QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Leonard Raymond GORDON**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Bundaberg
FILE NO(s):	2012/3657
DELIVERED ON:	28 February 2017
DELIVERED AT:	Brisbane
HEARING DATE(s):	23 June 2016; 8-9 August 2016
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, prison assault, supervision of prisoners.

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Family of the deceased:	Mr Simon Cooper (Instructed by Shine Lawyers)
Queensland Corrective Services:	Ms Kylie Hillard (Instructed by the Department of Justice and Attorney-General)

Contents

Introduction

1. Leonard Gordon was 22 years of age when he died at the Maryborough Correctional Centre (MCC) on 9 October 2012. His death was the result of a sudden, violent and unprovoked assault by another prisoner in the exercise yard of Unit S2, a protection unit within MCC.

2. The assault occurred while custodial corrections officers were searching cells within the unit. The assailant was a convicted murderer with a history of intimidating and assaulting other prisoners.

3. Tragically, Mr Gordon was just two days short of his date of release from a relatively short sentence of imprisonment. He had no history of violence within prison.

4. The immediate circumstances of Mr Gordon's death are clear as they were captured on CCTV. The offender was subsequently convicted of Mr Gordon's murder. These findings set out those circumstances and address the following issues:

   - The adequacy of facilities and procedures in place at MCC for the placement of prisoners into protective custody;

   - The availability within Queensland Prisons of items similar to the metal bar used to assault the deceased;

   - The reasons a material report relating to the death from a member of MCC staff was not provided to investigating police;

   - The adequacy of the supervision of prisoners at MCC when cell searches are being conducted; and

   - Whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

5. Investigations were conducted into the circumstances leading to the death of Mr Gordon by the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) and the Office of the Chief Inspector (OCI).

6. The QPS investigation was led by Detective Senior Constable Steven Peake. He submitted a report that was tendered at the inquest.

7. Detective Senior Constable Peake attended MCC with several other CSIU officers several hours after the incident occurred. In the interim, a local team of police from Maryborough attended the prison and conducted preliminary inquiries. Upon arrival at MCC, Detective Senior

Constable Peake inspected the CCTV footage of what occurred and viewed the scene at the exercise yard from a point outside the yard.

8. CSIU officers commenced the process of taking statements from staff and inmates of the Protection Unit. They took steps to seize all relevant records and interrogated the MCC's Information and Offender Management System (IOMS). Detective Senior Constable Peake spoke to intelligence officers at MCC and made arrangements for statements to be obtained from senior officials at the prison. He also seized the relevant CCTV footage.

9. Detective Senior Constable Peake attempted to interview Mr Gordon's assailant, Gregory Glebow, at the MCC. Mr Glebow exercised his right to remain silent at that time; and provided no explanation for his actions.

10. Scenes of crime officers took a series of photographs of the location of Mr Gordon's death. I am satisfied that the QPS investigation was thoroughly and professionally conducted and that all relevant material was accessed.

11. The Chief Inspector, Queensland Corrective Services, also appointed investigators to examine the incident under the powers conferred by s. 294 of the *Corrective Services Act* 2006. Those investigators prepared a detailed and thorough report which was submitted to the Office of the Chief Inspector (OCI Report). It examined matters within and beyond the scope of the inquest. The report was tendered at the inquest and was of assistance in the preparation of these findings.

12. A criminal investigation also took place. This process was concluded on 9 May 2014, when Gregory Glebow was sentenced in the Supreme Court of Queensland for the offence of murder. At sentence, Mr Glebow showed no remorse. The sentencing remarks of His Honour Justice Boddice were tendered at the inquest. In sentencing Mr Glebow to life imprisonment with a non-parole period of 30 years, His Honour noted:

> *Your criminal history shows that you have a significant history for violence. That history includes violence whilst in prison. This particular murder occurred whilst in prison. It involved a cold, calculated act of callousness on your part, to a young, unarmed and unaware victim. That victim was in the prison setting, and ought to have been protected in those circumstances.*

The inquest

13. A pre-inquest conference was held in Brisbane on 23 June 2016. Mr Johns was appointed as counsel assisting and leave to appear was granted to Queensland Corrective Services and Mr Gordon's family.

14. At the request of Mr Gordon's family, the inquest was held at Bundaberg over 8 – 9 August 2016. All 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. These were supplemented by written submissions.

15. I am satisfied that all the material necessary to make the findings required under the *Coroners Act 2003* was placed before me at the inquest.

The evidence

Personal circumstances and correctional history

16. On 13 December 2011, Mr Gordon was convicted at the Bundaberg Magistrates Court of breaching an intensive correction order, and breaching a bail undertaking. He was sentenced to 11 months' imprisonment, and on 28 February 2012, he was released to court-ordered parole. However, on 11 April 2012 he was returned to custody under a court-ordered parole suspension that followed a positive urine test.

