OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of David Edward SMITH**
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Brisbane
FILE NO(s):	COR/96 0458
DELIVERED ON:	**17 March 2006**
DELIVERED AT:	Brisbane
HEARING DATE(s):	7 June 2005
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: Inquest, Death in Custody, Prison Murder, Protective Custody, etc…
REPRESENTATION:	

Counsel Assisting:	Mr Darryl Rangiah
Next of Kin:	Mr Brian Devereaux
Department of Corrective Services:	Ms Kay Plilipson
Queensland Commissioner of Police:	Mr Wayne Kelly

Findings of the inquest into the death of David Edward Smith

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The Coroner's Act 1958 ("the Coroners Act" or "the 1958 Act") provides in s.43(1) that after considering all of the evidence before a coroner at an inquest the coroner shall give his or her findings in open court. What follows are my findings of the inquest into the death of David Edward Smith.

Introduction

On Wednesday, 28 September 1994, David Edward Smith was found dead in his cell at the Sir David Longland Correctional Centre (the SDLCC) at Wacol. He was 21 years of age.

Smith had been violently murdered by other prisoners. He had 31 stab wounds in his body. He had been tied by the neck to the vertical support of the double bunk in his cell with a coaxial cable.

More than a decade later, on 18 February 2005, Andrew Thomas Kranz pleaded guilty of the murder of Smith and on 16 June 2005 he was sentenced to life imprisonment with a minimum to serve of 20 years. He admitted that another prisoner was also involved in the murder but refused to name the other prisoner.

Mr Smith had been transferred to the unit in which he was killed less than 24 hours before his death. When told of the decision to transfer him to that unit two days before his death, Mr Smith immediately protested saying that there were prisoners there who would do him harm; that he would be stabbed and killed. He told this to numerous officers and at one stage he asked to be placed on protection rather than being placed in 5B. His objections were overruled and he was literally dragged to the unit in which he was murdered the next day.

These findings examine the circumstances leading to Mr Smith's transfer to unit 5B and his death. While findings in an inquest would usually seek to assist with the development of practices and procedures that it might reduce the likelihood of a similar tragedy in the future, the utility of doing so in this case has been substantially diminished by the passage of time since the death occurred and the development of new practices and procedures by the Department of Corrective Services.

The delay in the convening of the inquest

It is unusual for an inquest to be commenced more than 10 years after a death has occurred. It is therefore necessary to explain something of the history of events that have occurred since Mr Smith's death.

On 28 September 1995 the police officer in charge of the investigation sent an interim report concerning Mr Smith's death to the Brisbane Coroner indicating that investigations were continuing.

In March 1996, three inmates of unit 5B at the time of Mr Smith's death were charged with his murder and a few months later a fourth was charged with being an accessory after the fact.

Each of these prisoners was committed to stand trial but when the matter came on for hearing in the Supreme Court in June 1997, the principal Crown witness refused to testify. Accordingly, the Crown withdrew the indictments, a *nolle prosequi* was entered and the four accused were discharged.

On 17 February 1999, the Brisbane Coroner concluded that the holding of an inquest was unnecessary as no good purpose would be served. He considered that:

> *"The matters which would be required to be established by Section 24 of the Coroner's Act 1958 had been effectively identified by investigations and a judicial proceeding prior to the determination."*

Accordingly, in compliance with the legislative scheme set down in the *Coroners Act 1958* he recommended to the Director-General of the Department of Justice that an inquest not be held. The next day the delegate of the Director General confirmed that recommendation.

However, Mrs Sandra Croasdale, Mr Smith's mother, made submissions to the then Attorney-General that an inquest be conducted. By letter dated 20 December 2001 the then Attorney-General directed the Brisbane Coroner to hold an inquest into the death.

When I was sworn in as State Coroner in July 2003 that had not yet been done. I was advised by the detectives who were continuing to investigate the matter that fresh charges were imminent.

In April 2004, a prisoner confessed to the murder of Mr Smith. He was arraigned upon an ex officio indictment and pleaded guilty on 14 February 2005.

The inquest opened on 7 June 2005 even though that charge had not been dealt with because an important witness, a former custodial correctional officer Mr Les Pointon, was seriously ill and it was feared his evidence may be lost.

Mr Darryl Rangiah was appointed counsel assisting. Leave to appear was granted to Mr Smith's mother, the Commissioner of the Police Service and to the Department of Corrective Services.

After Mr Pointing's evidence was taken, the inquest was adjourned to a date to be fixed.

On 20 September 2005, after the prisoner who had confessed to murdering Mr Smith had been sentenced for the crime the Legal Aid Office, who acted for Mr Smith's mother, wrote to me saying:

> *"We write to you now confirming that our client has instructed us that she no longer holds an interest in the continuation of the hearing of an inquest into the death of her son, David Edward Smith.*
>
> *Our client instructs us that since the sentence of Andrew Thomas Kranz on 15 June 2005 she is 'at peace'.*

It is therefore the intention of Legal Aid Queensland to seek the leave of the State Coroner to withdraw from this inquest."

I acknowledge with admiration the long and determined struggle Mrs Croasdale has pursued in an endeavour to get from the justice system an appropriate response to her son's death.

In view of Mr Krantz' conviction and Mrs Croasdale's correspondence, I decided that it was unnecessary for me to take further oral evidence. It would serve no good purpose to do so given the passage of time since the death and the wealth of statements and other material available to me as a result of various investigations out are sufficient to enable me to make the findings necessary for the completion of this inquest.

The Coroner's jurisdiction

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

The basis of the jurisdiction

Although the inquest was held in 2005, as the death being investigated occurred before 1 December 2003, the date on which the *Coroners Act 2003* was proclaimed, it is a "*pre-commencement death*" within the terms of s.100 of that Act and so the provisions of the *Coroners Act 1958* ("the Act") are preserved in relation to it.

Because the death was violent and unnatural, and because the person who died was detained in a prison at the time of his death, the police officers who became aware of it were obliged by s.12(1) of the Act to report it to a coroner. Section 7(1)(a)(i) and (b) confer jurisdiction on a coroner to investigate such a death and s.7B authorises the holding of an inquest into it.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death.

The Act, in s.24, provides that where an inquest is held, it shall be for the purpose of establishing as far as practicable:

- the fact that a person has died;
- the identify of the deceased;
- when, where and how the death occurred; and
- whether anyone should be charged with a criminal offence alleging he/she caused the death.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proven.

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

> *"It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends … The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires"*[1].

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations[2], referred to as "riders" but prohibits findings or riders being framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence.[3].

