QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Duke Allan Wayne Schafer**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2020/1867
DELIVERED ON:	1 October 2025
DELIVERED AT:	Brisbane
HEARING DATE(s):	27 March 2024, 27 to 28 May 2024, written submissions 25 July 2024 to 9 September 2024.
FINDINGS OF:	T Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, prison murder, supervision of prisoners, prison mental health and psychological services, compulsory treatment, implementation of sentencing judge's recommendations.

REPRESENTATION:

Counsel Assisting:	Ms A Monardez and Ms N Macregeorgos
Schafer Family:	Mr S Wright, Bold Lawyers
West Moreton Hospital and Health Service (WMHHS):	Ms P Fairlie, WMHHS Legal
Queensland Corrective Services (QCS):	Ms A Cappellano instructed by QCS Legal Strategy & Services

Contents

Introduction 3
Coronial jurisdiction 3
The investigation 4
The inquest 6
The evidence 7
Autopsy results 12
Conclusions on inquest issues 30
Findings required by s. 45 30
- Identity of the deceased 30
- How he died 30
- Place of death 30
- Date of death 30
- Cause of death 30

Introduction

1. Duke Schafer was 36 years of age when he died at Woodford Correctional Centre ('Woodford') on 6 May 2020. At the time of his death, Mr Schafer was serving a term of imprisonment for drug trafficking, unlawful supply of weapons and using a carriage service to make threats to kill. His parole release date was recorded as 11 November 2021. His full-time release date was recorded as 13 May 2022.

2. At approximately 3:09pm on 6 May 2020, Mr Schafer was located unresponsive in the laundry room of Unit N14 with a ligature tied around his neck, fashioned from a torn, prison-issue bed sheet. Resuscitation attempts were unsuccessful, and he was pronounced deceased at 3:27pm.

3. An investigation into the circumstances surrounding Mr Schafer's death was undertaken by the Queensland Police Service ('QPS'). Carl William Sedgwick Bloomfield was subsequently arrested for murder on 11 May 2020.

4. The arrest occurred after a search warrant was executed and a razor blade and bed sheet, which had the hem removed, were located in Mr Bloomfield's cell. During an interview with investigating officers, Mr Bloomfield made full admissions to strangling Mr Schafer. He subsequently pleaded guilty and was sentenced to life imprisonment on 4 June 2021.

Coronial jurisdiction

5. At the time of his death, Mr Schafer was a prisoner in custody as defined in Schedule 4 of the *Corrective Services Act 2006* (Qld) ('CSA'). As such, Mr Shafer's death is a reportable death under section 8(3)(g) of the *Coroners Act 2003* (Qld) ('the Act') as it is a '*death in custody*'.

6. An inquest was mandatory pursuant to section 27(1)(a)(i) of the Act. An inquest is intended to provide the public and the family of the deceased with transparency regarding the circumstances of the death, and to answer any questions which may have been raised following the death.

7. In accordance with section 45(2) of the Act, a coroner is required, if possible, to make the following findings at the conclusion of the inquest:

   (a) the identity of the deceased;
   (b) how he died;
   (c) when he died;
   (d) where he died; and
   (e) what caused his death.

8. In accordance with section 45(5) of the Act, the Coroner must not include in findings, statements that a person is, or may be guilty of an offence, or may be civilly liable for something. The focus of the coronial process is on discovering what happened, not on ascribing guilt, apportioning liability, or attributing blame to any party. The purpose is to inform the family of the deceased, and the public of how a death occurred and, where possible, reduce the likelihood of similar deaths occurring in the future.

The investigation

9. Detective Sergeant Orchard of the QPS Corrective Service Investigation Unit ('CSIU') led the investigation into the circumstances of Mr Schafer's death.

10. At approximately 3:30pm on 6 May 2020, the CSIU were notified that a prisoner had been located deceased with a ligature around his neck. Officers from the CSIU, Homicide Investigation Unit ('HIU'), Forensic Services Unit ('FSU') and Scenes of Crime ('SOC') attended Woodford later that afternoon and a crime scene was declared. Officers from FSU and SOC processed the scene and investigators from CSIU and HIU liaised with Woodford Intelligence Officers and reviewed CCTV footage.[1]

11. All prisoners who entered or exited the laundry or were in the vicinity of the doorway between the time Mr Schafer and Mr Bloomfield entered the laundry, and the time Mr Schafer was discovered, were treated as persons of interest.[2] Mr Bloomfield was moved to the Detention Unit ('DU') and his cell was secured. He was believed to be the primary suspect as he was the last person seen with Mr Schafer.[3]

