. Mr Sloan died after he hanged himself. His death might have been prevented if he had been more closely observed in the exercise yard via the CCTV monitors. However, as noted above those observations could not be carried out easily because of the limited quality of the single camera angle in the exercise yard that was available to be viewed by the correctional officer in the MSU control room at the time of Mr Sloan's death.

64. Mr Sloan had moved frequently about the exercise yard. As noted above he had stood under the chin-up bar on at least eight separate occasions before he attached the ligature to the bar. It was not unreasonable in the circumstances for Mr Finn to not see Mr Sloan's precise movements in the window of time that he attached the ligature to the bar and stepped off the medicine ball.

65. The first aid Mr Sloan received afterwards was of a suitably high standard. Once he was found it is highly doubtful anything could have been done that would have prevented his death. At that time he had hanged from the bar for at least 15 minutes.

66. I adopt (where relevant) the findings of the investigation conducted on behalf of the QCS Chief Inspector (OCI Report). This report was tendered and referred to at the inquest. The relevant findings from the Report are set out below:

> ***"How, when and where the incident occurred including the circumstances surrounding its occurrence.***
>
> *[163] On 2 October 2013, at around 2.46pm, Prisoner Dane SLOAN attempted suicide by hanging, while in the B Wing exercise yard of the MSU at BCC.*
>
> *[164] Prisoner SLOAN had fashioned a noose from a piece of torn sheet, which he had brought with him into the exercise yard. Prisoner SLOAN tied the noose to a chin*

[8] Exhibit B3.2

up bar installed in the exercise yard, before placing his head through it and stepping from a medicine ball which had been placed beneath the chin up bar.

[165] At approximately 3.00pm, Prisoner SLOAN was noticed hanging by CO Ahmed Mohamud who had entered the B Wing control room.

[166] A Code Blue was immediately called and officers entered momentarily, cut Prisoner SLOAN down and commenced CPR and EAR, which they continued until nurses, a doctor and, a little later, QAS arrived on the scene.

[167] At approximately 3.55pm, Prisoner SLOAN was taken by ambulance to the PAH, accompanied by QCS officers.

[168] At approximately 1.40pm, on Sunday 6 October 2013, in the PAH, where he had remained since his admission, Prisoner SLOAN's life support system was discontinued.

[169] Prisoner SLOAN was declared deceased at 2.02pm."[9]

"Adequacy of surveillance

[176] The "Custodial Operations Standard Operating Procedure – Maximum Security Units – Security Management" procedure document provides, by section 2, that the MSU manager / supervisor must ensure that all prisoners are kept under surveillance either directly or by the MSU CCTV system. The procedure contemplates that such surveillance may be either direct or by the MSU CCTV system. In the case of the latter, the procedure requires it to be conducted by the unit movement control system operator through the "correct operation and application of the Security Management System (SMS) and associated equipment".

[177] The evidence revealed through the investigation discloses that while Prisoner SLOAN was the subject of CCTV surveillance while he was present in the B Wing exercise yard, his conduct - in scribbling notes on paper, handling the cloth with which he ultimately hanged himself, and hanging from the noose for approximately 16 minutes - went unobserved.

[178] The Inspectors note that Prisoner SLOAN was not (at the time of his suicide attempt) the subject of a regime of at-risk observations, and that, accordingly, the expectation of what MSU officers ought be expected to have observed must be informed by that fact.

[179] The Inspectors note that CO Finn explained that he thought Prisoner SLOAN was simply standing adjacent to the cigarette lighter, and he had no reason to suspect Prisoner SLOAN's health and wellbeing was imperilled.

[180] In the course of the investigation, the Inspectors visited the MSU control room to observe for themselves the size of the monitor, upon which the CCTV footage of the B Wing exercise yard was being shown, and (in a general sense) recreated the event of Prisoner SLOAN's suicide, by asking an officer to stand beneath the chin-up bar, so that the Inspectors could observe what was capable of being seen.

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[9] Exhibit C18, page 33.