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s.34 of the Act provides that *"the coroner may admit any evidence the coroner thinks fit"* provided the coroner considers it necessary to establish any of the matters within the scope of the inquest.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[4]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable[5]. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[6]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[7] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[8] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

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1 R v South London Coroner; ex parte Thompson (1982) 126 S.J. 625
2 s43(5)
3 s43(6)
4 R v South London Coroner; ex parte Thompson per Lord Land CJ, (1982) 126 S.J. 625
5 Anderson v Blashki [1993] 2 VR 89 at 96 per Gobbo J
6 Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
7 Harmsworth v State Coroner [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in The inquest handbook, Selby H., Federation Press, 1998 at 13
8 (1990) 65 ALJR 167 at 168

The evidence

The hierarchy of command at SDL in September 1994

In order to understand the events surrounding the death of David Smith it is necessary to have some appreciation of the command structure of the prison and the identity of the people occupying the key positions at the relevant time. This is set out below. Hereafter those officers will mostly be referred to by their position title or surname only.
Mr Noel Taylor – Acting General Manger
Mr David Crothers - Acting Manager Operations
Mr Michael Deegan – Acting Manager Programs
Mr Stephen Simmonds - Acting Operations Support Officer
Mr David Wright - Sentence Management Co-ordinator
Ms Michelle Moore – prison psychologist
Ms Sharon McAtee – prison education officer
Mr David Bales – Acting Sentence Management Support Officer
Mr Les Pointon - B Block Senior Correctional Officer

Events prior to Smith's death

Mr Smith's institutional behaviour was very poor. He had been involved in a number of violent incidents, including assaulting corrective service officers on four occasions in 1992. Smith was involved in an attempted escape from Borallan on 30 August 1992. He had also engaged in self - mutilation on several occasions.

Mr Smith was serving a term of 6 years and 6 months imprisonment on two counts of armed robbery. He was transferred to the SDLCC from Wacol Remand & Reception on 31 March 1994 and so was at the SDLCC for some six months prior to his death

Mr Smith had been domiciled in unit 7B until shortly after another inmate of that unit, Kevin Leslie, was seriously assaulted on 25 September 1994. Leslie refused to divulge the names of his assailant(s), claiming he fell off his bunk.

Mr Smith and inmate Perry Bennett were believed to be involved in the assault of Mr Leslie. As a result Mr Smith was held in the Detention Unit pending consideration of where he should be housed on a more permanent basis.

Decision to move Smith

On 26 September 1994, a Sentence Management Meeting at the centre considered the assault on prisoner Leslie and discussed the current institutional behaviour of Mr Smith.

Mr Smith was suspected of being responsible for another serious assault on an inmate in the previous month and in view of his poor institutional behaviour it was decided that both Messrs Smith and Bennett would move to unit 5B and that they would double up in the same cell.

At about 9:43am on 26 September 1994 an electronic message was sent to all relevant officers outlining that day's proposed prisoner movements, including that of Smith and Bennett.

A senior correctional officer working in the Detention Unit advised Mr Smith of the decision to move him into unit 5B. Mr Smith immediately objected to the move and provided limited information about concerns for his safety.

These claims were relayed back up the chain of command as far as the Acting General Manger of the prison, Mr Noel Taylor. In response, those involved in the care of Mr Smith were told that he would have to name those whom he claimed were likely to harm him and the basis of his belief that they posed such a risk.

There after Mr Smith gave three conflicting accounts of who might harm him and why. His versions included drug debts, gambling debts and a close association with a prisoner who some prisoners in 5B wanted to harm.

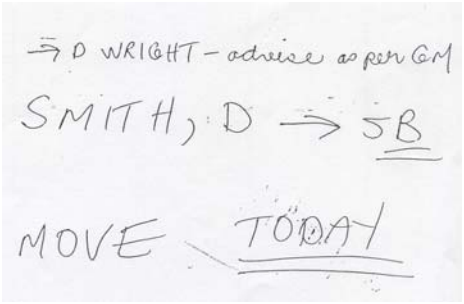
Mr Smith finally did nominate three prisoners whom he said would seek to do him harm if he were put in 5B. By this time it was after 8.00pm and so it was decided that he would stay in the Detention Unit overnight so that this information could be properly assessed the next day.

Smith is moved to Unit 5B

On Tuesday 27 September 1994 the Acting General Manager was required to leave the centre for work related meetings. Mr Taylor says that as he was leaving his office, he directed his secretary, Ms Tracey Hepburn, to see Mr Wright, the Sentence Management Coordinator, and tell him "*to have inmate David Smith seen this morning and review the accommodation arrangements*".

Ms Hepburn disputes this account of the conversation. She states she made a note of what A/General Manager Taylor told her, which was that he had seen Smith last night and that Smith was to move to unit 5B that day.

A note written by Hepburn as an *aide- memoire* to herself is duplicated below: -



Ms Hepburn immediately advised Mr Wright of her version of the message.

In response, at 9:16am, Mr Wright sent an electronic message to the Sentence Management Group to the effect that prisoner Smith was to be moved to unit 5B by direction of the General Manager.

At about 1:10pm Mr Smith was moved from the Detention Unit to unit 5B interview room.

A video recording exists of the escort of Smith as he is taken from the Detention Unit. It depicts the following.

Four Correctional Officers approach Smith who is in a cell in the Detention Unit. A correctional officer instructs Smith to grab his gear as he is being moved to unit 5B. Smith advises that he can not go there, that he "*has dramas down there*." A Correctional Officer states that it is the G.M.'s order. Smith replies that it was sorted out last night with Mr Simmons. Mr Smith is told he has five seconds to pack his gear. Mr Smith repeatedly states that he can not go there, that he has dramas down there. A correctional officer informs Mr Smith that he can double up with Perry Bennett, but Mr Smith replies that he does not know Mr Bennett.

Mr Smith then indicates that he wants protection. In reply, a correctional officer states that he doesn't have the necessary application form and that Mr Smith can sort it out at unit 5B. A correctional officer asks Mr Smith who he is scared of. Mr Smith replies that he told the other officers last night. Mr Smith states that he thought it was all sorted out last night. A correctional officer replies that Mr Smith does not meet the criteria. Mr Smith again states that he has "*real dramas down there"* and can not go. A correctional officer tells Mr Smith that when he gets down to 5B he can "*put it on paper*", as it has nothing to do with them. Mr Smith is then escorted out of the Detention Unit.

Concerns raised by correctional officers, program staff and Link Up

Later that day, Mr Wright received a number of phone calls about the move and he indicated to the callers that it was in accordance with a direction from the Acting General Manager and that any concerns should be raised through their respective managers. He gave a similar response to a member of a prisoner welfare group, Link Up, who had seen Smith as a result of concerns raised by another prisoner, who also tried to discuss the issue of the move with him.

Mr Wright states that he knew Mr Smith was continuing to express concerns, but he believed that the situation had not changed in any way since he had received the Acting General Manager's direction to move Mr Smith to unit 5B.

A prison psychologist, Michelle Moore, was advised that Mr Smith wanted to see her. Accordingly, at about 2:25pm she attended at the unit 5B interview room and spoke with Mr Smith. Ms obtained authority to take Smith to her office at the programs demountable building and he accompanied her there.

