WHEN WILL PEOPLE READ THE RECOMMENDATIONS?

Rory Downey*

This article looks at the deaths of three Aboriginal men who were in custody in Queensland. One death occurred shortly after the man was arrested and still in police custody. The other two deaths happened when the men were inmates at correctional centres. The purpose of this article is to show that the deaths could have been prevented by authorities and to restate the essential matters which can prevent similar situations recurring.[1]

As this article refers to three men who have passed away, it may be distressing for Aboriginal and Torres Strait Islander people, and especially the kin of these deceased men, to read this article. We have referred to official documents and the reports of the State Coroner when noting the circumstances of the deaths of these men and used their names as cited in those documents.

I Mulrunji Doomadgee

The Acting State Coroner for Queensland found that Palm Island resident, Mulrunji Doomadgee, died on 19 November 2004,[2] while he was in the cells at the Island's police station. The Island is offshore from Townsville and in a bygone era was the place where Aborigines were 'resettled' by government direction.[3]

The findings of the inquest were handed down on 27 September 2006. As well as carefully detailing the events that led up to this tragic death, the Coroner also made comment on how the police dealt with the deceased immediately prior to him being taken into custody and while he was in custody.[4] In addition, the Coroner addressed the official police inquiry into the matter, detailing how the police investigation was defective and how future investigations could be significantly improved.

I will briefly detail the facts that came out of the inquest and then discuss those comments made by the Coroner for improving the practices of the Queensland Police Service as they relate to Aboriginal and Torres Strait Islander people.

A Facts[5]

In the morning on the day that Mulrunji passed away, 19 November 2004, three sisters who lived on Palm Island claimed that one of the women's de facto husbands, Ron Bramwell, had assaulted them all. The women's complaints were followed up at the Palm Island Hospital by Senior Sergeant Christopher Hurley, who was the officer in charge on the Island. Senior Sergeant Hurley then agreed to help one of the women obtain medication from the Bramwell house. Together with the woman and Police Liaison Officer Lloyd Bengaroo, Senior Sergeant Hurley drove to the Bramwell household. While the woman went inside to get her medication, a man named Patrick Bramwell, who was outside the house and evidently intoxicated, began swearing at the police. He was arrested by Senior Sergeant Hurley. Mulrunji, who knew Patrick Bramwell and who appeared to also be intoxicated, was walking past as the arrest was being made, and he made comments to Mr Bengaroo criticising the arrest. He was told to move on by Mr Bengaroo, and he did so. As he walked off down the street, he turned back to the police officers and swore at them. Following this, Senior Sergeant Hurley drove down the street and arrested him. The fact that Hurley did not know Mulrunji after having

worked for two years on the Island was an indication that he was not a troublemaker.[6]

Mulrunji and Patrick Bramwell were driven to the police station, both in the rear cage area of the police vehicle. Senior Sergeant Hurley went to bring the men into the station, and Mulrunji was removed from the cage, 'still protesting his arrest and detention and resisting being taken into the police station.'[7] As this was happening, Mulrunji allegedly hit Senior Sergeant Hurley on the jaw with the back of his fist. Senior Sergeant Hurley, 'shocked at the challenge to his authority on Palm Island',[8] punched Mulrunji in the ribs. The pair then wrestled as Senior Sergeant Hurley dragged Mulrunji toward the door of the police station. After both men fell through the entrance, Senior Sergeant Hurley 'hit Mulrunji whilst he was on the floor a number of times'.[9] An Aboriginal witness stated that he saw Senior Sergeant Hurley bending over the prostrate Mulrunji, with Senior Sergeant Hurley's 'elbow going up and down three times'.[10] The witness said he heard Senior Sergeant Hurley saying, 'You want more Mr Doomadgee, you want more? Have you had enough Mr Doomadgee?'[11]'

The Coroner also noted that Senior Sergeant Hurley was a huge man, far bigger than Mulrunji. Senior Sergeant Hurley told the inquest he was 'six feet seven inches tall' and Clements found that 'his build was proportionate to [his] height'.[12] Mulrunji was 181 centimetres tall and weighed 74 kilograms.