12. Investigators tried to interview Mr Bloomfield in the early hours of 7 May 2020. After denying any involvement in Mr Schafer's death he declined to answer any further questions.[4]

13. On 9 May 2020, investigators returned to Woodford and executed a search warrant on Mr Bloomfield's cell. During the search, police located a blade from a safety razor located on the desk and a white bed sheet with its hem removed, folded on a shelf. Mr Bloomfield then commented, "*That's all you will need*".[5] During the search, police also located the following:

    (a) Two additional blades from a safety razor located in the upper vent of the cell; and
    (b) Three lengths of white fabric located in a rubbish bin outside Mr Bloomfield's cell. A review of the CCTV footage shows Mr Bloomfield placing the rubbish bin outside his cell that afternoon.[6]

14. After the search, Mr Bloomfield asked to speak to DS Orchard. He voluntarily participated in an electronic record of interview (EROI). He made full admissions to killing Mr Schafer.[7] This resulted in his arrest for Mr Schafer's murder on 11 May 2020.[8]

15. DS Orchard provided an investigation report to the State Coroner dated 2 June 2022.

16. As a result of his investigation, DS Orchard identified two issues within Unit N14.

[1] Exhibit D4, [11] – [12].
[2] Exhibit D4, [12].
[3] Exhibit A1, [1.3].
[4] Exhibit A1, [1.2]; Exhibit D5, [15] – [16].
[5] Exhibit A1, [11.1.2] – [11.1.4].
[6] Exhibit A1, [11.2.5].
[7] Exhibit A1, [11.1.6] – [11.1.7].
[8] Exhibit D4, [1].

17. First, it was identified the investigation that there were no CCTV cameras monitoring the laundry area in Unit 14. No cameras were fitted inside the laundry and no cameras were fitted externally that could provide secondary monitoring.

18. Mr Bloomfield admitted he took Mr Schafer into the laundry to commit the murder as he knew there were no cameras there. Further, throughout interviews with other inmates, it became evident they were aware of the lack of CCTV monitoring as they used the area to fight and engage in drug transactions.[9]

19. The second issue identified was the lack of prison staff patrolling Unit N14 in the period immediately following muster. Mr Bloomfield was aware that in the short period of time from when the prison officers moved from Unit N14 to Unit N15 to conduct musters, there were no officers patrolling within Unit N14. He also was aware that while there was a supervisor in the officers' station, their view of the laundry was limited.[10]

20. Given this, DS Orchard recommended the following:

    (a) Installation of a CCTV camera in the laundry area; and
    (b) A review of staffing movements after muster to ensure a suitable number of officers are left to always manage prisoners in each unit.[11]

21. DS Orchard concluded that:

    (a) neither QCS officers nor intelligence staff could have predicted the attack on Mr Schafer as there was no information to suggest any conflict between the two prisoners; and
    (b) there was no evidence to suggest Mr Schafer was under threat by anyone in the unit. Those who knew him spoke favourably of him.[12]

22. A parallel investigation was conducted by the Operational Inspection and Major Incident Review Group ('OIMIRG') within the Queensland Corrective Services ('QCS') Professional Standards and Governance Command, responsible for "investigative, operational review and oversight function to identify risks, issues and trends relevant to safe correctional environments, humane prisoner and offender management and contemporary correctional practice".[13]

23. The preliminary review was conducted by Internal Inspector Helen Gabriel, and the full operational review was conducted by Internal Inspectors Peter Stacey and Graham Morrison, appointed pursuant to s 294(1) of the CSA.[14] Those investigators prepared a detailed and thorough report which was provided to the Coroners Court in August 2022. The findings and recommendations of the OIMIRG operational review are considered further below at Issue 2.

[9] Exhibit A1, [13.2.1].
[10] Exhibit A1, [13.2.2].
[11] Exhibit A1, [13.2.2].
[12] Exhibit A1, [13.1.2].
[13] Exhibit C1, [3].
[14] Exhibit C1, [2] & [4].

The inquest

24. A Pre-Inquest Conference ('PIC') was held on 27 March 2024 in the Coroners Court at Brisbane. Ms Monardez and Ms Macregeorgos were appointed as Counsel Assisting. Leave to appear was granted to QCS, WMHHS and to Mr Schafer's family.

