IN THE MAGISTRATES COURT AT CANBERRA IN THE

AUSTRALIAN CAPITAL TERRITORY

NO.CD 32 of 1998

IN THE MATTER OF AN INQUEST INTO THE DEATH OF IAN GLEN BRANSBY AT CANBERRA ON 14.2.98

Reasons for Decision of Magistrate John Burns Delivered on the 5th day of August 1999

On 14 February 1998 the deceased, Ian Glen Bransby, died at Calvary Hospital in the Australian Capital Territory. At the time of the events leading to his death he was a detainee at the Belconnen Remand Centre. Despite the fact that the deceased did not ultimately die at the Remand Centre, but at a hospital, the circumstances are such that it cannot rationally be suggested that the Court should do otherwise than treat his death as a death in custody.

The ordinary obligations of a Coroner are set out in s.52 of the Coroners Act 1997, which provides:

52. (1) A Coroner holding an inquest shall find, if possible-

(a) the identity of the deceased;

(b) when and where the death occurred;

(c) the manner and cause of death; and

(d) in the case of the suspected death of a person - that the person has died.

(2) (Not Applicable)

(3) At the conclusion of an inquest or inquiry, the Coroner shall record his or her findings in writing.

(4) A Coroner may comment on any matter connected with the death, fire or disaster including public health or safety or the administration of justice.

In the case of a death in custody the Coroners Act 1997 provides, in Part VI of that Act, additional obligations. In particular s.74 provides:

"**74.** The Coroner holding an inquest into a death in custody shall include in a record of the proceedings of the inquest findings as to the quality of care, treatment and supervision of the deceased which , in the opinion of the Coroner, contributed to the cause of death."

S. 52(1) Findings

The formal findings required by sub-section 52(1) of the Coroners Act can be dealt with briefly. They are not in any way in dispute. The deceased was Ian Glen Bransby. His death occurred on 14 February 1998 at Calvary Hospital in the Australian Capital Territory. The cause of death was extensive global cerebral hypoxia following prolonged asphyxia following attempted self hanging.

In order to fulfil the obligations imposed by sub-section 52(4) and section 74 of the Coroners Act it is necessary to examine the circumstances surrounding the deceased's death, including the circumstances surrounding his period in custody at the Remand Centre, together with a brief consideration of his history leading up to his being remanded in custody prior to his death.

History of the Deceased

The deceased had a lengthy history of conflict with authority. He also had a lengthy history of substance abuse. He was first detained at Quamby when he was 15 years old. He was subsequently convicted of 5 counts of escaping from Quamby. He was remanded at BRC on 4 occasions commencing 9 September 1995, 14 November 1996, 2 October 1997 and 31 January 1998. He had served terms of imprisonment at Goulburn and Junee gaols, most recently being released from Junee on 13 September 1997.

During one of his periods at Quamby in 1995/1996 he was reported as being "depressed" and was apparently treated with anti-depressants. His history of unco-operativeness and escape at Quamby was such that staff at that institution instituted industrial action resulting in him spending long periods in his cell and being provided with his meals by management.

After being released from prison on 13 September 1997 the deceased was again remanded in custody on 2 October 1997. He was subsequently released upon recognisance a condition of which was that he was to attend Mancare for alcohol rehabilitation. The deceased only attended that program for a few days.

The deceased was arrested on 30 January 1998 after it was alleged that he was involved in an altercation in Dickson. On 31 January 1998 he was remanded in custody by the A.C.T. Magistrates Court and on the same date he entered the Belconnen Remand Centre.

Period on Remand up to 13 February 1998

Upon being remanded in custody on 31 January 1998 the deceased was conveyed to the Belconnen Remand Centre. Upon arrival at the Centre he underwent an induction assessment.

a) The Induction Assessment

The induction assessment was undertaken by Ms Louise Chia. Ms Chia is a Probation and Parole officer employed by A.C.T. Correction Services. She held the degree of Bachelor of Science from the Australian National University with a double major in psychology. In her studies in psychology she undertook readings that covered some aspects of suicide, depression and self harming behaviours. She is currently undertaking a Graduate Diploma in Counselling Psychology at Charles Sturt University.