Mulrunji was dragged away and deposited in a cell at 10:28 am, without any attempt to check on his state of health. As the Coroner noted,

> Mulrunji cried out for help from the cell after being fatally injured, and no help came. The images from the cell video tape of Mulrunji, writhing in pain as he lay dying on the cell floor, were shocking and terribly distressing ...[13]

It was concluded by the Coroner that his cries must have been able to be heard from the police station dayroom, where the monitor showing footage from the cells was also running. At 11:23 am, another officer nudged Mulrunji with his foot and then found no pulse. Of this, the Coroner commented: 'The so called arousal technique of nudging Mulrunji with a foot is not appropriate. It cannot be sanctioned.'[14] The Coroner concluded that 'the response [of police to Mulrunji's injuries] was completely inadequate and offered no proper review of Mulrunji's condition or call for medical attention. The inspections were cursory and dangerous even had Mulrunji been merely intoxicated.'[15] The Coroner found that, notwithstanding the subsequent medical evidence showing that Mulrunji was 'beyond saving', it was 'alarming' that no attempt at resuscitation was made.[16]

An ambulance was called and shortly after 11:30 am a paramedic pronounced Mulrunji dead. Soon afterwards, when Mulrunji's family came to the police station to inquire when he would be released, they were misled and 'sent away'.[17] Mulrunji's partner, Ms Tracey Waddle, informed the author, during a face-to-face interview at Palm Island on 30 November 2004, that she went to visit Mulrunji around 11:30 am at the watch-house in order to get him to sign a CDEP cheque. She was informed by police officers at the watch-house that Mulrunji was sleeping and that she should return later.[18]

Two autopsies revealed that Mulrunji had sustained a number of injuries, the most serious of which concerned his liver. In the words of the pathologist who performed the original autopsy, Mulrunji's liver had been 'cleaved in two',[19] and was only held together by some blood vessels. This had been caused by the application of 'severe compressive force'[20] to Mulrunji's abdomen, and had resulted in an intra-abdominal haemorrhage, which was found to be the cause of death. As the medical evidence showed, it was unlikely that the injury was caused by the fall of the two men through the police station door, and the Coroner found that the actions of Senior Sergeant Hurley, in hitting Mulrunji while he was on the floor, caused his fatal injuries.[21]

The initial police investigation of Mulrunji's death, which began on the day he died, was conducted by police officers who personally knew Senior Sergeant Hurley. Hurley met them at the airport and drove them to the scene of Mulrunji's arrest, something the Coroner thought was 'inappropriate'.[22] In addition, while the investigation was being conducted, the investigating officers shared a meal at Hurley's house. The Coroner found that this was 'completely unacceptable',[23] concluding that the investigation, 'so obviously lacking in transparency, objectivity and independence', was 'reprehensible'.[24] It was not until several days after Mulrunji's death that the Crime and Misconduct Commission ('CMC') took over the

investigation, the impartiality and thoroughness of which the Coroner was satisfied with.[25] Despite the Coroner's findings, Police Commissioner Atkinson did not suspend Senior Sergeant Hurley, but instead placed him on desk duties.[26]

B Issues and Recommendations

The Coroner made some 40 recommendations, which concerned, among other things, the training of police officers working in Aboriginal communities, the need for a greater emphasis on and awareness of alternatives to arrest and detention, and duty of care provisions regarding the detention and supervision of intoxicated persons placed in cells.[27] In relation to police training, the Coroner recommended that the Queensland Police Commission 'should give particular attention to the training of officers working in Aboriginal communities.'[28] The training should be provided before a police officer commences working in an Aboriginal community, and it 'should deal specifically with the recommendations of the RCIADIC [Royal Commission into Aboriginal Deaths in Custody] and how these are relevant to policing and the exercise of discretion to arrest.'[29] In relation to alternatives to arrest, the Coroner recommended that:

> Urgent attention ... be given by the Queensland Government to the establishment of a diversionary centre on Palm Island to provide an alternative to police custody for people who come to the attention of police while intoxicated.[30]