17. Because of this breach, he was ordered to serve the remaining eight months of the order in actual custody. This was the sentence Mr Gordon was serving at the time of his death. Mr Gordon's criminal history was tendered at the inquest, and demonstrated that he had previously served relatively short periods in custody for break and enter and other property related offences.

18. The evidence confirmed that Mr Gordon was a compliant prisoner, who was generally well liked by other inmates. He was of a quiet nature and kept to himself in prison.

19. Mr Gordon had no significant medical history. He was slightly built, weighing less than 60kg. Mr Gordon had a history of depression with related self-harming behaviours. He also had a history of intravenous drug use relating to methylamphetamine, and was a user of cannabis.

20. A statement under the hand of Mr Gordon's sister, Jacqueline, was tendered at the inquest.[1] It is clear from that statement, and from his family's attendance at the inquest, that they were very close to Mr Gordon. They remained in regular contact during his period in custody, during which Mr Gordon would talk about his plans on his release from prison. I extend my condolences to the family.

21. Mr Gordon's full time release date was only two days after his death occurred. He had been eligible for release for several months. However; he was not released as he was unable to identify suitable accommodation to go to post-release. It appears that Mr Gordon opted

[1] Exhibit B2

not to seek release after his initial application was declined. He had also declined an offer to move to a low security facility as he wanted to stay close to his family. This resulted in him retaining a security classification of 'high'.

22. On 3 October 2012, Mr Gordon had told his sister that he was happy that he was going to complete his whole sentence because this meant he would not be subject to any parole or reporting conditions after his release. He did not say anything to his sister that suggested he feared for his safety within Unit S2. The OCI Report did not identify any evidence of information available to the MCC to indicate that any other prisoner presented a specific risk to Mr Gordon.

23. The basis for the Parole's Board's decision to determine that Mr Gordon's proposed accommodation was not suitable was not explored in any detail at the inquest.

24. However, QCS was asked to provide advice in relation to recommendations contained in the Chief Inspector's Report. Recommendation 1 of the Chief Inspector's Report was as follows:

> *QCS consults with the Queensland Parole Board for possible solutions to the issue of prisoners who are eligible for release from secure custody but remain incarcerated due to the lack of a suitable address to be released to.*

25. This issue was addressed in the statement of the Executive Director, Specialist Operations, Queensland Corrective Services, Ms Samantha Newman.[2] Ms Newman noted that at the time of Mr Gordon's death his parole had been suspended indefinitely by the Central and Northern Queensland Regional Parole Board, subject to a suitable home assessment.

26. Ms Newman noted that the approach to prisoners subject to court ordered parole which had been suspended had altered during 2014.[3] The Queensland Parole Boards now take a case by case approach to requesting a home assessment prior to re-release, and the subsequent imposition of a 'reside' condition on a court ordered parole order. As canvassed during Ms Newman's evidence at the inquest, as Queensland Courts do not impose a requirement that a prisoner reside at a suitable address when granting Court Ordered Parole, it appeared inconsistent for such a requirement to be imposed by the Boards. This was also identified as an issue in the Queensland Parole System Review Final Report.

> *When prisoners are considered by the Parole Board for release on a parole order there are factors that are taken into account*

[2] Exhibit B66
[3] T2-page 20

that the Court was not required to consider when ordering release on parole on a fixed date. [4]

27. Ms Newman also told the inquest that a new model for helping prisoners with matters such as post-release accommodation was implemented from 1 July 2016. The new model is for contracted service providers to be located in correctional centres on a regional basis. The service providers can be approached by prisoners approaching their release date for assistance with an emphasis on attempts to secure accommodation for prisoners. Ms Newman noted that there was still a scarcity of housing for prisoners but efforts were made to provide contractual incentives to service providers to increase the likelihood that beds would be secured for prisoners on release.

28. Following the implementation of recommendations in the November 2016 Queensland Parole System Review Report[5], there are likely to be even more significant changes that would benefit a prisoner in Mr Gordon's position. Those recommendations are considered below.