25. In addition to the findings required by section 45(2) of the Act, the following issues were considered at inquest:

    (2) Mr Bloomfield's assessment and management while in QCS custody, including:

        (a) The adequacy and appropriateness of the provision of psychological and psychiatric treatment in accordance with the court's recommendation, including but not limited to whether recommended treatment of prisoners, including medication, can be enforced and, if so, in what circumstances; and

        (b) Whether the decision to reintegrate Mr Bloomfield into the mainstream population was appropriate.

    (3) Whether any preventative recommendations might be made that could reduce the likelihood of deaths occurring in similar circumstances in the future or otherwise contribute to public health and safety or the administration of justice.

26. The inquest was held in Brisbane from on 27 and 28 May 2024. All of the statements, records of interview, medical records, photographs, Closed Circuit Television ('CCTV') footage and materials gathered during the investigations were tendered at the inquest, without objection. Oral evidence was also heard from the following witnesses:

    (a) Dr Madsen, Forensic and Clinical Psychologist;
    (b) Dr Schramm, Consultant Psychiatrist, Prison Mental Health Service ('PMHS');
    (c) Dr Aboud, Consultant Forensic Psychiatrist;[15]
    (d) Superintendent Stacey, Director, Ethical Standards Group, Professional Standards and Governance Command, QCS;[16]
    (e) Assistant Commissioner Newman;[17] and
    (f) Assistant Commissioner Hamlett.

27. I am satisfied that all material necessary to make the requisite findings was placed before me at the inquest. Following the inquest written submissions were provided by counsel assisting and those granted leave to appear. The submissions were of great assistance in the preparation of these findings.

[15] Dr Aboud is the Clinical Director of the Prison Mental Health Service. Dr Aboud assessed Mr Bloomfield in a private capacity in 2014.
[16] At the time of the incident, Mr Stacey's role was Internal Investigator, Operational Inspection & Major Incident Review Group, QCS.
[17] At the time of the incident, Ms Newman's role was Executive Director, Specialist Operations, Woodford Correctional Centre, QCS.

The evidence

Mr Shafer

28. At the time of his death, Mr Schafer was serving a three-year custodial sentence for drug and weapons offences, as well as using a carriage service to make threats to kill. This was Mr Schafer's second term of imprisonment, having previously spent a brief time on remand from 2018 to 2019.[18]

29. Mr Schafer was first received into QCS custody at the Brisbane Correctional Centre ('BCC') on 26 November 2019. He was assessed as a 'Prisoner of Concern' due to his history of mental health concerns, suicide attempts and intellectual disability. He was referred to the PMHS and supports were put in place to manage his mental health, including regular psychology appointments and National Disability Insurance Scheme ('NDIS') support.[19]

30. Mr Schafer was assessed to be a high security inmate on 23 January 2020 and was transferred to Woodford the following day. During the period of his induction, Mr Schafer made a request to transfer to the Borallon Training and Correctional Centre ('BTCC') in order to be closer to his family and to access "better programs".[20] A Sentence Management Decision was made soon after. It was determined a placement at BTCC was unsuitable as intelligence suggested an adverse association between Mr Schafer and another prisoner already accommodated at the BTCC.[21]

31. After his induction, Mr Schafer was accommodated in Unit N14, where he stayed until his death.[22] Information obtained from QCS and as part of the QPS investigation indicated no issues or concerns were recorded in relation to Mr Schafer and his relationship with other prisoners housed in Unit N14.[23]

32. On 30 December 2019, Carl William Sedgwick Bloomfield, was transferred to Unit N14 where he remained until 6 May 2020.[24]

33. Mr Schafer's father, Allan, provided a family statement to the inquest. Allan said that his son's murder in custody has taken a great toll on the family, including Mr Schafer's mother, sister and grandmother. The family have struggled to come to terms with the senseless act and their constant feelings of loss.

34. Understandably, Mr Schafer's family consider that his death was preventable. They do not understand why Mr Bloomfield was permitted to return to the general prison population. They were particularly concerned that there was no surveillance in the Unit N14 laundry, which created "a place where violence can happen unchecked".

[18] Exhibit A1.1 - Appendix A; Exhibit C1, [31].
[19] Exhibit C1, [32] – [33] & [39] – [41].
[20] Exhibit C1, [37].
[21] Exhibit C1, [38].
[22] Exhibit C1, [35] – [36].
[23] Exhibit C1, [41] - [43].
[24] Exhibit C1, [65] & [69].