The Coroner also commented that it was completely unjustified for Senior Sergeant Hurley to decide to arrest Mulrunji, particularly if that decision was solely influenced by a desire to check the computer for any outstanding warrants.[31] In addition, the Coroner stated that

> [t]he decision to arrest Mulrunji reflects a lack of awareness on Senior Sergeant Hurley's part of the alternatives to arrest and confusion about their availability in the case of intoxicated persons.[32]

As to the assessment and monitoring of the health of persons placed in custody, the Coroner made a number of recommendations, including the improvement of police health training and the amendment of the Queensland Police *Operational Procedures Manual*. It was evident, the Coroner said, from the inadequate police assessment of Mulrunji's health that not only is there a lack of appropriate health assessment training for police officers in relation to persons held in custody, but that there is also a lack of compliance with RCIADIC recommendations.[33]

The police reaction in some quarters to close ranks around Senior Sergeant Hurley and in effect intimate that police officers should be immune from prosecution is simply unacceptable within our justice system. At present there is virtually no accountability of police officers in the field whatsoever. Matters referred to the CMC are as a matter of course referred back by the CMC to the police service for internal investigation. Human nature being what it is, the police service (seemingly without exception) finds its own officers as being without fault. The Coroner recommended that the CMC 'be actively involved in all investigations into deaths in custody from the outset.'[34]

II Darren Michael Fitzgerald

A Facts[35]

By the time that Darren Michael Fitzgerald, or 'Fitzy' as he was known to just about everyone, was 15 years old he was already appearing in the Children's Court charged with minor criminal offences. Over the next 15 years, he served short periods of imprisonment before being convicted of murder in 1998 and sentenced to life imprisonment, which is the mandatory sentence for murder in Queensland.[36]

At the time of his death, on 13 June 2004, Fitzy was an inmate of the Woodford Correctional Centre, which is situated about 100 kilometres north of Brisbane and is designed for high security male prisoners.[37] He had been under a high security classification for the entire time he was at the Centre.

Fitzy had a lengthy history of drug abuse. Whilst in prison he returned positive results to urine drug screening tests on 15 separate occasions and he was breached for drug-related offences on nine separate occasions. However, Fitzy was described by prison officers as a 'mainly compliant prisoner who was generally easy to manage'.[38] Fitzy was proud that he was an Aborigine. He mainly associated with his half-brother, who was housed in the same unit.

The Coroner found that, on the day of Fitzy's death, 'there was nothing noteworthy or suspicious ... known about [his] actions.'[39] Early in the day he had played football on the oval

at the correctional centre, and at about 2:00 pm he went to the medical unit for some minor treatment of a chronic shoulder injury. Fitzy's half-brother said he saw Fitzy at about 4:00 pm and it was obvious to him that Fitzy had ingested heroin.[40] Fitzy's half-brother was housed on the second level on the opposite side to Fitzy's ground floor cell. He stated that at about 8:00 pm he called out to Fitzy to ascertain if Fitzy was all right, as he knew Fitzy had been using heroin. Fitzy eventually responded, saying he was all right.

A check on the prisoners occurred at 2:00 am on 13 June 2004, when officers saw Fitzy slumped over his desk. A number of officers and a nurse attended the scene and it was evident that Fitzy was dead. An orange syringe cap was lying on the desk and a small syringe and a needle was on the floor under the desk. There was also a small piece of torn envelope with Fitzy's name printed on it that was found to contain traces of heroin. Following an autopsy, it was discovered that Fitzy had a blood morphine level in the high end of the fatal range.[41]

Of the 34 prisoners housed in the unit at the time of Fitzy's death, eight tested positive for opioids. In addition, medical evidence showed that two had been drinking excessive amounts of water, which is used to rid the body of traces of illicit drugs.[42]

B Issues and Recommendations

The State Coroner, Mr Barnes, commented on the negative impact of drug abuse in the community, which is often 'replicated and magnified when the abuse occurs in prison.'[43] He referred to the health risks of drugs in prison, such as the spread of blood-borne diseases, accidental overdose and addiction, and he also referred to the attendant crime risks, such as increased violence and 'standover' tactics between inmates in relation to drug supply and unpaid drug debts.[44] In addition, drugs in prison led to an