Classification and accommodation of Mr Gordon

29. At the time of his death, Mr Gordon had been accommodated in cell 45 of Unit S2, which was described as an induction unit for protection prisoners. Mr Gordon was initially placed in the MCC Detention Unit because of concerns for his health, safety and well-being, particularly as he had returned a positive drug screen during the reception process. He was moved from the Detention Unit to Unit S2 on 19 April 2012.[6]

30. Accommodation Manager Alan Ingham's evidence was that Unit S2 was one of four units in the protection area (S1) at the prison. Each protection unit contained 50 cells. The other protection units were S3, S4 and S5. Units S3 and S5 were regarded as privileged units as prisoners enjoyed greater freedom in terms of movement within those units. Prisoners could apply to progress to a privileged unit within S1 after completing the induction process in S2, or they could be relocated due to behavioural issues.[7]

31. Mr Ingram's evidence was that Unit S2 was used to accommodate prisoners who had very little exposure to life in prison. However, returning prisoners, as well as problem prisoners from other units, were also accommodated in S2. There was no evidence of overcrowding within Unit S2 at the time of Mr Gordon's death.

[4] https://parolereview.premiers.qld.gov.au, page 83
[5] ibid
[6] Exhibit B65, page 6
[7] Exhibit B29

32. The evidence at the inquest was that protection prisoners were housed according to their type of offending. As Mr Gordon was in prison for breaching a court order, his offending was not regarded as serious.

33. However, at the time of Mr Gordon's death, several long-term prisoners convicted of very serious offences classified with 'protection' status were also accommodated in Unit S2. Evidence was heard at the inquest that this was necessary due to 'association problems'. This effectively meant that prisoners with protection status faced as much risk from other protection prisoners as they did from the mainstream prison community.

34. Ms Newman's evidence at the inquest was that since Mr Gordon's death there have been significant changes in relation to the capacity for protection prisoners to be moved between prisons in Queensland. At the time of Mr Gordon's death there was no centralised management system in place, and transfers were the responsibility of general managers of each correctional Centre. There are now sentence management staff located in each centre who report to the Sentence Management Services Unit within the head office of Queensland Corrective Services.[8]

35. There are now 19 placement options with respect to the number of secure units. These units are located at the Maryborough, Capricornia, Townsville, Woodford and Wolston Correctional Centres. While the decision to give protection status is still made within correctional centres, the movement of those prisoners is now a centralised decision.

Gregory Glebow

36. Gregory Glebow had been classified as a protection prisoner since March 2000, at which time he was remanded on a murder charge. He was convicted of that charge in March 2002, and sentenced to life imprisonment. He subsequently spent time at the Arthur Gorrie Correctional Centre (AGCC), before returning to MCC in October 2007. At the time of Mr Gordon's death, Mr Glebow was accommodated in cell 47 of Unit S2. He had entered Unit S2 on 29 September 2011.

37. Recordings from the Integrated Offender Management System indicated that Mr Glebow had been associating closely with another prisoner, Carl McLaren, within Unit S2. Mr Glebow was allocated the role of unit cleaner at the prison. Despite this, a number of entries on IOMS recorded that other prisoners were undertaking his duties.

38. Mr Ingram's evidence was that Mr Glebow and Mr McLaren were the 'heads' of Unit S2.[9] He said they exerted considerable influence over other prisoners within the unit, which resulted in them receiving various

[8] T2 – page 18
[9] Exhibit B 29

favours and advantages. These included obtaining extra rations through buy-ups, sexual favours and pressuring other prisoners to perform daily tasks normally assigned to the heads. A failure to comply with the demands of the heads could lead to further intimidation and assaults.

39. There were several recorded incidents involving Mr Glebow's participation in fights with other prisoners. A prisoner had also alleged he had been raped by Mr Glebow on several occasions while he had been imprisoned with Mr Glebow at the AGCC in 2007.

40. Further intelligence provided to investigators about prisoners Glebow and McLaren was that other prisoners housed in S2 had been raped by Mr Glebow and McLaren throughout 2012. During the course of the CSIU investigation, it was discovered that prisoners performed sexual favours for other prisoners as a form of prison currency, such that personal debts could be paid in that manner. However, those who made these allegations did not give sworn statements to the investigators.

41. Investigators were unable to confirm whether Mr Gordon was indebted to any prisoners within Unit S2. There had been contact between him and correctional officers in June 2012 where he alleged he had been raped. Mr Gordon was taken to an interview room so he could be spoken to by correctional officers about his complaint. However, Mr Gordon then told correctional officers that he was joking; and no further action was taken.

42. DSC Peake's evidence at the inquest was Mr Glebow was able to present to prison staff as 'a model prisoner' but he had to be treated very carefully, because he was using that as a means *to avert suspicion from what he was actually up to and what he was actually doing. They left him – if they didn't worry about Mr Glebow, then Mr Glebow was free to – to get up to what he wanted to do*.

43. CCO Ingram's evidence was that Mr Glebow would often be involved in physical altercations with other prisoners. These tended to be related to other prisoners questioning his status – *somebody else that was pushing his buttons and he wanted to continue with his status, so he would fight them*. He said that Mr Glebow was *very involved in prison politics and it was his lifestyle and he worked it very well*.