Mr Smith advised Ms Moore of his fears for his life in unit 5B. Mr Smith informed Ms Moore that he had concerns regarding three Murri's in the unit and that inmates had wanted Mr Smith's girlfriend to bring drugs into the centre. Mr Smith told Ms Moore he was considering applying for protection.

While still with Mr Smith, Ms Moore spoke with Mr Simmons, the Acting Operations Support Officer. She advised him that Mr Smith was at her demountable; that he was not prepared to return to unit 5B and that he was considering requesting protection. She heard Mr Simmons talk to Mr Crothers about the situation. She heard Mr Crothers say "*David Smith will go back into unit 5B*". Mr Simmons informed Ms Moore

that Mr Crothers would arrange for officers to remove Mr Smith from the demountable and return him to unit 5B.

A social worker, Janet Connor, then entered Ms Moore's office and Ms Moore explained to Ms Connor what had occurred in relation to the placement of Mr Smith. Ms Connor then contacted Acting Manager Programs, Mr Deegan and passed on Ms Moore's concerns.

A short time later Ms Moore again spoke to Mr Simmons and told him Mr Smith was seeking protection. He asked Ms Moore to notify Sentence Management Coordinator Wright of Mr Smith's request.

The senior custodial corrections officer from unit 5B, Mr Pointon, then arranged for officers Mulcahy and Kavanagh to escort Mr Smith from the Ms Moore's office to unit 5B. It had been misinterpreted that Mr Smith's objection to going to that unit meant that he would resist. Mr Smith did not resist the escort and voluntarily accompanied the officers.

Smith applies for protection

As the officers and Mr Smith entered 'B' Block, Mr Smith told them that he wanted protection. The escorting officers noted that he appeared to have '*fear in him'*. CCO Mulcahy spoke with SCCO Pointon about Mr Smith's request and Mr Pointon directed that he be placed in the interview room of unit 5B whilst an application for protection was processed.

While in the interview room Mr Smith also told the Unit Manager CCO Mr Reid that he wanted protection.

A protection application form could not be located so Mr Pointon obtained a specimen from the annexures to General Manager's Rules, which were kept in the Senior's Office. Mr Smith completed the application and handed it to CCO Reid who took it to Mr Pointon.

Around this same time, Ms Moore entered the interview room of unit 5B where she saw Ms Connor speaking with Mr Smith. Ms Moore informed Ms Connor and Mr Smith that she was going to brief the Unit Manager, Gordon Reid, Les Pointon and Acting Manager (Programs) Michael Deegan about the issue.

A short time later there was a disturbance at the unit 5B interview room door from the common room side. Inmates in 5B were shouting abuse at Mr Smith and banging on the door. Mr Pointon believed that inmates wanted to use the telephone located in that room. It was known that inmates had previously forced an interview room door by repeatedly banging on it, so Mr Pointon directed that Mr Smith be placed in the exercise yard of the Detention Unit.

At 4:00pm Acting Sentence Management Officer Bales came to 'B' Block where SCCO Pointon briefed him on the issue and handed him Mr Smith's application for protection.

Mr Bales then went to the Detention Unit where he interviewed Mr Smith in the exercise yard. Mr Bales was in the yard with CCO Irvin who was stood a short

distance away and could not hear the conversation, with one exception that is detailed later.

Mr Smith told Mr Bales he could not remain in unit 5B as inmates Hill and Abell were planning to '*get him*'. This was, according to Smith, a result of an incident in unit 4B when an Aboriginal inmate, Kenny Bradfield, stabbed Mr Abell and Mr Smith did not support Messrs Hill and Abell in their conflict with a group of Aboriginal prisoners. Mr Smith said that he thought Messrs Hill and Abell were going to pay him back. Mr Smith also claimed that inmates Bruce Hooper and Ray Garland had pressured him to arrange for his visitors to bring drugs to the centre, but he had refused and he believed they were also planning to harm him as a result.

Mr Bales says that he explained to Mr Smith that it would be difficult to place him in a protection unit such as unit 4B on account of his having allegedly been involved in two recent serious assaults on other inmates at the centre. Mr Bales says he also told Mr Smith that his application for protection was on an old form and that he would have to fill out the current form if he still wanted to apply for protection.

Mr Bales states that Mr Smith then asked if he could tear up the form because he didn't want to go on protection and be known as a "*dog*". Mr Bales replied that he had to keep the form and give it to the Sentence Management Coordinator Wright.

The only evidence that Mr Smith withdrew his application for protection is this account by Mr Bales. Neither Mr Bales nor Mr Smith endorsed the application to the effect that it had been withdrawn. CCO Irvin did not hear it – he says he stood too far away. The only conversation heard by Mr Irvin was Mr Smith saying twice, in a loud tone, "*Don't put me back in 5B, they'll kill me.*"

Mr Bales agrees that Mr Smith told him that he did not want to go back to unit 5B saying, "*They'll kill me"* or "*They'll stab me*".

Mr Bales says that he attended Sentence Management Coordinator's office, handed Mr Wright the application for protection form and advised him that Mr Smith no longer wished to proceed with it. Mr Bales says he advised Mr Wright that Mr Smith was visibly distressed and that in his opinion the best option was to accommodate him in the Detention Unit until a further decision was made based on all available information.

Mr Wright states that he and Mr Bales had a general discussion about Mr Smith no longer wanting protection and just wanting a move from unit 5B. Mr Wright could not fully recall the conversation but says that Mr Bales told him about Mr Smith's new story about siding with Aboriginal inmates and also being asked to bring drugs into the centre for inmates in unit 5B. Mr Bales told Mr Wright of the names of the prisoners Mr Smith said would harm him.

Mr Wright said that when Mr Smith declined to sign the new form, the issue of protection was not taken further. Mr Wright states that once Mr Bales handed him the old application form he placed it aside on his desk and it was mislaid or discarded as he considered it was no longer of any importance.

Decision to move Smith to unit 5B is confirmed

After his discussion with Mr Bales, Mr Wright attended at the General Manager's office where he saw Acting General Manager Taylor and Acting Operations Manager Crothers at about 5pm. He asked if the move of Mr Smith had been stopped and was advised that it had not been. Mr Wright states there was then general discussion about the move. He cannot recall all the issues discussed, but remembers relaying Mr Smith's new reason for not wanting the move and it was discussed that these had changed from previous reasons. There was no discussion of Mr Smith's aborted protection application. Mr Wright says that Mr Taylor decided the move should still take place.

Mr Taylor confirms that Mr Wright did not notify him or Mr Crothers of the application for protection by Mr Smith nor of the statements by Mr Smith that if he was returned to unit 5B, "*They'll kill me*" or "*They'll stab me*".

Mr Crothers recalls later that evening he again spoke with Mr Wright who enquired if he was aware of any change concerning the decision to place Mr Smith in unit 5B. Mr Crothers then discussed with Mr Wright the preference for a single cell for Mr Smith to enable Mr Smith to secure himself in the cell if he felt threatened. Mr Wright agreed and arranged cell moves to facilitate Mr Smith having a single cell.