In addition to her normal duties, Ms Chia was placed on a roster at the BRC to carry out induction assessments on new detainees on weekends. In November 1997 she was provided with a one hour training course on the Detainee Contact Screening form, the form which was used during the induction assessment. The training given to Ms Chia about the process of induction into the BRC was clearly inadequate. Ms Chia was not advised of the Standing Orders of the BRC relevant to the induction process. She was not informed that only those detainees assessed as "at risk" would subsequently be discussed by staff at the Detainee Review Meetings. She was left with the impression that all detainees were discussed at these meetings. She was also left with the impression that all assessments made by weekend roster staff such as herself would be reviewed during the week by management and other specialist staff.

If, contrary to Ms Chias expectations, the assessments she was to make at inductions on weekends were not to be interim assessments, the information available to her to allow her to conduct the assessment was inadequate. At that time records relating to prior admissions of detainees, including medical records, were locked away on weekends and were unavailable to staff conducting induction assessments. In the case of Mr Bransby the unavailability of this material meant that Ms Chia was unaware of his history of depression at Quamby and the fact that he had been prescribed medication for that depression. Mr Bransby had divulged that history in an induction assessment for an earlier period at the BRC, but did not do so to Ms Chia.

The failure to assure that Ms Chia had access to these documents in order to complete a thorough assessment of Mr Bransby is, as submitted by counsel assisting, not easily excused. Exactly the same issue was addressed by Coroner Somes in his findings in relation to the death of Shannon Robert Camden at BRC on 15 April 1996. These findings were handed down on 1 October 1997. In his findings Coroner Somes said:

"Of even greater concern is the unavailability of past histories of detainees when they first arrive at the BRC."

Evidence was given at the Inquest that more information of detainees histories was now available on a computer data base that was accessible on weekends. It is far from clear to me, however, that all material relating to a detainees history of previous remands is available at the time of initial assessment, particularly on weekends. There is no suggestion that Ms Chia or others who undertake the induction assessments are not adequately qualified to undertake that task. The difficulty is that the task cannot be properly undertaken without access to the past custodial history of the detainee. It would appear logical that detainees should be assumed to be at risk of self harm until an adequate assessment has been completed, which can only occur when the person undertaking the induction assessment has had access to any detainee history. With the technology that is presently available, such as the scanning of documents onto computers and downloading of such information onto storage discs, the traditional problem of storage space for detainee histories should not be a real problem.

Recommendations

1) that no induction assessment be considered to be complete until the officer conducting the assessments has access to the detainees custodial history and has received that material;

2) that until an induction assessment is completed the detainee is to be considered as at risk of self harm;

3) that consideration be given to storing detainee histories in electronic form accessible by an induction officer at all times.

In her submissions the Community Advocate examined the deficiencies in the induction assessment, including the lack of training given to people who like Ms Chia may be called upon to undertake such an assessment. The fact that Ms Chia had a flawed understanding of the procedures of the BRC, particularly on the issue of review of her assessment and ongoing review of detainees who are not initially assessed as at risk of self harm is concerning. Of even more concern is the apparent lack of any formal mechanism for referring detainees who present at induction with alcohol or drug addiction to a specialist alcohol and drug professional for assessment. Whilst I recognise that detainees are not convicted persons, and may exercise their right to co-operate in an assessment with an alcohol and drug addiction professional, the attempt should nevertheless be made. I adopt two of the recommendations of the Community Advocate with regard to this aspect of the case.

Recommendations

4) that all staff conducting induction assessments receive collective training so that both the use of the induction instrument and the procedural arrangement such as reviews and Standing Order, are clearly understood and adhered to;

5) that all detainees who present with a history of illicit drug or excessive alcohol use be referred to a specialist alcohol and drug professional on induction.

Some criticism was made of the assessment of Mr Bransby as not being at risk, even on the material available to Ms Chia. At the time of the induction assessment undertaken by Ms Chia it was observed that Mr Bransby had a wound to his arm. That wound had been previously sutured, but the sutures had been unpicked by Mr Bransby. Ms Chia questioned Mr Bransby about the unpicking of the sutures. In her evidence before the inquest she testified as to that conversation and her assessment of the unpicking of the sutures by Mr Bransby:

"**Q.** I discussed the fact that he'd unpicked his wound because I was concerned. And he described to me that he had been coming - like he had been drunk. He had sort of been in a process of coming down off his alcohol use. And that he had picked at the stitches without really realising what he was doing. More or less describing someone who's bored. Who's sort of in a cell with really nothing to do and he's picking at something as a small child sort of picks at a scab when they're sitting there with nothing to do. He also really expressed some regret at having done that because it was now hurting him. And in fact, you know, mentioned several times that he was concerned about his arm and he wanted to get it attended to because

it was hurting him. In that way I didn't assess him as having committed something which was - what I would consider of concern in terms of self harm.