Events leading up to the assault

44. In the lead up to Mr Gordon's death, correctional staff and management were attempting to manage serious issues involving prisoners from S2 and S4.

45. The CSIU investigation revealed that on 15 August 2012, a fight occurred between a prisoner also housed in Unit S2, Cameron Smith, and prisoners Mark Cone and Jamie-Lee King from Unit S4. It was suspected that this incident may have been a pre-cursor to Mr Gordon's

murder, as Mr Glebow and Mr McLaren were both known to be supporters of prisoner Smith.

46. Mr Ingram's evidence was that as tension between Units S2 and S4 appeared to be unresolved, he had interviewed Cameron Smith about the issues on 9 October 2012, together with intelligence analyst, Brett Cunnington, and MCC's general manager, Trevor Craig.[10] After this interview it was determined that Glebow and McLaren would be transferred to units S4 and S3 respectively to break up prisoner Smith's power base. Mr Glebow had previously resided in S4 from September 2010 to September 2011.

47. After Mr Glebow was informed by senior prison management that he was being moved from Unit S2 to Unit S4, he was reported not to have voiced any objections to the move or concerns for his safety within S4. On the other hand, McLaren said that he was concerned that his move to S3 would make him look like a 'grub', as he was being moved to a privileged unit immediately after being interviewed by senior officers within the prison.

Searches in S2 and S4

48. On the day of Mr Gordon's death, correctional staff also conducted a number of unplanned searches of prisoners and their cells in Units S2 and S4, based on recent intelligence received about a potential fight involving weapons between prisoners in those units. There was no formal plan or risk management associated with the search.

49. The evidence at the inquest was that the searches involved 100 separate cells. The methodology used in Unit S4 was that prisoners were ramped as searches progressed. This meant that only three prisoners were permitted to be out of their cells as those cells were being searched. The others were locked down.

50. As the day progressed there were delays in finalising the searches. It was reported that in order to avoid tiredness for the drug dogs involved in the search a different methodology was adopted in Unit S2. This was to progressively decant the 25 prisoners from each floor of Unit S2 into the exercise yard as the searches proceeded in lots of three cells. That is, as the search of each lot of three cells was completed the three relevant prisoners were sent to the yard.

51. It would appear that whatever methodology was adopted, Mr Glebow and Mr Gordon could still have been placed in the exercise yard at the same time as they were in cells 47 and 45 respectively.

[10] exhibit B29

52. In addition, the evidence was that prisoners within S2 were ordinarily permitted to associate in the exercise yard as a group on a daily basis and, as DSC Peake conceded, there was no specific intelligence that anyone within the unit was at risk at the time of the assault on Mr Gordon.[11]

53. CCO Lamprey's evidence was that by the time Mr Glebow's cell was searched he had already packed up his room in readiness for the move. He was compliant during the search of his cell.

54. Only one officer was allocated to supervise prisoners from Unit S2 in the exercise yard during the search. Observations were conducted from the officer's station which was shared between secure units S2 and S3. One officer was responsible for observing both units at the same time, and it was not possible to observe the whole exercise yard from within the officers' station. Reliance was also placed on CCTV surveillance.

55. It is significant that the current General Manager at the MCC, Darryl Fleming, expressed the view that this level of supervision was inadequate.[12] His evidence was that current search practices require direct observations to be conducted from within the unit and the exercise yard. Unless the search is emergent, a detailed plan is required that includes prisoners supervision roles and responsibilities. This plan must be approved by a senior officer prior to the search activity being undertaken.

Weapons in the exercise yard

56. While prison officers were conducting detailed searches of the 50 cells in Unit S2 for weapons that might be used in a conflict with prisoners in S2, the unit's exercise yard contained an array of readily available items that could be used to attack another prisoner or a CCO. Gym equipment has previously been used to carry out murders in Queensland prisons and it is a matter of concern that loose items of gym equipment continued to be accessible in 2012.

57. Detachable handle bars from a Pilate's machine were the most concerning item, along with broom handles. The presence of these items formed the basis of an issue for investigation at the inquest, namely the availability within Queensland prisons of items similar to the metal exercise bar used to assault Mr Gordon.