At 6:45pm CCO Irvin and SCCO Pointon provided a meal to Mr Smith at the Detention Unit. Mr Pointon told Mr Smith that he could not find anyone who would make a decision and that Mr Smith would have to bed down for the night at the Detention Unit.

At 7:10pm Mr Pointon made contact with Movement Control and established that all Program Staff had finished work and had left the Centre. Mr Pointon was annoyed that no instructions had been given to B Block staff concerning Mr Smith's placement.

At about 8:05pm that evening, Mr Simmons was informed by Mr Crothers that Mr Smith was to be returned to unit 5B. Inmate Speedy was to vacate cell 12 and to double up with inmate Rose, so that Mr Smith could occupy cell 12. Mr Smith was to be told that if he feared for his safety within unit 5B, he could secure the cell door from the inside.

At 8:22pm CCOs Andrew and Reid proceeded to the Detention Unit from where they escorted Mr Smith to unit 5B and placed him in cell 12. Mr Smith was unhappy with this move and did not willingly go to unit 5B. The officers were required to physically lift Smith by the arms and drag him through the corridors.

Following the move, CCO Andrew informed SCCO Pointon that Mr Smith was frightened and had broke out in a "*death sweat*". Mr Pointon asked Mr Andrew if he had made a note in the Supervisor's Log Book that Mr Smith was to stay in his cell until he was seen tomorrow. CCO Reid replied that he was working in the morning and that he would see to it.

Events of Wednesday 28 September 1994

On 28 September, when the inmates were unlocked at 7:00 am, Smith remained in his cell. CCO Kavanagh spoke to Mr Smith and says that he was adamant about

remaining locked in. Unit Manager Reid tried to talk with Mr Smith on the intercom but he did not answer. At 8:00am as Mr Smith was still not answering the intercom. Unit Manager CCO Reid obtained assistance from CCO S O'Connor and entered the unit and opened cell 12 and spoke with Mr Smith and told him to answer his intercom, as Mr Reid was checking to see that he was all right. Mr Smith replied that he would answer in future.

During the early part of the morning Unit Manager Reid observed inmate Hill at Mr Smith's cell door apparently talking to him. Mr Reid activated the intercom but the conversation could not be heard. CCO O'Connor who was a Spine Officer on the 6:00am – 2:00pm shift also saw activity near Smith's cell door. He recalls also seeing inmates Kranz, Abell and Fyfe apparently talking to Mr Smith through the louvre windows above the door.

At 10:00am Mr Smith left his cell and proceeded to the Unit Managers Office and abused CCO Reid. No explanation has been given for this action and it would be pointless for me to speculate about its motivation. Mr Smith then walked off and mixed with other inmates. During the morning Mr Smith returned to his cell for 15-20 minutes on two occasions. Mr Smith was spoken to by intercom on both occasions and stated he was all right.

Moore again tries to protect Smith

Between 8:30am and 9:00am Education Officer Sharon McAtee, who had seen Mr Smith's application for protection at the B Block Senior's Office on the previous day, saw Mr Wright and asked why Mr Smith couldn't go on protection. She was informed that "*They would have to sort it out with the General Manager and he would be difficult to handle and felt it wasn't going to be discussed*".

At about 9:30am Ms Moore approached Mr Simmons and repeated her concerns for Mr Smith's safety if he was to remain in unit 5B. She informed Mr Simmons of the information she had received from Mr Smith on the previous afternoon. Mr Simmons inquired if Ms Moore had advised her superiors of this information. Ms Moore told him that she had previously informed Messrs Crothers and Deegan.

Mr Simmons advised her to again bring the matter to the attention of Acting Programs Manager Deegan and suggested she submit a detailed report. Ms Moore then contacted Mr Deegan and repeated her concerns. He told her to provide him with a written report. Ms Moore then completed a report, which she handed to Mr Deegan between 11:00am and 11:30am.

In her report, Ms Moore wrote that at approximately 3:00pm on Tuesday 27 September 1994 she interviewed Smith who appeared nervous and was visibly shaking. Mr Smith told her that he did not want to go back into unit 5B and would consider protection. Ms Moore wrote that Mr Smith had explained to her that three Aboriginal inmates had asked Smith to arrange for his visitors to supply drugs and he had refused. Mr Smith had also told her that he was indirectly involved in an assault on two other unit 5B inmates and that these inmates had made verbal threats against Mr Smith. Ms Moore wrote that she had already contacted Operations Support Officer Simmons in relation to the situation.

Mr Deegan says that he was otherwise occupied when handed this report but that he read it after lunch and endorsed it "*Noted M Deegan 28/9/94*". Mr Deegan then made two photocopies of the report and placed one on Acting General Manager Taylor's table and one on Acting Operations Manager Crother's table.

At 2:40pm, by previous arrangement, Mr Smith was escorted from 5B to the Visits Area for a legal visit. Nothing of relevance to his death transpired during that meeting and at about 3.07 Mr Smith returned unescorted to unit 5B.

At 4:45pm, in response to a request from him, Education Officer Sharon McAtee attended the interview room at unit 5B where she spoke with Mr Smith. He complained of sore arms from being dragged from the DU the previous night. She observed that he was very quiet, withdrawn and nervous. He displayed an attitude of hopelessness.

CCO O'Connor says that at about 4.30, while he was the 2:00pm – 10:00pm Unit Manager, prisoner Fyfe came to his office and said "*When are you going to tea, boss*" He was not given an answer. Mr O'Connor subsequently had his meal break from about 5:10pm to 5:45pm.

Mr O'Connor says he and C.C.O Brennocks entered unit 5B at about 5.00pm via the main spine door in order to lock and check the exercise yard. At that time Mr O'Connor observed Mr Smith seated at a table near an area commonly referred to as the '*fish bowl*'. Mr Smith was playing cards with other inmates.

CCO O'Conner left unit 5B at about 5:10pm for his meal break. Supervision of the unit passed to the unit 4B manager during this period. On Mr O'Connor's return, the unit 4B manager went for a meal break and Mr O'Connor supervised both units.

The Acting General Manager of the prison. Mr Taylor, returned to his office about 5:00pm and saw the report from the psychologist Moore. Mr Taylor says that after reading it he endorsed it on the top right with "*A/Mgr Programs, please discuss with me - NFT*". He then endeavoured to phone Acting Programs Manager Deegan to discuss it with him, but he could not raise him and he thought that Mr Deegan must have ceased duty and left the centre. The report was taken by his secretary, Ms Hepburn, and placed on Mr Deegan's table.

The Discovery of the Deceased's Body

At about 6.30pm Registered Nurse Hennie Veldcamp attended unit 5B to administer medication to the inmates domiciled in that unit. On her arrival, the Unit Manager CCO O'Connor used the unit intercom to advise all inmates of her presence and to alert those on medication of the need to attend the interview room to receive it.