> increased risk of official corruption and a resulting compromise to security if prison officers succumb to the temptation to supply drugs in exchange for the inflated prices that will be paid in the captive market.[45]

The Coroner made a number of recommendations designed to reduce the supply and demand of illicit drugs into the Woodford Correctional Centre, and also to improve harm minimisation. The first recommendation was for an increase in resources for the Centre's intelligence section, so as to reduce the supply of drugs into the Centre.[46] The Coroner noted that, since Fitzy's death, a new and more effective drug detection scanner (an 'Ionscanner') had been deployed, and there had been an increase in the number and use of drug dogs at the Centre.[47] The Coroner commented on the fact that visitors are the main focus of the Centre's efforts to reduce drug supply. While drug dogs are occasionally deployed at the Centre's staff entrance, and although all staff are subject to Ionscanning at least once a year, there is much more attention paid to importation by visitors rather than by staff and private contractors.[48] Despite this imbalance between the scrutiny of visitors and staff, the Coroner concluded that there was no evidence received that would enable him to suggest ways of improving the supply reduction strategy.[49] It would seem, however, that regular drug testing of staff might be one way of reducing the supply of drugs in prisons.

The second recommendation was directed at reducing prisoner demand for drugs, the Coroner recommending that, 'as a matter of urgency', the Department of Corrective Services re-establish opioid replacement therapy programs.[50] These programs, which utilise methadone and buprenorphine (or 'Subutex'), are directed at reducing drug withdrawal symptoms, so as to bolster other behaviour-focused programs aimed dealing with the causes of drug abuse.[51] While the Department of Corrective Services already has a number of these behaviour-modification programs in place – indeed, Fitzy had been involved in several 'narcotics anonymous' programs, to little effect – there is only a very limited opioid replacement therapy program running in Queensland correctional centres.[52] Evidence in the inquest suggested that Fitzy had shown interest in going on a Subutex program, but such a program was not available.[53] Notwithstanding the evidence demonstrating the positive effect opioid replacement programs have on crime prevention (both within prisons and in the community after prisoners are released) and prisoner health,[54] a more extensive rollout of these programs has not been forthcoming since program funding ceased in 2003.[55] The Department of Corrective Services is yet to implement the Coroner's recommendation for these programs to be reintroduced.

Lastly, it was recommended by the Coroner that a harm minimisation strategy of providing prisoners with access to clean syringes be adopted by the Department of Corrective Services.[56] This recommendation was made in light of

> the inability of the Department of Corrective Services to keep prisons drug free, and in recognition of its obligation to minimise the spread of blood borne viruses among the prison population and those prisoners will come in contact with after release ...[57]

Despite the Department's claim to being pro-active in its harm minimisation strategy, the Coroner stated that in his view the Department's approach was 'limited to an information campaign'.[58] The unsafe practice of needle-sharing, stated the Coroner, was almost certainly resulting from the Department's treatment of syringes as contraband.[59] The Department's approach, supposedly committed to harm minimisation, flew in the face of the clear evidence of intravenous drug use inside prisons.[60] The approach of the Department to harm minimisation could not be justified on security grounds, with evidence being given that the availability of syringes in European prisons does not result in any reported incidents of syringes being used as weapons.[61] It was concluded by the Coroner that there were no compelling reasons for access to clean syringes to be denied.[62] The Department is yet to implement the Coroner's recommendation.

III Jason Ernest McAvoy

A Facts[63]

Jason Ernest McAvoy was 36 at the time of his death. He was being held on remand from 10 March 2000 until his death on 26 or 27 November 2000 (eight and a half months) at the Townsville Correctional Centre, on a number of sexual offences. Awaiting the resolution of his trial, Jason became anxious as to the trial's outcome, and the effect that the process was having on his family. On a number of occasions, Jason was placed in the Centre's Crisis Support Unit ('CSU') because of concerns that he was at a risk of self-harm – he had stated that he might 'neck himself'.[64] A psychologist's assessment revealed that Jason had a limited ability to cope with his incarceration and the effect it was having on his family. The assessment also revealed that, despite the feelings of guilt and shame visits from his mother brought on, Jason looked forward to those visits. The great importance Jason placed on his mother's visits was known to Centre staff.