Mr Bloomfield

35. Mr Bloomfield first entered custody in 2012 at age 17, when he was remanded for the offences of assault occasioning bodily harm and robbery. He ultimately pleaded guilty and was sentenced to three years imprisonment on 25 July 2012, with a Court Ordered Parole date set at 24 October 2012.[25] He was released on that date.

36. Within a matter of months, Mr Bloomfield was charged with further violent offences. His parole was suspended and he was returned to QCS custody.[26] The charges arose after Mr Bloomfield lured two teenage boys unknown to him to a jetty and robbed them. He then attempted to cut the tongue of the first complainant and severed the second complainant's ear.[27] Mr Bloomfield pleaded guilty to the offences.

37. Upon Mr Schafer's arrival at Unit N14, Mr Bloomfield was serving a head sentence of nine years imprisonment. He had been declared a serious violent offender for the offences of acts intended to maim/disfigure/disable, robbery, common assault, and deprivation of liberty.[28] Mr Bloomfield was classified as a high security offender.[29] Notably, he had attempted to stab another prisoner[30] and had been described as being "capable of sadistic acts".[31]

Woodford and Unit N14

38. Woodford is classified as a high security placement correctional centre and is one of two correctional facilities in Queensland equipped with a Maximum Security Unit ('MSU'). Woodford accommodates inmates classified as 'mainstream' and 'protected'. Prisoners are also allocated security classifications, being either 'low', 'high' or 'maximum'.[32]

39. Unit N14 is located within the 'Secure 2' area of the prison, which accommodates mainstream prisoners. The unit is two storeys and contains an indoor common area, common toilet, common food preparation area, common laundry, an officers' station and exercise yard. The officers' station is shared with neighbouring Unit N15.[33]

[25] Exhibit A1.2, 1.
[26] Exhibit A1.2, 1; Exhibit C1, [46].
[27] Exhibit C40, 2.
[28] Exhibit A1.2, 1 – 2.
[29] Exhibit A1, [3.5].
[30] Exhibit C1, [53]; Exhibit A1.4, 1 – 3.
[31] Exhibit D2, 2.
[32] Exhibit C1, [27]; Exhibit C12, [3] – [4].
[33] Exhibit A1 - Coronial Investigation Report, [4.2]; Exhibit C1, Fig. 1 – 3.

40. Within Unit N14 are thirty cells with a capacity to house thirty-five inmates.[34] On the day of Mr Schafer's death, Unit N14 was operating above capacity, housing a total of fifty-five prisoners. As a result, the unit was operating on a modified schedule. Half of the prisoners were released from their cells in the morning and the other half during the afternoon.[35] Musters were conducted twice daily at varying times, as well as head counts.[36]

41. In total, there were nine Closed Circuit Television ('CCTV') cameras positioned within Unit N14. Each camera had its own reference number and captured discrete sections of the unit.[37]

42. As found in the OIMIRG Operational Incident Review Report ('the OIMIRG Review Report') and confirmed by Superintendent Stacey during his oral evidence, the Unit N14 laundry is located in an area where blind spots prevent CCTV camera coverage and visual observation by Custodial Correctional Officers ('CCOs).[38] Superintendent Stacey said:

    (a) the view of the laundry was, and still is, slightly obstructed by the infrastructure;
    (b) a drink machine partially obstructed part of the window into the laundry;
    (c) through normal visibility, the machines and the trough area are not visible from the officers' station at all;
    (d) when he inspected Unit N14, there was paper on the officer's window that partially obstructed the view; and
    (e) the Body Worn Camera ('BWC') footage from the day of the incident depicted paperwork on the officers' window.[39]

43. At the time of the incident, the Unit N14 laundry was unlocked and freely available to prisoners when they were out of their cells. This was due to an increase in the number of prisoners accommodated in Unit N14 needing to use the laundry to wash their clothes.[40]

Events of 5 and 6 May 2020

44. Mr Bloomfield and Mr Schafer were known to one another as they were accommodated in Unit N14 together and had spoken 'here and there'.[41]

45. On Tuesday 5 May 2020, Mr Bloomfield showed Mr Schafer a photo of his two daughters. Mr Schafer asked whether he could buy the photo and then laughed. Mr Bloomfield took offence at this, and formed the view that Mr Schafer was a paedophile.[42] It should be noted that:

    - Mr Schafer had never been charged with or convicted of any sexual offences; and

[34] Exhibit A1 - Coronial Investigation Report, [4.2]; Exhibit C1, [28].
[35] Exhibit C1 [28].
[36] Exhibit C1, [28] – [29].
[37] Exhibit A1, [4.5].
[38] Exhibit C1, 26; T2– Peter Stacey, p 10, lines 30 – 31.
[39] T2– Peter Stacey, p 10, lines 30 – 31.
[40] Exhibit C1, 47 – 48.
[41] Exhibit B89.1 at 13:18; Exhibit D5, [1] – [2].
[42] Exhibit A1, [11.1.8].