58. Dog Squad Supervisor, Peter Beaumanis, had been employed at the MCC for nine years at the time Mr Gordon's death. He told the inquest that on the morning of the death he attended a briefing with two other dog handlers in relation to the planned search of units S2 and S4. The

[11] T1- page 21
[12] Exhibit B65

officers assisted in the search using drug dogs. Their role was to put a passive alert drug dog over the prisoners and through the cells and through the rest of the units.[13]

59. Mr Beaumanis' evidence was that at approximately 8:45am he found a blue box filled with bags and broken bits of exercise equipment in the exercise yard of Unit S2. He had not seen this equipment previously and noted that he was not regularly within the exercise yard of Unit S2. He said that he then briefed supervisor Carl Jespersen and suggested that the equipment be removed. Mr Jespersen told him that he would talk to Accommodation Manager Alan Ingram about the exercise equipment.

60. Mr Jespersen agreed in his evidence at the inquest that he spoke with Mr Beaumanis and Mr Ingram about the presence of the loose exercise equipment. Mr Ingram had directed Mr Jespersen to remove the equipment so it could be inspected later. However, Mr Jespersen did not pass on this request to Mr Lamprey but was aware that Mr Lamprey had discussed it with Mr Beaumanis.

61. Mr Beaumanis later spoke directly to Mr Ingram, who agreed that the equipment was to be removed and placed in his office. Mr Beaumanis said that he also conveyed this information to Mr Lamprey.

62. Mr Ingram agreed that he spoke to Mr Jespersen about the gym equipment on 9 October 2012. However, Mr Jespersen told him the equipment was not broken but was a box of interchangeable pieces for the Pilates machine. Notwithstanding, he told Mr Jespersen that it should be removed and assessed and *if there's nothing wrong with it, we'll put it back*. [14]

63. The evidence of search coordinator CCO Lamprey was that he arrived at work on 9 October 2012 unaware that he would be searching Units S2 and S4 for makeshift weapons on that day.[15] He had been employed at MCC since 2003 and was aware that the loose and broken equipment had been in Unit 2 and other units *for a considerably long time*.

64. Mr Lamprey said that a search was conducted of the exercise yard before prisoners were placed in the yard. He said that he would have looked for drugs *or what we were actually looking for, weapons, that could have been hidden behind the bars*.

65. Mr Lamprey acknowledged that Mr Beaumanis had told him on the morning of 9 October 2012 that the boxes of loose equipment should be removed. He had removed a box from another unit and agreed that leaving the items in the exercise yard of Unit S2 was an oversight – 'it was just overlooked'.

[13] T1- page 24
[14] T1 – page 65
[15] T1 – page 36

66. Mr Lamprey's evidence was that it had already been accepted by prison management that it was an appropriate idea for the items to be removed and a direction had been made for that removal to occur. In accordance with this direction, items had been removed in relation to the other units. He acknowledged that, with respect to the search of Unit S2, correctional officers had simply overlooked the direction.

Beaumanis' report

67. Later on 9 October 2012 Mr Beaumanis generated an Officer's Report to the General Manager about his earlier discussions with Officers Jespersen and Ingram. The subject line of the report was 'Broken Gym Equipment in Secure two yard'.

68. It became apparent after the conclusion of the CSIU investigation that this report was not provided to investigating police from the CSIU. As it was concerning that that report did not find its way to investigating police and, further, took some time to get to the investigators appointed by the OCI, the issue became one considered during the inquest.

69. After hearing all the evidence regarding the issue, I am satisfied that the reasons for it not being provided to the CSIU investigators are now well enough established. It was confirmed during the inquest that the report was submitted. It was emailed to at least six other officers at the prison, including the General Manager.

70. There is insufficient evidence for me to find that there was anything sinister or fraudulent in the process and how it did not find its way to being included in the incident report for Mr Gordon's death. The evidence of Mr Jespersen, who was charged with that process, was clear enough. He noted that the report was about 'broken gym equipment' and he did not immediately appreciate its relevance to the inquiry into Mr Gordon's death, consequently did not attach it to the Integrated Offender Management System.[16]

71. I agree with the submission of Counsel Assisting that there is no basis on which I can find that Mr Jespersen was dishonest. I accept that the reason the report was not annexed initially was an oversight.

Assault and aftermath

72. Footage of the assault inflicted on Mr Gordon by Mr Glebow was captured on CCTV, a copy of which was tendered at the inquest. The relevant passage runs from 14:41:10 hours to 14:45:00 hours. It is apparent from that footage that Mr Gordon was seated on a bench in the exercise yard with his back to Mr Glebow at the time of the assault. A

[16] T1- page 51

blue crate, containing two sets of metal handlebars was also positioned on the bench.

73. At 14:43:34 hours, Mr Glebow can be seen on the footage and appears to swing an object in the direction of Mr Gordon's head. Mr Gordon then fell onto prisoner Davidson, who had been sitting next to him on the bench. Davidson stood up and moved away. Mr Gordon remained slumped onto the bench and he appeared to be bleeding heavily from his head. Mr Glebow then informed correctional staff, words to the effect that there was a dead prisoner in the yard.