In the afternoon of 26 November 2000, Jason's mother, who had come to the Centre to visit her son, was refused entry because a visit had not been booked.[65] When Ms McAvoy said that she was a permanent visitor, one of the corrective services officers explained that permanent visitor bookings had been discontinued about a month earlier. Ms McAvoy said that she had not been informed of this. No consultation took place between Centre staff in charge of visits and staff who knew of Jason's history and the importance he placed on his mother's visits. In addition, staff did not check the possible effect the refused visit might have on Jason. After his mother was refused entry, Jason had a telephone conversation with her. A transcript of this conversation recorded Jason saying that the Centre staff should not be allowed to stop the visit, that he was going to the hospital because otherwise he would do something to himself, that his mother should not fret for him, and that he felt trapped.[66]

The decision was made to return Jason to the CSU. The clinical nurse who made the decision had been told by Jason that he felt fine, but had also been told the contrary by him earlier. The nurse had also observed that Jason was visibly upset and had been crying. The nurse's assessment of Jason was not reviewed by a psychologist.[67] In the CSU he was placed in a cell with another prisoner as a precaution against self-harm, and was checked on every two hours. When an observation was undertaken at around 2:25 am, Jason was found to have hanged himself with plaited material, and a milk crate (which prisoners used to have in their cells as furniture) was at his feet.[68]According to Ms McAvoy, three officers, none of whom were Aboriginal, told her of the death of her son that morning.

B Issues and Recommendations

It is evident from Jason's death in custody that family visitors are very important to Aboriginal and Torres Strait Islander inmates. This fact has, however, been known for a long time. The significance of family for Aboriginal and Torres Strait Islander prisoners had been recognised in 1988 by the Kennedy Review[69] of corrective services in Queensland and also by RCIADIC, in recommendations 168–71.[70] Jason's death also demonstrates the need for consultation with correctional centre staff who are reliably able to assess the impact on a prisoner of such matters as a cancelled visit. It seems likely that the unreflective refusal of a visit pushed Jason over the edge.[71]

The Coroner recommended that risk assessments of prisoners always be conducted by professionally-trained psychologists, rather than by persons (such as clinical nurses) lacking the necessary expertise to make these important assessments. It

was also recommended that, if necessary, an inmate should be kept in the CSU until a psychologist is available to make a proper assessment.[72]

The Coroner found that it was negligent to return Jason to the cell in which he died without first having checked to ensure that there was no opportunity for Jason to self-harm. Checks for hanging points should have been made and items such as milk crates, which could assist an inmate in carrying out acts of self-harm or suicide, should have been removed.[73] The Coroner recommended that the matter of the illegal items in the cells also had to be addressed – such items are either prohibited or not.[74]

A recommendation was also made for the 'buddy system' to be reviewed and implemented. The buddy system is a system where a younger Aboriginal or Torres Strait Islander prisoner is placed in a shared cell with a family member or another Aboriginal or Torres Strait Islander prisoner. It is aimed at reducing feelings of isolation or separation from family which the prisoner might be experiencing, and at providing cultural and spiritual support to the prisoner. The review of the buddy system recommended by the Coroner was to ensure that 'buddies' are adequately informed and that buddy relationships work effectively.[75]

Lastly, the Coroner recommended that a training program be introduced in order to increase the number of Aboriginal and Torres Strait Islander specialists in counselling, psychology and psychiatry.[76]

IV Synthesis of Coronial Recommendations and Necessary Reforms

A Robust Attitude and Common Sense Required of Police Officers

A spontaneous expletive that is an understandable reaction to an unexpected comment or action should not ground an arrest. Many Aboriginal and Torres Strait Islander people, especially many who are homeless, have such a limited vocabulary or ability to express themselves in English that arresting them for swearing reflects the lack of balanced decision-making of the arresting officer. The inappropriate use of 'move-on powers' by police is also often a precursor to such arrests.