- there is no independent evidence to confirm that this conversation had occurred.

46. On the morning of 6 May 2020, Mr Bloomfield decided that he was going to kill Mr Schafer as he, "…*just thought he was a kid fucker and shouldn't have said what he said*".[43] Mr Bloomfield twice attempted to fashion a ligature by cutting the hem of a prison-issued bed sheet with a blade from a safety razor. His second attempt succeeded. Mr Bloomfield then concealed the ligature in his pants and kept it on his person for the rest of the day.[44]

47. In his EROI with police[45], Mr Bloomfield indicated that while he did have second thoughts about killing Mr Schafer, those thoughts changed upon seeing him.[46]

48. At 2:46pm, a muster was conducted and prisoners were directed to the exercise yard. They were then instructed to walk in single file back into Unit N14 and were cross-referenced against their official QCS photo within the muster book. Mr Bloomfield was the fourth prisoner to be checked and Mr Schafer was the eighteenth.[47]

49. Upon re-entering the Unit, Mr Schafer stood near the meal tables and was approached by Mr Bloomfield. Mr Bloomfield shook Mr Schafer's hand, placed his arm around Mr Schafer's shoulder, and they then walked to the laundry together.[48] Mr Bloomfield stated in his EROI that he asked Mr Schafer to go for a walk and talk with him.[49] They entered the laundry at 2:47pm and spoke briefly.[50] Less than one minute later, prisoner Ioane exited the laundry.[51]

50. While this was occurring, CCOs were transitioning to Unit N15 to conduct an afternoon muster and supervise approved prisoners moving from N14 to N15. Consequently, one CCO, Andrew Bird, was left in the officers' station to supervise the unit.[52]

51. Mr Bloomfield explained in his EROI that while in the laundry:

    (a) He sat on top of the washing machine and when he and Mr Schafer were alone, told him to "come over"[53] for a massage;
    (b) Mr Schafer approached Mr Bloomfield and turned around, at which time Mr Bloomfield started massaging Mr Schafer;
    (c) Mr Bloomfield then pulled the bed sheet hem out of his pants and wrapped it around Mr Schafer's neck;
    (d) Mr Schafer tried to run away towards the door, however Mr Bloomfield "yanked"[54] Mr Schafer back;

[43] Exhibit B89.1 at 16:55; Exhibit D5, [20].
[44] Exhibit A1, [11.1.9]; Exhibit C1, [74].
[45] Interview on 9 May 2020.
[46] Exhibit B89.1 at 23:12 – 23:38; Exhibit A1, [11.1.9].
[47] Exhibit D4, [5] – [6]; Exhibit C1, 29; Exhibit D5, [5].
[48] Exhibit D4, [6]; Exhibit D5, [5] & [7].
[49] Exhibit B89.1 at 04:03 – 04:24.
[50] Exhibit C1, Table 2; Exhibit A1, [5.3].
[51] Exhibit C1, Table 2; Exhibit B39, [6].
[52] Exhibit D4, [7]; Exhibit A1, [7.4.2].
[53] Exhibit B89.1 at 05:58.
[54] Exhibit B89.1 at 05:44 - 05:51.