Mr Smith did not attend for his medication. After several attempts to contact him via the cell intercom, Correctional Officers Brennocks and O'Connor entered the unit and proceeded to cell 12.

Mr O'Connor cannot recall whether the cell door was unlocked or whether he had to unlock it, but when he opened the door he observed Mr Smith sitting on the floor with coaxial cable around his neck fastened to the metal upright of the bunks. He immediately saw that Mr Smith had numerous wounds that were bleeding.

Mr Brennocks felt Mr Smith's neck below the '*noose*' for a pulse and Mr O'Connor put his hand over Smith's face and on his chest for evidence of respiration. Neither could detect any sign of life.

In view of the injuries to Mr Smith and the background of the remaining 15 inmates in the unit, the officers immediately locked Cell 12 and exited the unit. At the office, Mr O'Connor summoned help via the block intercom.

Additional officers quickly arrived and they entered the unit and directed all inmates into the unit 5B exercise yard. Mr O'Connor, together with RN Veldcamp, A/SCCO Graham and CCO Brennocks the returned to cell 12. Nurse Veldcamp was unable to find any sign of life and instructed that an ambulance be called.

A/SCCO Graham, who was in B Block at the time the alarm was raised and who entered the cell with Messrs O'Connor and Veldcamp, on observing the cable around the neck of the deceased, obtained a rescue knife from CCO Irvin, who was present outside the cell, and cut the cable. Mr Smith was then laid on his back on the floor.

The officers and the nurses present observed that there was a large quantity of blood and water on the floor of the cell. It appeared that the deceased had water poured over him following the attack. The bedding was also wet. The officers noted that the Cell 12 intercom was hanging by wires from the console above the cell desk.

As the additional officers entered unit in response to the call for assistance, the washing machine within the unit was observed to be in use. It was immediately turned off.

The Acting Operations Support Officer, Mr Michael Taylor, went to the scene and directed the 'B' Block be locked down, a head count be undertaken, and patrols be conducted around the outside of the block.

The Acting General Manager Noel Taylor and the Acting Operations Manager David Crothers were, at the time of the discovery of Smith's body, on the perimeter in connection with a problem with the security fence. Both officers were in contact with the Centre's control room and were immediately advised.

During the evening of 28 September 1994 Acting General Manager Taylor, Acting Operations Manager Crothers and Director of Custodial Corrections Krikorian all attended unit 5B in relation to this incident.

The post death response

Preservation Of Scene & exhibits by correctional staff

Soon after Mr Smith's body was discovered, CCO O'Connor declared Smith's cell a crime scene. This response was timely, but a more extended area covering the hallway between the cells should have been secured to prevent the procession of officers unnecessarily viewing Smith's cell before the arrival of police.

Inmates in unit 4B doubled up to allow unit 10B (Detention Unit) inmates to also move into unit 4B. This allowed unit 5B inmates to be placed into the Detention Unit. All cells of the Detention Unit were first searched.

The showers in the cells occupied by inmates Kranz, Hills, Hooper, Clarke and Fyfe had obviously recently been used.

Attendance by ambulance officers

At 6:51pm Ambulance Control received telephone notification of the incident at the Sir David Longland Correctional Centre and a unit was immediately dispatched arriving at the centre at 6.58.

At 7:00pm Paramedic Officer HULL examined the deceased. Mr Smith's body was cold and there appeared to be slight stiffening in the joints. A degree of postural lividity was present in the lateral aspect of the right arm. He formed the opinion that Mr Smith was dead and would not respond to resuscitation attempts; none were therefore attempted. This was clearly a reasonable decision. A Government Medical Officer attended at the centre and certified life extinct. The body was transported directly to the John Tonge Centre for lodgment pending a post mortem.

Post mortem examination

On 29 September, a post mortem examination of Mr Smith's body was conducted by Doctor Ansford, a forensic pathologist. He issued a *Post Mortem Examination Certificate* showing the cause of death to be multiple stab wounds.

Samples of blood, urine and liver were taken from the deceased for alcohol and drug analysis. Nothing of significance was found.

Professor Ansford also completed a '*Post-Mortem Examination Report*' dated 23 November 1994.

In summary, there were a total of 31 stab and incised wounds to the face, neck, arms, hands, sides and back of the body. Eight wounds penetrated into body cavities. The most significant were one into the right lung, one into the spleen; two into the right kidney, and one into the left kidney. These led to bleeding into the right chest cavity and into the bladder.

Police investigation

Police Officers from the Oxley Police Station were first to respond. They arrived at the centre at 7:41pm. They were briefed on the situation and directed to unit 5B where the scene was already secured and a running log was commenced.

At 7:45pm, senior officers from the Correctional Services Investigation Unit (the CSIU) attended and took initial charge of the investigation. Later in the evening detectives from the Homicide Investigation Squad attended at the scene and assisted in the investigation.

Scientific, fingerprint and photographic examinations of the scene and surrounds were carried out on the evening of 28 September and over the following days.

Clothing in the washing machines was seized and examined. Luminol light testing for blood was carried out in cell 12 in the corridors. Bedding and clothing from the deceased's cell was tested. Samples of blood from the top and lower bunks, sidewall and toilet area were screened. It seems that all examinations that may have been of benefit to the investigation were undertaken. However, it appears the water that was thrown over the deceased and around the walls and floor of the cell following the murder washed away all trace evidence. In summary, nothing of significant evidentiary value to identify the perpetrators(s) was discovered.

The next day C.S.I.U. officers conducted a search of the cells in unit 5B. During the afternoon and into the following day, Q-Build plumbers conducted a search of relevant drains and plumbing in unit 5B. The ceiling, roof and external areas of the block were also searched. Despite these efforts, the murder weapon was never located.

On the night of the murder, Detectives Banks and Herpich briefly questioned inmates in relation to their version and movements during the day. Their responses varied from vaguely cooperative to complete silence. No inmate admitted to having any direct knowledge of the murder. During this process the inmates were searched and the clothes worn by them were seized for examination purposes.

On the day following the murder police obtained an important statement from an inmate who I shall refer to as the first co-operating inmate.[9] He alleged that prisoners Hills, Kranz, Abell and Fyfe were all involved in the murder in some way. He said that on the morning of 28 September 1994 he saw Kranz standing outside the doorway of cell 12. He saw Mr Kranz talking to Mr Smith and heard him say words to the effect:

> *"We know that the screws are trying to set you up. Just come out and face it like a man and it will be sweet."*

The first co-operating inmate said that he went into inmate Hills cell and Mr Hills said words to the effect that he was going to get someone.

The first co-operating inmate also alleges that late in the afternoon he saw Mr Hills with a butter knife blade about 6 to 8 inches long, the point of which had been sharpened. It had white strapping tape at the other end to form a handle. The first co-operating inmate says that he asked Mr Hills "*What's going on?*" Mr Hills is alleged to have replied "*I'm going to work*".