74. After being alerted by Mr Glebow, correctional officers entered the exercise yard at 14:45 hours and saw Mr Gordon slumped over the bench. All other prisoners were maintained around the outer perimeter of the exercise yard. Correctional officers Craig Dennison and Glen Eastaughffe commenced first aid, and were assisted by correctional officer Peter Mackenzie once he returned to the scene. A medical team consisting of two registered nurses arrived on the scene at 14:48 hours.

75. CPR efforts consisted of chest compressions and use of Automatic Electric Defibrillator pads attached to the chest. There was no palpable pulse, and a cardiac rhythm could not be detected. An oxy-viva mask was also applied; however, Mr Gordon's teeth were clenched firmly shut so an airway could not be placed inside the mouth. Dr Lawrence Lip arrived on scene and assessed the situation. He subsequently declared Mr Gordon deceased at 14:57 hours.

Motive for the assault?

76. A range of theories about why Mr Glebow assaulted Mr Gordon on 9 October 2012 emerged during the investigation.

77. The CSIU investigation raised allegations that some prisoners had informed Mr Glebow that Mr Gordon had been providing information to custodial officers to divert suspicion from themselves.

78. A conversation between Mr Glebow and Mr McLaren was also overheard by other prisoners and CCO Eastaughffe in which Mr McLaren said to Mr Glebow words to the effect *You gotta do what you gotta do to get a ticket to the MSU*. According to CCO Eastghauffe, this conversation took place just before the murder, during the lunch period on 9 October, 2012.

79. The initial CSIU investigation concluded that Mr Glebow probably killed Mr Gordon to avoid being transferred from S2 to S4. It was believed at that time that Mr Glebow received threats from another prisoner in relation to a number of sexual assaults by Mr Glebow on other prisoners.

80. The evidence of DSC Peake at the inquest[17] was that Mr Glebow was not concerned about the implications of being placed in S4 in the aftermath of the conflict between prisoner Smith and other prisoners in S4. He said that Mr Glebow had a *bigger issue with a drug debt owed to another prisoner in S4 who was also very influential and very likely to carry out his threats*. However, this fact was not known to officers within the prison until after Mr Gordon's death.

81. Statements were tendered at the inquest from a number of prisoners, which outlined a number of alleged rapes involving Mr Glebow. The statements from those prisoners also indicate Mr Gordon may have been exploited or pressured to perform menial tasks or sexual favours for Mr Glebow and Mr McLaren. Several prisoners also confirmed that they saw Mr Gordon performing paid employment on behalf of Mr Glebow and Mr McLaren.

82. Ms Samantha Newman's evidence was that she had two conversations in March and May 2016 with Mr Glebow about the circumstances surrounding Mr Gordon's death. Ms Newman, a psychologist, described Mr Glebow as *a complex individual with high levels of anxiety*.

83. Mr Glebow told Ms Newman that he was stressed at the time of the death about conflict with other prisoners in the protection area at MCC and the subsequent advice that he would be moving to Unit S4. Ms Newman said that he had decided that he needed to get out of the MCC, and to do so he made the decision to kill another prisoner in order to give effect to that outcome.

84. Mr Glebow told Ms Newman that Mr Gordon was not in any way deliberately targeted by him in terms of particular selection as the chosen victim. He had identified another prisoner that he could assault but that prisoner was not in the unit at the relevant time. This led to him ruling out other people that he was associated with, and it appears that Mr Gordon was simply a prisoner available to him to inflict harm upon at the relevant time. Mr Glebow denied that he was fearful of any particular prisoners in Unit S4.

85. In the absence of any direct evidence from Mr Glebow, his disclosure to Ms Newman is likely to be best explanation of his motive for assaulting Mr Gordon. It is likely that he was trying to avoid moving to Unit S4 and the assault would ensure that he would be sent to the MSU.

Autopsy results

86. A full internal autopsy examination was carried out by forensic pathologist Professor Peter Ellis on 12 October 2012. Professor Ellis completed a report, and that report was tendered at the inquest.

[17] T1 – page14

87. Preliminary CT scanning revealed an obvious oval defect in the right temporal bone of the skull together with evidence of bone fragments had been pushed into the cranial cavity. Additionally, there was evidence of damage to the underlying brain tissue, the introduction of air into the cranial cavity and damage of the tissue around the carotid artery and pituitary fossa in the middle of the head.

88. Professor Ellis explained in his report that whilst the bone of the skull was fairly thin at the point of contact, it is likely that considerable force was used to penetrate it without causing radiating fractures of the temporal bone. It was evident that the penetrating object extended into brain tissue, the pituitary fossa and the carotid artery. Professor Ellis considered that death would have occurred very quickly.