Q. Possibly with the benefit of hindsight can I put something to you? Would you agree with me that a psychological assessment instrument in its kind of cold objective form would require you to record that unpicking of the wound as an act of self harm and that your subjective assessment of it was in fact that he was concerned about that and that that was contrary to self harm, would you agree with that?---Not necessarily, no.

Q. Could you explain to me why is it the case that you did not record that unpicking of the wound as an act of self harm on the instrument?---In terms of self harm with regard to the persons being seen - being risk of self harm refers in my mind, in terms of a psychological assessment, to refer to a set of behaviours in which the person deliberately self harms themself due to some underlying factors which are unresolved. And that the act of self harm is in a way a means of drawing attention to their problems. In fact a very dangerous way of drawing attention to their problems. This type of behaviour is often continuous, it is not a one off act, it's a problem behaviour which is likely to continue. Of course, in custody any form of self harm would be of concern. But Mr Bransby didn't, by picking at his sutures, hadn't to me indicated that he was - at least when he was going to be not intoxicated, going to be continuing to do acts of self harm. In fact he indicated that he regretted picking at his stitches and was protective of himself."

(transcript 28.1.99 pp 35-36)

It was suggested by the Community Advocate that the actions of Mr Bransby in unpicking the sutures was "objectively" an act of self harm and should have been identified as such. I cannot accept that unqualified proposition. Ms Chia was appropriately qualified and trained to make an assessment of whether Mr Bransbys actions were indicative of a propensity to self harm. To reason from Mr Bransbys later act of self harm that an earlier act should have been identified as an act of self harm (or worse, was such an act) is invalid reasoning. All of the evidence is to the effect that the actions of Mr Bransby in unpicking his sutures was not an attempt at self harm.

(b) Medical Evidence

A number of issues were raised about the nature and standard of the medical care given to Mr Bransby during his remand at the Remand Centre.

The concerns that were raised were:

i) Mr Bransby presented to Dr Rosendahl with a history of consuming a bottle of bourbon a day, using heroin twice per week, using cannabis daily and consuming 5 Rohypnols a day. Dr Rosendahl doubted that history and was concerned that Mr Bransby may have been exaggerating his alcohol and drug history in order to obtain medication, or increased levels of medication;

ii) Dr Rosendahls decision not to have Mr Bransbys arm resutured at hospital, but instead to resuture it at the Remand Centre. This decision was based upon, or at least influenced by, Dr Rosendahls view that the unpicking of the sutures by Mr Bransby was a manipulative act undertaken for the purpose of getting a trip to hospital;

iii) the failure of Dr Rosendahl and other health professionals at the Remand Centre to refer Mr Bransby to a drug and alcohol professional or service;

iv) the fact that Mr Bransbys medical records make no reference to the sutures being removed. The sutures should have been removed 10 days after being inserted. There is evidence of a request for consultation by Mr Bransby "for belly ache and stitches out" but no clinical notes that he was attended to. It is most likely that he was attended to and the sutures removed as there is no note of any sutures remaining in situ on the external examination of Mr Bransby conducted by Dr Jain as part of the autopsy;

v) the decision of Dr Rosendahl to prescribe Largactil to Mr Bransby for his drug withdrawal and insomnia problems, rather than to prescribe a benzodiazapine or similar drug;

vi) the probable failure of the medical authorities at the Centre to organise and follow through on the preparations of a sleep chart for Mr Bransby after his complaints of insomnia. Dr Rosendahl believed he had seen such a chart showing Mr Bransby to have had adequate sleep on the night of observation, by Nurse Dexter who was responsible for organising the preparation of the sleep chart. Certainly no sleep chart has been located on the medical records of Mr Bransby;

Insofar as these concerns raise issues of inappropriate medical treatment of Mr Bransby, I do not accept that such concerns are substantiated. At the time of his arrival at BRC Mr Bransby had unpicked sutures on a wound on his arm. Dr Rosendahl resutured Mr Bransbys arm at the BRC. Although there is some criticism voiced by the Community Advocate of the reasons given by Dr Rosendahl for deciding to suture the wound at BRC and not to take Mr Bransby to hospital to have it sutured, I cannot accept that criticism. There was no suggestion in the evidence before me that the wound to Mr Bransbys arm could not be adequately treated within the environs of the BRC. Dr Rosendahls speculations as to a possible motive for Mr Bransby unpicking the sutures was simply irrelevant to the issue of whether Dr Rosendahl treated Mr Bransbys wound appropriately. All of the evidence is to the effect that he did. Nor is there any suggestion that, even if not commonly prescribed in drug rehabilitation facilities, the drug Largactil was not a proper drug to be prescribed for Mr Bransbys circumstances.