[181] The Inspectors concede that the noose itself is difficult to observe in the CCTV footage – even when, with the benefit of hindsight, it is known to be present - and that if CO Finn had not seen Prisoner SLOAN tie the noose to the chin up bar, it could (not unreasonably) have been missed.

[182] On one view, the fact that Prisoner SLOAN hung motionless in the same position for approximately 16 minutes is something which, the Inspectors consider might (had CO Finn been alert to it) have put CO Finn on enquiry as to Prisoner SLOAN's health and wellbeing.

[183] Against that, it may be observed that Prisoner SLOAN was not on at-risk observations and, as discussed above, in the context of CO Finn's responsibilities to other staff and prisoners that day, and his reasonable explanation about the proximity of the cigarette lighter, the fact that CO Finn did not observe Prisoner SLOAN does not, of itself, provide a sufficient basis to conclude that CO Finn breached the procedure or his duties otherwise."[10]

67. Although not an issue specifically investigated at the inquest, I also note the findings of the OCI investigation regarding the adequacy of the personal search conducted on Mr Sloan in the lead up to his being transferred to the exercise yard. Those findings are as follows:

"Adequacy of personal search

[193] The "Custodial Operations Standard Operating Procedure – Search – Prisoners and Corrective Services Facilities", by section 1, defines a "personal search" of a prisoner to mean "a search in which light pressure is momentarily applied to the prisoner over his or her general clothes without direct contact being made with the prisoner's genital or anal areas or (for female prisoners) the prisoner's breasts.

[194] Section 3 of that same procedure provides further detail about searches to be undertaken of prisoners. In particular, it provides that the searching officer must "search the seams on the collar of the clothing on the side facing the officer", "apply light pressure with the palms of the hands and pat over the prisoner's torso, paying particular attention to the recess of the spine, until reaching the belt line" and "search the waistband of clothing by running a thumb around the inside of the band".

[195] The Inspectors reviewed CCTV footage of the search conducted upon Prisoner SLOAN between his cell and the B Wing exercise yard on 2 October 2013. That search comprised of the searching officer momentarily and slightly touching either side of Prisoner SLOAN's torso between his shoulders and waist only – in a manner that, in the Inspector's view, did not constitute a thorough personal search of Prisoner SLOAN.

[196] The various officers interviewed contended (and the Inspectors accept) that soft items – like parts of torn sheets – concealed on a prisoner's person are extremely difficult to identify and very easy to conceal in those areas that officers are forbidden to touch. For that reason, even a thorough and properly conducted personal search of Prisoner SLOAN may well have failed to have detected the torn sheet and other items he took with him into the exercise yard.

[197] However, of concern is that almost every officer who was interviewed by the Inspectors was unable to explain how a personal search is to be conducted, as envisaged by the procedure – for example, while all knew that touching anus, genitals and breasts is forbidden, none described the need to run a thumb around the inside of the waistband of prisoners' pants.

[10] Exhibit C18, pages 34-36.

[198] Because improperly conducted personal searches have the potential to result in catastrophic outcomes in other circumstances, these matters are the subject of a root cause identified below.

68. Again, while not an issue specifically investigated at the inquest, I also note the findings of the OCI investigation regarding the adequacy of the RAT process in the weeks leading up to Mr Sloan's death. Those findings are as follows:

"[206] Prisoner SLOAN had, in the weeks prior to his attempted suicide, been the subject of at-risk observations because of threats of self-harm.

[207] The observations of Prisoner SLOAN had been discontinued, pursuant to the determination of a RAT meeting on 27 September 2013 that had had regard to risk assessment reports completed in respect of Prisoner SLOAN.

[208] The Inspectors are satisfied that in all the circumstances the risk assessment reports were carried out appropriately, that the at-risk observations were discontinued upon a reasonable and explicable basis, and that there appears otherwise not to have been any intelligence or other information in existence prior to the incident which might have indicated that the incident was likely to have occurred."[11]

Findings required by s. 45

69. 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 evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – The deceased person was Dane Benjamin Sloan.