89. Professor Ellis was shown the metal handlebar at the time of conducting the autopsy. Professor Ellis confirmed that the dimensions of the protruding ends of the handlebar were consistent with the dimensions of the injury in the right temporal bone. Toxicological examination revealed nothing of significance. Professor Ellis determined the formal cause of death to be from a penetrating head injury.

Conclusions

90. Mr Gordon died two days before his release date as a result of a violent, unprovoked assault from another prisoner. Mr Gordon's death could have been prevented if he had been released from prison earlier, or had been accommodated in another unit at the MCC (or elsewhere) where he was not exposed to other inmates with a propensity for violence.

91. Mr Gordon was unable to be released from prison before his sentence expired because he was not able to identify an address to be released to that was acceptable to the Parole Board. He was not a person who posed a significant risk to the community. As the family's submission noted, he would likely have been released to homelessness at the end of his sentence. Neither his interests nor those of the community were served by his imprisonment at the time of his death.

92. The inquest examined the adequacy of facilities and procedures in place at MCC for the placement of prisoners into protective custody. Evidence was heard with regard to the capacity of the General Manager at the MCC to accommodate protection prisoners at the time of Mr Gordon's death, and the decisions that were required to be made in relation to the placement of protection prisoners.

93. Mr Gordon's family submitted that he should have been moved to another protection unit within MCC or to another low security facility. However, it is clear that he did not want to be relocated from MCC and had not applied to be moved to another protection unit. Having regard to his short sentence, he appeared happy to remain in Unit S2, until he was eligible for unsupervised release into the community.

94. It was also clear from that evidence that the options in relation to the placement of protection prisoners within MCC were very limited at the time of Mr Gordon's death. The situation at MCC has not improved significantly since 2012, as prison numbers now exceed built capacity, and prisoners are sharing cells with increasing frequency.

95. Considering those limitations, I accept the submission by Counsel Assisting and QCS that there exists no basis for criticism of the authorities in charge of MCC at the time of Mr Gordon's death with respect to the decisions they made in relation to the placement of protection prisoners, including Mr Gordon.

96. Notwithstanding, it is less than ideal for a slightly built and young non-violent prisoner like Mr Gordon to be accommodated in the same unit as a prisoner with a known history and potential for violence like Mr Glebow, who was free to associate with all other prisoners within the unit.

97. Counsel Assisting submitted that the only recommendations I could reasonably make in the circumstances relate to the built infrastructure and capacity of MCC. However, these matters were not examined in any detail during the course of the inquest.

98. I accept that some progress has been made in relation to putting in place systems that allow those in charge of prisons more options with regard to placement of prisoners across the State. There is now a centralised process for the transfer of protection prisoners between prisons, and between the 19 protection units throughout Queensland.

99. I accept the evidence of Ms Newman as to the changes in procedure that are in place, and the further options that are available.

100. Mr Gordon's death might also have been prevented if equipment that was easily used as weapons was not readily available to the prisoners in the exercise yard within the Protection Unit.

101. The failure to remove loose items of metal exercise equipment was an oversight that led to a catastrophic result. Counsel Assisting submitted that it was a failure that is understandable in the circumstances, as officers were trying to conduct a search and to get that search completed as quickly as they could.

102. I acknowledge that the failure to remove the equipment on the day of Mr Gordon's death may have been a simple oversight. Of greater concern is the fact that the evidence indicated that the items had been in the exercise yard, and thus available to a large number of prisoners on a relatively unsupervised basis since 2003. This was despite other prison deaths as a result of assaults with exercise equipment.

103. The evidence at the inquest confirmed that MCC has since removed such items, and that a system of risk assessment is now in place.

104. The adequacy of the supervision of prisoners at MCC during cell searches was also an issue canvassed during the inquest. The evidence on this issue confirmed that there was a deviation from the usual procedure in this case. The evidence at the inquest confirmed that such a search was necessary that day, given the intelligence provided to prison authorities warranted that all cells in units S2 and S4 be searched expeditiously.

105. I consider that it was reasonable for the CCOs to conduct such significant cell searches earlier on the day of Mr Gordon's death, given the intelligence that had been received about the potential conflict involving makeshift weapons between Unit S2 and S4 prisoners.

106. In the circumstances, I accept the submission of Counsel Assisting that such deviation in the search methodology was one which was adequately explained and reasonable in the circumstances. It was one that was necessary to conclude a very significant search of cells.

107. However, I consider that the degree of planning for the search and the level of supervision of prisoners within the exercise yard during the search of Unit S2 were both inadequate.