The first co-operating inmate states that in the early evening he saw Mr Kranz walking with Mr Smith from the common room area towards the cells. They walked into cell 12 together, with Mr Smith entering first. There appeared to be some pushing and lunging between Mr Kranz and Mr Smith, but the first co-operating inmate could not see exactly what was going on. He heard Mr Smith say "*What's going on?"* He saw Mr Hills running into Mr Smith's cell and saw the cell door close.

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[9] This inmate has given evidence in various proceedings concerning this matter and it is likely that it is well known in the prion population that he gave varying levels of assistance to the investigation of Smith's murder. However I have no evidence concerning any risk to his safety that may ensue, now or in future, if I were to name him here and as it is not necessary for the purpose of the findings I choose not to do so.

The first co-operating inmate alleges that he then heard a stereo start playing loud music. He heard screaming coming from cell 12.

The first co-operating inmate alleges that after this he walked out of his cell and towards the common area. He saw prisoner Fyfe pacing up and down outside Mr Smith's cell.

The first co-operating inmate says that he saw Mr Fyfe approach the glass window of Smith's cell and nod his head. Immediately after this Messrs Kranz and Hills came out of Mr Smith's cell and walked to their own cells. The first co-operating inmate says that he saw prisoner Abell picking up clothes which had been left at the doorway of Mr Kranz's cell, and roll them up in a bundle and place them into a washing machine. The first co-operating inmate also alleged that another inmate, Robert Speedy, had said earlier that afternoon that "*I'm going to bust Smithie's intercom" and later said "I've done it, I've busted it with a knife*".

It was not until 15 March 1996 that further significant corroboration was obtained in a statement from a second co-operating inmate who alleged that he saw Messrs Hills and Kranz enter Mr Smith's cell at the time of the murder.

The second co-operating inmate also said that before the murder he saw Mr Hills appearing to have a conversation with Smith during which he appeared scared and was flinching. He later saw a fight start when Messrs Hills and Kranz grabbed Mr Smith and dragged him down the spine of the cell block in a headlock.

About 10 to 15 minutes later, he saw Mr Hills walking fast about halfway along spine of unit 5B. Mr Hills looked like he had just showered as his hair and face were drenched and his t-shirt was clinging to his body. His face was red and his eyes were glassy.

Charges are laid

In March 1996, relying on the evidence provided by the two co-operating inmates, Messrs Hills and Krantz were charged with Smith's murder. In September 1996, inmates Fyfe and Abell were also charged for their alleged involvement.

Committal proceedings

The charges against Messrs Hills, Kranz, Abell and Fyfe came before a committal hearing in September 1996. All defendants were committed to stand trial.

Indictments presented

On the 29th of April 1996 the following indictment was presented in the Supreme Court of Queensland,

Count 1: Murder, Section 302, 305 of the Criminal Code.
That on the twenty-eighty day of September 1994 at Wacol in the State of Queensland, Rodney Thomas Hills, Andrew Thomas Kranz, Wayne Anthony Fyfe and Phillip Graham Abell murdered one David Edward Smith.

Alternatively

Count 2: Accessory after the fact to Murder, section 307(1) of the Criminal Code.

That on the twenty-eighty day of September 1994 at Wacol in the State of Queensland, Rodney Thomas Hills, Andrew Thomas Kranz and Wayne Anthony Fyfe murdered one David Edward Smith.

And that Phillip Graham Abell on the twenty-eighty day of September 1994 at Wacol in the State of Queensland, knowing that the said Rodney Thomas Hills, Andrew Thomas Kranz and Wayne Anthony Fyfe had committed the said crime assisted them in order to enable them to escape punishment.

Nolle Prosequi entered

On 5 June 1997 the first co-operating inmate was called as the first witness in the trail of the four prisoners charged with murdering Mr Smith. He refused to take an oath and informed the Court that he did not propose to give any evidence. The jury was then excused. The prosecutor then submitted to the Judge that consideration should be given to holding the first co-operating inmate in contempt of Court but understandably, the Judge concluded that little would be achieved by this.

The Crown withdrew the indictments and a *nolle prosequi* was entered. All four accused were discharged.

Further investigation - Operation Cashbox

During 2000 and 2001 officers from Department of Corrective Services Investigation Unit and the Department of Corrective Services Intelligence Group conducted an intelligence assessment in relation to a number of suspicious deaths at correctional centres. This culminated in the submission of an Intelligence Assessment Report concerning 12 deaths that had occurred over about a ten-year period. The murder of Mr Smith was one of those identified as warranting further investigation.

During the cold case review process, a third co-operating inmate gave a statement in relation to the murder of Mr Smith. This witness claimed that in 1995 Mr Hills was trying to impress other inmates by bragging about his violent exploits. The third co-operating inmate alleged that Mr Hills confessed to killing Mr Smith. He alleged that Mr Hills told him that he killed Mr Smith because Smith had told inmate Bradfield that he and Abell had a '*shiv*' (hand made knife) hidden. Mr Hills allegedly told the third co-operating inmate that Mr Smith just laid there as he didn't think "*he would cop fifty*." Mr Hills told the third co-operating witness that he had to strangle Smith and tie him down. Hills did not tell the third co-operating witness who else was with him at the time of the killing.

It was considered that the evidence of the second and third co-operating witnesses was not sufficient to enable a prosecution to succeed and therefore although the investigators were determined to re-lay charges at some stage that had not been reached when an unexpected breakthrough occurred.

Kranz re-arrested

On 31 August 2004 Detective Sergeants Miers and Lawrence of the State Homicide Investigation Group interviewed Kranz at the Arthur Gorrie Correctional Centre as a consequence of receiving information that Kranz now wished to confess to the murder.

Mr Kranz admitted that another inmate, whom Kranz refused to nominate, asked Mr Kranz to assist him to murder Mr Smith. Mr Kranz claimed not to know the motive behind the murder but agreed to assist. Mr Kranz stated that he had preliminary discussions with this other inmate in the laundry of the unit, where he alleged that the other inmate told him that Mr Smith had to be killed, and the plan was to stab him while he was in his cell. Prior to the murder, the other inmate placed a mop and bucket in the hallway near to Mr Smith's cell so that it could be used to clean up.

Mr Kranz stated that later that same day around 5.30pm, a time when supervision of the Unit was reduced to only one correctional officer, he caused Mr Smith to return to his cell and on entering the cell Mr Kranz punched Mr Smith, and the second inmate offender entered the cell and they both subdued Mr Smith. The second offender repeatedly stabbed Mr Smith with a bread and butter knife that had been sharpened to a point. The knife was then passed to Mr Kranz who also stabbed Mr Smith numerous times. Mr Kranz was then handed a TV coaxial cable and he placed it about Mr Smith's neck to strangle him, but noticed that Smith was already dead. Mr Kranz then tied Mr Smith to the upright of the bunk bed. Both prisoners then cleaned down the scene by wiping the walls, throwing water over the floor, and by mopping the hallway down. They then showered and placed their clothes and footwear into the washing machines. He believed that the knife was then bent over and flushed down a toilet.