B Independent Investigation and Prosecution of Police Officers

A totally independent police watchdog is absolutely fundamental to police and correctional accountability – and thus to the maintenance of the rule of law. That watchdog also needs to have the legislative power to lay charges against police or correctional officers.

C Increased Employment of Aborigines and Torres Strait Islanders in the Justice System

ATSILS recommends employing more Aboriginal or Torres Strait Islander people as police and correctional officers, or as police liaison officers and correctional liaison officers. The recruitment of Aboriginal people and Torres Strait Islanders to 'regular' positions is an important initiative. The special value of these officers is their ability to overcome the communication barriers that exist between Aboriginal and Torres Strait Islander people and authority figures, their awareness of the needs of Aboriginal and Torres Strait Islander people, and their capacity to engender respect for their authority because they do their job in a culturally appropriate way. In addition to the recruitment of more Aboriginal and Torres Strait Islander police and correctional officers, a meaningful training program should be introduced in order to increase the number of Torres Strait Islander and Aboriginal specialists in counselling, psychology or psychiatry, as recommended by the Coroner in the inquest into Jason McAvoy's death.

D Cultural Awareness Education for Police and Correctional Officers

ATSILS considers that something in the nature of the *Aboriginal Benchbook for Western Australian Courts*[77] should be developed to educate police and correctional officers as to cultural awareness issues. The *Benchbook* is intended to provide guidance and assistance to Western Australian judges in relation to cross-cultural issues that may arise in the process of a trial. The *Benchbook* is open to all participants in the criminal justice process. In ATSILS' opinion, the *Benchbook* is a good example of how judicial officers and others in the criminal justice system can be informed of cultural values and of how to communicate in a culturally intelligent way. A similar publication, with a similar form of education, should be mandatory for police and correctional officers.

E Protocol for the Communication of Death to Aboriginal and Torres Strait Islander Relatives

A protocol should be established to ensure that the news of a death in custody is sensitively conveyed to an Aboriginal or Torres Strait Islander next of kin, if possible by an Aboriginal or Torres Strait Islander person.

F The Buddy System

ATSILS considers that, as recommended by the Coroner in the inquest into Jason McAvoy's death, the buddy system should be re-examined and implemented in all Queensland correctional centres. Queensland Corrective Services' guidelines on procedure state that the buddy system 'should not be used as a suicide prevention strategy.'[78]

G Hanging Points

Hanging points include cell bars, air-conditioning vents, shower fittings and any other points in a cell which could be used to support a noose. Nooses are usually made from torn blankets, sheets, clothing, belts or shoe laces. ATSILS considers that these points and all other means of facilitating a suicide, such as milk crates, have to be removed from cells. This removal process is particularly important in cases where it is known that the prisoner is at risk of self-harm, or has experienced a significant setback, family tragedy or trauma.

H Clean Syringes and Drug Dependency Reduction Programs

It is like putting a telescope to the blind eye to suggest that there are not drugs in correctional centres. Supplying 'clean' syringes and instituting effective drug-substitution programs, such as opioid replacement therapy programs, work in reducing levels of infectious disease and drug dependency in the prison population. Politicians should look to the effectiveness of policies and be critical of the 'tough on crime' media hype of some pressure groups.

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1 *Inquest into the Death of Mulrunji* (Unreported, Queensland Coroner's Court, Acting State Coroner Clements, 27 September 2006) 27 <http://www.courts.qld.gov.au/mulrunji270906.pdf> at 21 November 2008.

2 Ibid 2.

3 Foundation for Aboriginal and Islander Research, *Shameful White History of Palm Island* (1999) <http://www.faira.org.au/lrq/archives/199901/stories/shameful-white-history.html> at 21 November 2008.

4 *Inquest into the Death of Mulrunji* (Unreported, Queensland Coroner's Court, Acting State Coroner Clements, 27 September 2006) 2 <http://www.courts.qld.gov.au/mulrunji270906.pdf> at 21 November 2008.