(e) As Mr Schafer fell over, he wrapped the ligature around Mr Schafer's neck a further two times and strangled him for twenty to thirty seconds;
(f) Mr Schafer was choking before his legs gave out;
(g) He then tied a knot in the ligature at the front of Mr Schafer's neck "just to make sure" and "shoved" his body under the bench.[55]

52. At 2:51pm, Mr Bloomfield exited the laundry alone and entered the exercise yard, where he is seen to dispose of his shiv behind the wall-mounted telephone, socialise with other inmates and change shoes to train.[56]

53. Approximately twenty minutes elapsed before two other prisoners located Mr Schafer in the laundry and raised the alarm with prison staff in the officers' station.[57] In the previous twenty minutes, four prisoners saw a prisoner in the laundry under the bench but did not raise any concerns. This was said to be for the following reasons:

(a) They believed one of the prisoners was mucking around;[58]
(b) They did not think much of the sight as prisoners often went to the laundry if they wanted time to themselves or to nap;[59]
(c) They believed the person was simply relaxing or sleeping.[60]

54. After being notified about an unresponsive prisoner in the laundry, prison staff immediately responded and attended upon the Unit N14 laundry. A 'Code Blue – Medical Emergency' was called.[61] CCO Bird was the first to discover Mr Schafer, followed by CCO Smith.[62]

55. CCOs Bird and Smith observed Mr Schafer lying on the floor of the laundry to the right-hand side, with his head and upper torso underneath the laundry tub and his legs facing outwards. Mr Schafer's face was swollen, blue and covered in blood, and there was a ligature tied tightly around his neck.[63] They moved Mr Schafer from under the bench to render first aid and give chest compressions.[64]

56. At 3:13pm, Queensland Health medical staff entered Unit N14 and took over the provision of medical assistance to Mr Schafer. CPR continued for approximately seventeen minutes. RN Bolarinwa checked for signs of life but there were none.[65]

57. Nursing staff decided to cease resuscitation attempts. At 3:27 pm, Mr Schafer was declared deceased by RN Bolarinwa.[66] Queensland Ambulance Service paramedics subsequently arrived.[67]

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[55] Exhibit B89.1 at 06:23 – 06:37.
[56] Exhibit D5, [10] – [11].
[57] Exhibit A1, [5.6]; Exhibit B45, [5] – [10]; Exhibit B41, [5] – [10]; Exhibit B96 from 19:09.
[58] Exhibit B39, [8].
[59] Exhibit B43, [9] – [10].
[60] Exhibit B44, [5] – [6].
[61] Exhibit C1, [18].
[62] Exhibit C1, [18]; Exhibit B17, [10].
[63] Exhibit C1, [18]; Exhibit B17, [15]; Exhibit B35, [10].
[64] Exhibit B17, [16].
[65] Exhibit B57, [14].
[66] Exhibit B57, [15]; Exhibit A2.
[67] Exhibit C1, Table 2.

Autopsy results

58. On 7 May 2020, Dr Rebecca Williams conducted an autopsy consisting of a full internal and external examination of the body, blood tests, toxicology and a whole-body CT scan. Forensic biology samples were also taken, including fingernail scrapings and swabs.[68]

59. Toxicological testing was undertaken and no alcohol or illicit substances were detected in Mr Schafer's blood. However, the following substances were detected:

    (a) Diazepam (anti-anxiety medication) and its active metabolite nordiazepam, present at a therapeutic level;
    (b) Amitriptyline (anti-depressant medication), present at a therapeutic level;
    (c) Nortriptyline (anti-depressant medication), present at a low level; and
    (d) Aripiprazole (anti-psychotic medication), present at a therapeutic level.[69]

60. Dr Williams concluded that:

> *Autopsy examination showed a distinct ligature mark encircling his neck. His head was heavily congested and there were numerous petechial haemorrhages and subconjunctival haemorrhages. There was a fracture in the larynx as well as haemorrhage overlying deep neck muscles. These findings are typical of ligature strangulation. Third party involvement can neither be confirmed nor excluded on the basis of autopsy findings.*[70]

61. The official cause of death was recorded as "1(a) Ligature strangulation".[71]

OIMIRG operational review

62. Following Mr Schafer's death, QCS conducted an operational review into the death. This review was conducted by OIMIRG.[72]

63. The full operational review was conducted by Superintendent Stacey (in his role as Inspector at the time) and Inspector Morrison, appointed pursuant to s 294(1) of the CSA. The terms of reference were as follows:

    (a) The particulars of the death, including when, where and how, as well as any other contributing factors to the reasons why the death occurred and the circumstances surrounding its occurrence;
    (b) Whether appropriate policies, procedures and practices were in place for the proper assessment and continuing management of the prisoner involved and if they were adequate and complied with;
    (c) Whether any intelligence or other information existed prior to the incident which might have indicated that the prisoner's death may, or was likely to occur;
    (d) The timeliness and effectiveness of the centre management and staff in responding to the incident, including whether or not appropriate contingency plans were in place and were implemented immediately following the incident; and

[68] Exhibit A5, 8.
[69] Exhibit A5, 16 – 17.
[70] Exhibit A5, 17.
[71] Exhibit A5, 17.
[72] Exhibit C1, [3].