Of much greater concern is the lack of focus in the medical management of Mr Bransby. Mr Bransby had significant medical issues which were identified during his stay at the Remand Centre. These included substance abuse and insomnia. Yet it appears that no plan for management of those ongoing medical issues was devised and implemented. Such a plan could have included referral to appropriate drug and alcohol professionals, and should have included the preparation of a sleep chart. Decision making on medical issues appears to have been ad hoc, and implementation of such decision as were made was not monitored. It is true that Mr Bransby was a remandee and not a prisoner. He had not been convicted of the charges which he faced. He could have refused to undertake alcohol or drug rehabilitation programs. But from the point of view of Mr Bransbys medical well-being a formal, structured attempt should have been made to convince him of the desirability of undertaking such a program. If such a plan had been formulated for Mr Bransby and properly monitored by the medical staff it is unlikely that the preparation of a sleep chart would have been overlooked.

It is also of considerable concern that appropriate records were not kept of Mr Bransbys treatment. No notes were kept of the removal of Mr Bransbys sutures.

Both the Community Advocate and Counsel assisting referred in their submissions to attitudinal problems on the part of Dr Rosendahl and Ms Dexter towards remandees which was partly reflected in an attitude of suspicion towards the histories of substance abuse provided by detainees. There is much to be said for the comments of counsel assisting that:

"...there is a danger involved in health care professionals operating exclusively in an environment like the BRC. There are risks of becoming professionally isolated and perhaps desensitised."

Whilst Dr Rosendahl did not practice solely within the BRC environment, he was the sole medical practitioner who did practice in that environment. The dangers of desensitisation are, however, still very real.

In November 1998 a discussion paper entitled "Improving Health Services to People in Custody in the ACT" was published by A.C.T. Community Care. In her submission the Community Advocate recommended that the adoption of the proposal contained within that discussion paper would substantially alleviate the problems to which I have referred. I understand that the proposals contained in the discussion paper have been implemented, so that further recommendations by this court are unnecessary.

The Events of 13 February 1998

Mr Bransby was observed at 1.55 am by Custodial Officers Collins to be watching television. At 2.23 am Custodial Officers Collins entered A yard and touched the Smartguard sensor. Shortly thereafter he noticed Mr Bransby hanging from the end of his bed. He immediately attempted to radio the Control Room. Owing to a malfunction of the radio he was unable to get an answer to his call. He ran to the Control Room. On the way to the Control Room he encountered Custodial Officers Michael Ryan. Custodial Officers Ryan had been in the Control Room and had heard part of Custodial Officers Collins transmission. Realising that there was a problem he went to find Custodial Officers Collins.

Custodial Officers Collins called for C.O. Ryan to get the master key and the Hoffmann Knife. He returned to A yard. When C.O. Ryan arrived with the master key and unlocked Mr Bransbys cell C.O. Ryan cut the sheet.

Mr Bransby was observed to be blue but warm. There were no vital signs. Custodial Officers Ryan left the scene to obtain a face mask, and when he returned manual CPR was performed. Custodial Officers Allen was in the control room at the time. He contacted the A12 unit over the intercom and was asked to call an ambulance. The ambulance received the call at 2.29 am. One of the ambulance officers, Michelle Blewitt, noted on arrival that Mr Bransbys appearance was "pale in the face, there was no obvious cyanosis or anything in the face". This indicates that the CPR performed by Custodial Officers Collins and Ryan was effective. The ambulance officers took over Mr Bransbys care and he was conveyed to Calvary Hospital.