Kranz indicated he was making full admissions as he has been reading the Bible and was now seeking forgiveness from God. He also believed it was the right thing to do, and it would also help Mr Smith's family.

Mr Kranz was arrested and charged with the murder of Mr Smith.

On 18 February 2005, Kranz entered a plea of guilty to the murder of Smith on an ex officio indictment. He also pleaded guilty to 11 other counts, including another count of murder. The sentencing was adjourned to enable the prosecution to apply for the imposition of indefinite sentences. On 16 June 2005, Mr Kranz was sentenced to life imprisonment for the murder of Mr Smith with a minimum term to serve of 20 years imprisonment.

Findings required by s43(2)

I am required to find, so far as has been proved, who the deceased was and when, where and how he came by his death.

As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, I am able to make the following findings.

Identity of the deceased – The deceased was David Edward Smith

Place of death – Mr Smith died at the Sir David Longland Correctional Centre, Wacol, Queensland

Date of death – He died on 28 September 1994

Cause of death – Mr Smith died as a result of multiple stab wounds inflicted by Andrew Krantz who was assisted in the murder by other prisoners

The committal question

I am also required to consider whether any person should be committed for trial on any of the charges referred to in s24(1)(d) of the Act.

Mr Kranz declined to identify or to testify against other suspects in this matter. There is considerable evidence indicating that Messrs Hills, Abell and Fyfe[10] played some part in the murder but in view of the course this inquest has taken this can not be proven with sufficient certainty to enable me to commit them for trial.

I note that the statement given by the first co-operating inmate on 29 September 1994 substantially accords with the account given by Mr Kranz during his confessional interviews and although not identical in its terms, it is corroborated by the version of the second co-operating witness.

On 27 December 2001, Detective Sergent Myers and Detective Senior Constable Burge, homicide detectives attached to Operation Cashbox, attended the SDLCC to speak to the first co-operating inmate. He indicated that he was willing to give evidence at any trial concerning the murder of Mr Smith. The first co-operating inmate explained that he previously refused to take the oath at the trial in 1997 because he was concerned for his own safety, having then recently been sentenced to an indefinite life sentence.

Accordingly I recommend that the investigation police officers seek advice from the Director of Public Prosecutions as to whether they should charge the two surviving suspects referred to above.

Preventive recommendations – riders

Section 43(5) of the Act prohibits a coroner from expressing any opinion on a matter outside the scope of the inquest except in a rider which is, in the opinion of the coroner, designed to prevent the recurrence of similar deaths.

The facts of this case clearly raise concerns about the way the prison managers and officers responded to the ample information they had that Mr Smith was at risk of harm if housed in unit 5B. This aspect of the matter was closely analysed in a report commissioned by the QCSC.

[10] Fyfe has since died

In accordance with usual practice, the day after the death, the QCSC appointed two external inspectors to review the circumstances in which it occurred and to advise whether all relevant policies and procedures had been adhered to and/or whether any changes to policy, procedures or practices were necessary to avoid future deaths.

The inspectors undertook a through examination of, among other things, the circumstances of the death and the actions of the officers who were involved in responding to Mr Smith's claims that he was at risk of harm if moved to unit 5B. In a report addressed to the Minister for Corrective Services and the Director General of the Corrective Services Commission, the inspectors found what is obvious from the facts summarised earlier in these findings, namely,

> *Smith quite openly told staff that if he was returned to unit 5B he would be killed"*
>
> *Irrespective of whether Smith did withdraw this application (for protection), his orally expressed fears that he would be killed if he was returned to unit 5B along with other indicators should have been acted on…*[11]

The inspectors concluded that the mistakes that occurred in this case were in part attributable to the failure of some of the officers involved to take reasonable precautions which amounted to a breach of their duty of care to the prisoner. I can only agree with this conclusion.

As usual, however, there were also systems failures that made it less likely that individuals would perform optimally. The inspectors point to a failure of the managers of the SDLCC to update their policies and procedures so that they complied with QCSC policy; in particular the policies concerning the segregation of "at risk" prisoners.

The legislation in force at the time of the death provided authority for the QCSC to formulate rules, called *Commission Rules*, for the State's correctional centres. The legislation also provided for the general managers of correctional centres to also formulate rules, called *General Manager's Rules* that were to comply with QCSC policy and the Commission Rules.

A new policy concerning the segregation of at risk prisoner had been approved by the QCSC about 15 months before the death of David Smith but it had not been effectively implemented in the SDLCC. The officers initially responding to Mr Smith appeared to be unaware of the existence of new forms and the new policy, notwithstanding that the new policy had been introduced some 4 months earlier. There was obviously a failure at the Centre to adequately notify and train all correctional staff of these changes.

The inspectors concluded that:-

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[11] Report of DCS Inspectors at p30

> *Had the General Mangers Rule 18 – 2 accurately reflected the QCSC policy and procedure on the provision of protection, then it is quite possible, had the procedure been followed, that the application for protection and oral statements of David Edward Smith would have at least caused his segregation and probably prevented his murder.*[12]

The inspectors concluded that the death of Smith was both *predictable* and *preventable*. I respectfully agree with their assessment in this regard. It seems likely that Mr Smith committed a number of reprehensible acts during his relatively short life. At the time of his death he was not making a positive contribution to society and was causing problems in the prison system. Not withstand this, he did not deserve to die such a gruesome and painful death and he was entitled to be protected by the custodial authorities, particularly when he repeatedly drew to their attention the risks facing him.

The managers and officers of the Sir David Longland Correctional Centre failed to satisfy Mr Smith's most basic need, that of personal safety. Undoubtedly, prisons can be dangerous places but it is the responsibility of those paid to run them to take all reasonable steps to remove or reduce the dangers. In my view, those responsible did not so in this case. However, there is no evidence that these failures were the result of any wilful neglect by prison officers nor that there was any collusion between officers and those wanting to harm Mr Smith.

As one would expect much has changed in the operation of prisons since this sad and violent death, indeed the legislation governing corrections has been extensively amended and the management systems of the department and of individual correctional centres, including the SDLCC, have been overhauled. Many of the staff involved in these events have left the prison system.

Never the less it is appropriate to consider the shortcomings the inspectors identified in this case and the recommendations they made in order to make an assessment of whether those changes have made it less likely that a death could occur in similar circumstances now.

Therefore the Court sought and received from the Department of Corrective Services advice as to how the issues identified by the inspectors have been responded to. The inspectors' recommendations and the Department's responses are set out below.