How he died - Mr Sloan died after he hanged himself in the exercise yard of the Maximum Security Unit of the Brisbane Correctional Centre. Unknown to correctional staff, Mr Sloan was in a state of psychological distress at the time. Although the exercise yard was subject to constant remote monitoring, Mr Sloan was not observed via the CCTV in the control room at the Maximum Security Unit when he attached the ligature to the chin-up bar and hanged himself. Mr Sloan was found to be unresponsive and, despite resuscitation efforts, did not regain consciousness.

Place of death – He died at the Princess Alexandra Hospital, Brisbane in the State of Queensland.

[11] Exhibit C18, page 39.

Date of death – He died on 6 October 2013.

Cause of death – Mr Sloan died from hypoxic ischaemic encephalopathy due to or as a consequence of being hanged.

Comments and recommendations

70. Section 46 of the *Coroners Act 2003*, 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.

71. The OCI report made a number of recommendations, including that QCS action matters arising from a Root Cause Analysis (RCA) that was conducted. That RCA was tendered at the inquest[12], and identified a level of complacency by staff at the BCC MSU as one of the root causes.

72. I am satisfied that the RCA conducted by the OCI identified all relevant root causes relating to Mr Sloan's death. The OCI recommended that QCS action all matters arising from the RCA. I heard evidence at the inquest about these matters from the General Manager, Custodial Operations – State Wide Operations for QCS, Mr Peter Shaddock.

73. Mr Shaddock's evidence was that the QCS Incident Oversight Committee had accepted the recommendations arising from the OCI report. Implementation of recommendations was tracked via an 'Initial Directorate Response' form. This document outlined the issues in a general sense, and determined which part of QCS would be responsible for addressing the various matters identified. A copy of that form was tendered at the inquest.[13]

74. Mr Shaddock confirmed that the camera and recording facilities currently in place at the MSU are as they were at the time of Mr Sloan's death. However, images from both cameras in the exercise yard are now visible to the control room operator.

75. The information provided in this regard by QCS was that replacing the current video recording system would cost an estimated $2.5 million. I note that the current system is due for replacement in 2017/2018, subject to funding being available at that time.[14]

76. With respect to the issue of general complacency of staff working in the MSU, consultation has occurred between BCC and the QCS Academy to address this issue.[15] Mr Shaddock accepted during his evidence that there is currently no training package available to address complacency in the MSU. However,

[12] Exhibit C18.40
[13] Exhibit B9.1
[14] Exhibit B9.2
[15] Exhibit B9.1

the BCC MSU performance framework, induction process, staff performance reviews and regular briefing processes are used to highlight the risks of complacency, with reference to Mr Sloan's death as an example.

77. With respect to training for the MSU control room operator position, Mr Shaddock confirmed that BCC MSU induction training and accreditation in control room operation must be completed satisfactorily before an officer is posted in the control room. No posts in the MSU are offered to officers without the requisite accreditation.[16]

78. Having heard evidence from Mr Shaddock at the inquest relating to the current system of the CCTV monitoring from the MSU control room, and the actions taken to address the RCA findings, I am satisfied that those actions taken together support the conclusion that a death in similar circumstances to Mr Sloan is likely to be prevented from happening again.

79. I am mindful of the evidence that the current recording system is due for replacement in 2017/2018, subject to funding being available at that time.

80. Prisoner and officer safety in the MSU depends on the capacity of control room operators to clearly see what is happening within the unit. I recommend that in considering the replacement of current CCTV monitoring systems, QCS take into account the evidence heard during this inquest, with a view to ensuring that any new recording system clearly displays all relevant camera angles. Consideration should be given to potential hanging points within the cells and exercise yards in the MSU, and ensuring that the best available camera angle, with reference to the potential hanging points, can be fed clearly to the main control room monitors.

81. Having regard to the evidence about working in the control room I consider that it is likely that staff simply become fatigued, and lose focus, after looking at a large number of images on screens for an extended period of time. I recommend that QCS explore the merits of a policy of more frequent rotations of officers through the control room as a way of minimising that risk.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
10 February 2017

[16] Exhibit B9.1