A number of issues arise out of the events of 13 February 1998:

i) *The failure of the radio;*

The cause of the failure of the radio is problematic. It may have been a problem with the particular radio unit itself, or it may have been that the area in which the radio was used within the BRC was not conducive to good reception. In any event the evidence before the court is that the radios which were then used in the BRC have now been replaced with a better model.

ii) *The Hoffman Knife;*

A Hoffman Knife was not routinely carried by custodial staff at the time of the incident. Subsequently a decision has been made that Custodial Officers should routinely carry such a knife. I accept that the making of that decision has involved a compromise between remandee safety and the safety of Custodial Officers. Whilst a Hoffman knife is not capable of being used for stabbing, it is still capable of being used to inflict an injury.

In all of the circumstances I am not prepared to be critical of the decision which had been made up to that time not to have Custodial Officers routinely carry Hoffman knives.

iii) *The Master Key*;

Undoubtedly the necessity for Custodial Officers Collins to obtain the master key in order to gain access to Mr Bransbys cell resulted in a delay in providing assistance to Mr Bransby at a critical time. It is undoubtedly true that if Custodial Officers Collins had been in possession of the master key such a delay would not have occurred. However I must also acknowledge the legitimate security concerns expressed by Mr James Ryan, the Director of ACT Corrective Services, and Mr Barry Folpp, the superintendent of the Belconnen Remand Centre. Both Mr James Ryan and Mr Folpp expressed the view that it would be inappropriate and would jeopardise the security of the Belconnen Remand Centre if Custodial Officers were to routinely carry the master key. If an inmate were to overpower a Custodial Officer and obtain the master key, then they could release all of the detainees within the centre. Bearing in mind these legitimate concerns, no criticism can be made of the policy that Custodial Officers not carry the master key routinely.

However it is apparent that in circumstances such as those that occurred on 13 February 1998 quick access to the cell is imperative. Undoubtedly the carrying of radios by Custodial Officers was intended to provide a mechanism by which the master key could be rapidly obtained, and entrance to a particular cell facilitated. On this occasion that mechanism failed. There is much to be said for the recommendation of the community advocate that an alarm system in each of the yards would provide a back up mechanism for provision of the master key in the event of a future failure of the radio equipment. As the yards are monitored by video from the control room, the potential for inappropriate use of that alarm system by detainees to obtain the master key would be minimised.

Recommendation

6) That an alarm system be installed in each yard of the BRC to notify staff in the Control Room of an emergency requiring access to a cell as back-up to the radios used by Custodial Officers

No criticism can be voiced of any of the actions of staff at the remand Centre on 13 February 1998 with respect to the death of Mr Bransby. Indeed Custodial Officers Collins and Michael Ryan are to be commended for their actions in performing CPR upon Mr Bransby until the arrival of Ambulance Services.

The Remand Centre Environment.

A number of issues relating to the Remand Centre and the accommodation of detainees within that centre were raised during the proceedings:

i) *Cell Design*

The cell in which Mr Bransby was housed at the time of his attempt at hanging himself had a number of "hanging points". The number of available hanging points had been increased by the relatively recent installation of an upper bunk above the single bed which was originally installed in the cell. The cell in which Mr Bransby was housed was not a "safe cell", but neither was it intended to be. Safe cells are available at the Belconnen Remand Centre. As I understand it those cells are used to house remandees who are determined to be "at risk" of self harm. Mr Bransby had not been assessed as being at risk, and accordingly was housed in an ordinary cell.

Evidence given at the inquest was to the effect that the safer a cell is made (ie the fewer the hanging points) the less habitable it becomes. Safe cells are generally stark, sterile environments which can in themselves engender in detainees feelings of depression and a desire to self harm.

It must also be emphasised that detainees at the Remand Centre are not convicted prisoners. They are entitled to the presumption of innocence, and to be dealt with in a way consistent with being a member of the community who has not been convicted of any offence. There is also much to be said for the proposition that once a cell is less than completely safe (ie it has one or more hanging points) then the number of hanging points within the cell becomes academic. It would be inappropriate to house all detainees within safe cells in order to avoid a remote possibility that a detainee who does not present as being at risk of self harm does in fact attempt to injure themselves. A balance must be struck between the rights of detainees to live in as normal an environment as is possible and the obligations of the state to ensure the safety of detainees within the remand centre. It is for this reason that the assessment of detainees both at the time of induction and throughout the period of their remand in order to determine whether they should be assessed as at risk is so important.

There is much to be said for the proposition that one of the best preventatives of suicide in custody is the housing of more than one detainee to a cell where that is practicable. In Mr Bransbys case the cell in which he was accommodated was designed to house two detainees. It would be preferable in cells with double bunks wherever possible that two detainees be housed rather than one.