Recommendation (a) - Review of protective custody –

> *That an urgent review be carried out of the Q.C.S.C Policy and Procedure for the assessment of the requirement for Protective Custody (Protection). This must include an assurance that Centres are familiar with the intention of the policy".*

The Department advised that this recommendation was endorsed by the Director-General at the time and the Director of Custodial Corrections was requested to carry

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[12] ibid, at p39

out the review on 15 May 1995. The review occurred and resulted in significant changes to the procedure.

The Department implemented the current amended version of the procedure relating to protection of prisoners on 12 December 2002. The procedure provides for the protective management of offenders who are assessed as being at risk of harm from others. The procedure has been implemented in all correctional centers and is applicable to all correctional officers.

The Department considers that the current protection policy adequately provides for the protective management of offenders who are assessed as being at risk of harm from others. The current protection policy can be viewed at http://www.dcs.qld.gov.au/docs/procedures/ofm/ofmproapp.shtml

Under the current policy the Department accepts a duty of care to provide a safe environment for offenders in the correctional system. Protection status should be approved for a prisoner who, based on assessment and review processes, cannot be effectively managed within the mainstream prison population. The policy acknowledges that requests for protection may arise from a range of sources, including the courts, solicitors, police, the prisoner and staff or management.

It is a requirement that every prisoner received into custody be assessed using the '*Immediate Risk Needs Assessment'*. In a number of circumstances, including where a prisoner requests protection, there is a requirement to refer the matter to the Sentence Management Coordinator/Sentence Management Officer.

There is still a requirement that a written application for protection be made on the '*Application for Protection*' form, which is to be forwarded to the Sentence Management Coordinator/Sentence Management Officer. However, there is a clearer requirement relating to verbal requests. A person in charge of a facility is responsible for the safety of a prisoner who makes a verbal request or written application for protection from the time the request or application is received until the matter is determined.

All relevant information pertaining to the request for protection is to be assessed and verified by the Sentence Management Coordinator/Sentence Management Officer using the '*Protection Needs Assessment'*.

A request for withdrawal of protection must be made in writing. If the prisoner refuses to sign a withdrawal form, the prisoner's protection status, can only be removed if the relevant officer is satisfied that the prisoner can be safely managed within the mainstream system.

Recommendation (b) General Manager to explain why policy and procedure was not followed –

> *That the General Manager, Sir David Longland Correctional Centre, should in our view be called upon to explain why the Q.C.S.C Policy and Procedure in respect of Protection Prisoners, although known at the Centre, was not followed*".

The Department advised that the Acting General Manager provided an explanation of events both in written form and verbally to the Investigations Review Committee. The I.R.C. concluded there was insufficient specific information to allow the committee to reach a definite conclusion on the question of whether procedures were properly followed.

Recommendation (c) - Assessment of Deegan's ability to perform his duties –

> *That Mr Deegan's ability to perform the function of Acting Programs Manager must be re-assessed. We are unaware of the basis for his selection to relieve in this position. Further, that the General Manager Sir David Longland Correctional Centre should be directed to have Mr Deegan assessed and given any appropriate training before he is again permitted to perform the duties of Acting Programs Manager.*"

The Department advised that the Acting General Manager provided a written report to the I.R.C. in response to this. The I.R.C. was satisfied that the selection of Mr Deegan and his qualifications for the position of Acting Manager, Programs, was adequate. Mr Deegan resigned from the Department in 1996.

Recommendation (d) - Wright failed in his duty as Sentence Management Coordinator –

> *Further, that Mr Wright, the permanent occupant of the Sentence Management Coordinator position, has, in our opinion, failed in his duty. His appointment to this position should be investigated and if sufficient evidence be forthcoming then appropriate decisions made. At the least he should be required to undergo training on risk management associated with the management of prisoners. His error of judgment in this instance has, we believe, been a substantial reason for the deceased prisoner Smith being left where the prisoner's life was at risk*'.

The Department advised that the Acting General Manager provided a written report to the I.R.C. in response to this. The I.R.C. agreed that there was failure on the part of one or more persons at the centre to effectively discharge their duties. However, the persons concerned were not able to be identified. The I.R.C. did not support that the error of judgment by Wright was a substantial reason for Smith being left in a situation where his life was at risk. Mr Wright ceased employment with the Department in March 2003.

Recommendation (e) - The Q.C.S.C. should establish a succession training program –

> *That Sir David Longland Correctional Centre should be required to undertake, as an urgent issue, the establishment of a Succession Training Program for all staff from SCCO upward. This should not be limited to Sir David Longland Correctional Centre but should be a QCSC-wide strategy*".

The Department advised that a Management Development Program has been designed, developed and implemented state-wide.

Recommendation (f) - S.D.L Correctional Centre should establish a system of random audits to ensure compliance with searching procedures etc. –

> *That the Centre introduce a system of random audits to ensure compliance with existing Rules and Procedures in respect of searching of prisoners and the searching, transportation and disposal of rubbish from the Units and the Blocks"*;

The Department advised that this recommendation was referred to the Director of Custodial Corrections for further assessment and implementation.

Current searches policy, implemented on 10th April 2003, reflects improvement made in this area. The procedure provides both management and operational processes for the conduct of searches at Correctional Centres that contribute to the safety and security of corrective service facilities and persons at those facilities. The Internal Audit branch of the Department apparently conducts operational audits, examining compliance to operational and administrative requirements and provides advice on the effectiveness of controls.

Recommendation (g) - The Director-General should consider disciplinary action

> *That consideration be given by the Director-General as to whether the findings in this report justify or warrant disciplinary action*".

The Department advised that the I.R.C. sought a formal response in respect of whether disciplinary action was warranted or justified. The I.R.C. did not consider that any disciplinary action was warranted against any officer as a result of the report. The committee also considered that disciplinary action could not be taken against any officer as a result of the lack of clarity pertaining to the actual events which occurred surrounding the death of Smith.

Conclusions

Mr Smith told numerous staff over three days of concerns for his safety if he was placed in unit 5B. These communications commenced as non-specific allegations and substantially changed over time. However, almost everyone who heard them was convinced that he was genuine in his claims that he believed that he would be harmed or killed. The professional women in the programs section of the prison did their utmost to have these very serious issues addressed. They were unsuccessful because the correctional officers all the way up the chain of command to the Acting General Manager failed to give sufficient consideration to the risks or perform a basic risk assessment before forcibly moving Mr Smith into the unit.

Bureaucratic nonsense, such as the wrong form, and administrative incompetence, such as the failure to tell the Acting General Manager all of the relevant information, combined to drag Mr Smith to his death.

The changes made to policies and procedures by the Department of Corrective Services as a result of the recommendations of the external inspectors and the continuing reform of the prison system appear to have addressed the formal and structural issues that contributed to the death. By themselves, however, they will not

guarantee safety if employees fail to respond with clarity and commitment. In view of the passage of time since the death of Mr Smith, I do not think that it would serve any useful purpose for me to make further recommendations and I therefore decline to do so.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
17 March 2006