108. I do not accept the submissions of Counsel Assisting and QCS that Mr Glebow would have carried out the assault on Mr Gordon or another prisoner regardless of the level of supervision in place.

109. While he clearly had the intent to carry out an act to avoid being moved to Unit S4, it appears that he acted in an opportunistic fashion and it is possible that the death might have been prevented if an officer was located in the exercise yard, and supervising a smaller number of prisoners.

110. I consider that the first aid Mr Gordon received after the attack 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.

Findings required by s. 45

111. 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 Leonard Raymond Gordon.

How he died - Mr Gordon died as a result of being assaulted by another prisoner with a metal bar while he was an inmate in the Protection Unit at Maryborough Correctional Centre.

Place of death – He died at the Maryborough Correctional Centre in the State of Queensland.

Date of death – He died on 9 October 2012.

Cause of death – Mr Gordon died from a penetrating head injury.

Comments and recommendations

112. Section 46 of the *Coroners Act*, 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.

113. I note that a number of recommendations were made as a result of the OCI report. I consider the following recommendations from the OCI report are directly relevant to the issues considered at the inquest:

Recommendation No. 1
QCS consults with the Queensland Parole Board for possible solutions to the issue of prisoners who are eligible for release from secure custody but remain incarcerated due to the lack of a suitable address to be released to.

Recommendation No. 2
MCC is reminded of the requirement to document/record significant intelligence and decision-making processes and also asked to consider the merits of increased monitoring and supervision of prisoners during and immediately after searches.

Recommendation No.5
QCS take steps such that there are greater incentives for prisoners who do not wish to go to low custody centres in order to continue to have contact with friends and family from the local area.

Recommendation No. 6
QCS take steps to ensure that prisoners who present a significant risk to other protection inmates should instead, where reasonable to do so, be managed in the mainstream population on the basis of limiting their association with key individuals.

Recommendation No. 7

QCS implements a more accountable progression process in respect of its protection units.

114. I was provided with detailed statements setting out the QCS response to these recommendations.[18] I am satisfied that the recommendations made in the OCI Report, and the actions that QCS has taken with respect to them, will contribute towards preventing a death in similar circumstances from happening again.

115. Recommendation 3 of the OCI Report concerned the response to several specific complaints of sexual assault. Recommendation 4 concerned the barriers to making complaints of sexual assault in prisons, and effectively responding to complaints or suspected assaults. While there was insufficient evidence at this inquest to conclude that Mr Gordon had been sexually assaulted in prison, I was also provided with a detailed statement setting out the QCS response to these recommendations.

116. As noted above the Report of the Queensland Parole System Review also contains a number of recommendations that, once implemented, would assist a prisoner in Mr Gordon's position though more effective case management, access to accommodation and planning for re-entry into the community. The Report identified that three of the most important factors in a prisoner's success on parole were a home, a job and freedom from substance misuse.

> *Parolees the subject of court ordered parole commonly start parole homeless. For others, there can be no parole without proof that there will be suitable accommodation; but accommodation is difficult enough to secure for anyone convicted of a serious crime and it is even harder to secure from behind the walls of a prison.*[19]

117. Relevant recommendations, which have been accepted by the Queensland Government, include:

Recommendation No. 12
Queensland Corrective Services should implement a dedicated case management system that begins assessing and preparing a prisoner for parole at the time of entry into custody and should consider utilising a model whereby a dedicated Assessment and Parole Unit is embedded in each correctional centre.

Recommendation No. 16
Queensland Corrective Services should provide for continuity of case management for offenders returned to custody on parole suspension.

Recommendation No. 32

[18] Exhibits B62-B66
[19] Page 16

The Government should undertake a short-term evaluation of Queensland Corrective Services redesigned re-entry service after 12 months of implementation, with a further review prior to the contract renewal period.

Recommendation No. 33
Queensland Corrective Services should expand its re-entry services to ensure that all prisoners have access to the services, including specialty services to assist remandees and short sentenced prisoners.

Recommendation No. 34
An intergovernmental taskforce, with representation from the Department of Housing and Public Works, Queensland Corrective Services and the Department of Premier and Cabinet, should be established to examine the issue of the availability of suitable long-term accommodation for prisoners and parolees.

118. I have had regard to the recommendations made in the report of the Office of the Chief inspector and the QCS response to those recommendations.

119. I have also had regard to the relevant recommendations made in the Queensland Parole System Review Report and the Queensland Government's commitment to implement those recommendations.

120. I do not consider that there are any further recommendations I could reasonably make at this time to prevent a similar death from happening in the future.

121. I close the inquest.

Terry Ryan
State Coroner
Brisbane
28 February 2017