(ii) *Contact Visits*

Mr Bransbys mother was denied contact visits on two occasions. As counsel for the Australian Capital Territory acknowledged in their submissions this was regrettable. On the evidence before the court it appears that the practice at that time at the Remand Centre was that detainees were not permitted contact visits within the first 48 hours of their admission. This is unsatisfactory. It does not accord with practice in jurisdictions such as New South Wales. The period immediately after a detainee is remanded in custody is likely to be one of, if not the most, stressful periods for a person whilst in custody. There should be no blanket policy of refusal of contact visits in the period immediately after a person is remanded in custody, and each case should be addressed on its own merits.

(iii) *Isolation*

As pointed out by counsel for Mr Bransbys family, Dr Rosendahl in October 1997 wrote a letter raising concerns about the isolation of detainees for long periods of time. He recommended that lock down time be extended from 6 pm to 10 pm. His recommendations were not implemented due to funding concerns. The isolation of detainees in locked cells within the Remand Centre for long periods of time, including up to half a day, is inexcusable. If the present funding of the Remand Centre is not sufficient to enable staff to allow detainees to remain out of their cells at times other than when a lock down is required for security purposes or ensuring the well-being of all remandees during a sleep period then the onus is clearly on the government of the Territory to provide sufficient funds for the proper staffing of the Remand Centre.

It is necessary to return to the proposition that detainees are not convicted prisoners. The present Remand Centre incorporates all of the worst features of a gaol without having any of the ameliorating facilities available to provide the detainees with meaningful employment, occupations or recreations. It is therefore even more important that detainees not be isolated in cells for long periods of time. It would, of course, be preferable for a new facility to be constructed to replace the present, inappropriate Remand Centre.

(iv) *Police Visits*

It is inevitable that from time to time police will need to speak to detainees. In Mr Bransbys case police spoke to Mr Bransby and made him aware of the fact that he was to face new serious charges on his next appearance before the court. The staff at the Belconnen Remand Centre were not aware of the reason for police speaking to Mr Bransby. It is common sense that Mr Bransbys status in terms of whether he was or was not at risk may change after a significant event such as being advised that serious new charges are to be proffered against him. It is preferable that appropriate staff review the status of a detainee in those circumstances. Evidence was give at the inquest that a new protocol has been drawn up between the police and Corrective Services to ensure if a police officer attends at the Remand Centre to interview a detainee about a matter which could influence the detainees "at risk" status, the police undertake to pass on to Remand Centre staff such information as is necessary for the Remand Centre to be aware of a possible change in the detainees status.

Conclusions - S.74 Coroners Act

In these findings I have concentrated upon what I perceived to be the failings within the Remand Centre in the period leading up to the death of Mr Bransby. However for the purposes of section 74 of the Coroners Act I must determine whether any of those failings can be identified as having contributed to the cause of death of Mr Bransby.

Having considered all the evidence carefully I am not able to form a positive opinion that any of those failings contributed to the death of Mr Bransby in any meaningful way. I am not persuaded that Mr Bransby should have been identified as a detainee at risk of self harm. Whilst it would have been preferable for Remand Centre staff to have access to Mr Bransbys custodial history at the time of his induction assessment, the evidence of his presentation at the time of his assessment and in the weeks following would not have warranted his being labelled at risk.

And whilst a focussed structured medical regime would have been preferable in the interests of Mr Bransbys well being, it is difficult to infer from the evidence that Mr Bransby perceived that his needs were not being met. Certainly there is no evidence of complaint by Mr Bransby to other detainees, or to Remand Centre staff, with some of whom he was on quite good terms.

I must therefore decline to make a finding that the care, treatment and/or supervision of Mr Bransby at BRC contributed to the cause of his death.

Attitude of Mr James Ryan to the Inquest

Before concluding I am moved to comment upon the lack of co-operation shown by Mr James Ryan, the Director of ACT Corrective Services, with the investigation of Mr Bransbys death by police assisting the Coroner. Despite numerous requests over many months Mr James Ryan declined to provided a statement to investigators, and only provided a statement to the Coroner a day before the inquest was due to commence on 8 December 1998. As a consequence a scarce community resource, two days of court time, was wasted together with the cost of the legal representation for other parties. I direct that my comments in this regard be brought to the attention of the Minister for Justice and Community Safety, as the Minister responsible for Corrective Services.