5 This summary of facts is taken from the Coroner's findings in the inquest: see ibid.

6 Ibid 2.

7 Ibid 3.

8 Ibid 26.

9 Ibid 27.

10 Ibid 26.

11 Ibid 21.

12 Ibid 8.

13 Ibid 32.

14 Ibid 32–3.

15 Ibid 32.

16 Ibid 33.

17 Ibid 33.

18 Interview with Ms Tracy Waddle (Palm Island, 30 November 2004).

19 Guy Lampe, quoted in *Inquest into the Death of Mulrunji* (Unreported Queensland Coroner's Court, Acting State Coroner Clements, 27 September 2006) 7.

20 Ibid 7.

21 Ibid 7, 27.

22 Ibid 10.

23 Ibid 31.

24 Ibid 33.

25 Ibid 11.

26 Amanda Watt and Neil Hickey, 'Police Shame' , *The Courier Mail* (online), 27 September 2006 <http://www.news.com.au/couriermail/story/0,23739,20487785-5007200,00.html> at 21 November 2008.

27 *Inquest into the Death of Mulrunji* (Unreported, Queensland Coroner's Court, Acting State Coroner Clements, 27 September 2006) 28ff.

28 Ibid 29.

29 Ibid.

30 Ibid.

31 Ibid 4.

32 Ibid 28.

33 Ibid 30.

34 Ibid 32.

35 This summary of facts is taken primarily from the Coroner's findings in the inquest: see *Inquest into the Death of Darren Michael Fitzgerald* (Unreported, Queensland Coroner's Court, State Coroner Barnes, 19 January 2007) <http://www.courts.qld.gov.au/fitzgerald190107.pdf> at 21 November 2008.

36 Ibid 3.

37 Queensland Corrective Services, *Woodford Correctional Centre* <http://www.correctiveservices.qld.gov.au/About_Us/The_Department/Custodial_Corrections/Woodford_Correctional_Centre/index.shtml> at 21 November 2008.

38 *Inquest into the Death of Darren Michael Fitzgerald* (Unreported, Queensland Coroner's Court, State Coroner Barnes, 19 January 2007) 3.

39 Ibid 4.

40 Ibid 5.

41 Ibid 6.

42 Ibid 5.

43 Ibid 6.

44 Ibid 7.

45 Ibid.

46 Ibid 9.

47 Ibid.

48 Ibid 10.

49 Ibid.

50 Ibid 15.

51 Ibid 10–11.

52 Ibid 11.

53 Ibid.

54 Ibid 13–15.

55 Ibid 13.

56 Ibid 16.

57 Ibid.

58 Ibid.

59 Ibid.

60 Ibid.

61 Ibid 16.

62 Ibid.

63 This summary of facts is taken from the Coroner's findings in the inquest: see *Inquest into the Death of Jason Ernest McAvoy* (Unreported, Queensland Coroner's Court, Coroner Smith, 16 June 2003) (copy on file with author).

64 Ibid 1.

65 Ibid.

66 Ibid 2.

67 Ibid.

68 Ibid.

69 J J Kennedy, *Commission of Review into Corrective Services in Queensland: Final Report* (1988).

70 Commonwealth, RCIADIC, *National Report* (1991) vol 5, pt G, 'Recommendations'.

71 *Inquest into the Death of Jason Ernest McAvoy* (Unreported, Queensland Coroner's Court, Coroner Smith, 16 June 2003) 5 (copy on file with author).

72 Ibid.

73 Ibid.

74 Ibid 4.

75 Ibid 5.

76 Ibid.

77 See Stephanie Fryer-Smith, *Aboriginal Benchbook for Western Australian Courts* (2002) Australian Institute of Judicial Administration <http://www.aija.org.au/online/ICABenchbook.htm> at 21 November 2008. See also Queensland Courts, *Supreme and District Court Benchbook* <http://www.courts.qld.gov.au/2265.htm> at 21 November 2008.

78 Queensland Corrective Services, *Procedure – At-Risk Management (Self Harm/Suicide)* [3.1] <http://www.correctiveservices.qld.gov.au/Resources/Procedures/Offender_Management/documents/ofmprosuicprevention.shtml#3.1> at 21 November 2008.