(e) Any other matter(s) relevant to the events and/or which may have contributed to the occurrence of the incident.[73]

64. Relevant to Inquest Issue 2, the OIMIRG operational review considered Mr Bloomfield's assessment and management while in QCS custody.

Mr Bloomfield's return to custody

65. After being released on parole for the offences of assault occasioning bodily harm and robbery, Mr Bloomfield returned to custody after he was charged with and pleaded guilty to:

    (a) two counts of deprivation of liberty;
    (b) three counts of robbery;
    (c) three counts of common assault; and
    (d) one count of unlawfully doing grievous bodily harm with intent to disfigure.[74]

66. For sentencing purposes, the following expert reports were obtained (the 'pre-sentence reports'):

    (a) a Pre-Sentence Report dated 17 July 2014 by Dr Aboud, Consultant Forensic Psychiatrist;
    (b) a further Pre-Sentence Report dated 16 March 2015 by Dr Kovacevic, Consultant Psychiatrist in response to Dr Aboud's report; and
    (c) a Psychological Violence Risk and Treatment Needs Assessment dated 7 September 2015 by Dr Madsen, Consultant Clinical and Forensic Psychologist.

67. During his assessment, Mr Bloomfield expressed pleasure at mutilating a teenager. Other relevant disclosures included:

    (a) His violent thoughts and fantasies commenced at the age of thirteen in the context of bullying he had been subjected to. His thoughts escalated over a three-to-four-year period from fantasizing about bashing people to imagining cutting people up, dismembering them and pulling out their internal organs;[75] and
    (b) In the prison environment, he was triggered by other people saying or doing things that he disagreed with, too many negative interactions with a person, or having someone stare at him/look at him fairly innocently. Mr Bloomfield reported that these thoughts could occur on most days, sometimes on a number of occasions. However, he was able to resist the urge to act on them.[76]

68. Notwithstanding the above, during all assessment interviews, Mr Bloomfield expressed motivation to change and engage in psychological treatment.

69. Dr Aboud assessed Mr Bloomfield as, '…a significant risk to others and, if unaddressed, this [would] most likely remain the case'.[77] Dr Aboud confirmed this assessment at inquest. He said Mr Bloomfield would remain a significant risk based on a number of factors identified in his assessment:

[73] Exhibit C1, [7].
[74] Exhibit D9, 25.
[75] Exhibit C41, 5.
[76] Exhibit C41, 4.
[77] Exhibit C40, 10 – 11.

> *So key factors would've included his antisocial personality traits or – or disorder; secondly, his propensity to use drugs and alcohol; but, most importantly, his description of obsessive sadistic thinking, fantasy, rehearsing that fantasy in his mind, onset at a – at a young age, probably 10 or 11 years old, to my recollection, and the fact that these fantasies were egosyntonic, that is, that they gave him a sense of pleasure or – or relief. I thought that was very worrying because he had no reason to arrest those thoughts. Those thoughts were actually making him feel better within himself.*[78]

70. Dr Aboud confirmed that Mr Bloomfield required highly specialised psychological treatment while in custody (specifically commissioned by QCS). He said at a minimum, Mr Bloomfield would need to be prescribed a high dose of anti-depressant.[79] Psychological therapy would be, '…far more important than the psychotropic medication' but, '…it was important to try and assist [Mr Bloomfield] in every way.[80]

71. Dr Aboud commented, both in his pre-sentence report and in evidence at inquest, that Mr Bloomfield would not be referred to the PMHS for psychological treatment. Further, that the level of treatment required was not within the capability of QCS Psychology Services. Dr Aboud stated that:

> *But, specifically, the Prison Mental Health Service at the time back in 2014 would not have had dedicated psychological services. I think that it would have been later than that. There is a limited psychological service provision…But, typically, psychological treatment – assessment and treatment is provide to – in the correctional environment by the Queensland Corrective Services who have a large number of psychologists working for them. Prison Mental Health would typically advocate for someone's needs by liaising with the Queensland Corrective Service. In the case of Mr Bloomfield, I thought – and this was my view as a private psychiatrist who happened to know quite a lot about the Queensland Corrective Services, I thought that the level of need that Mr Bloomfield had was high and the type of psychologists would have to have a level of expertise that would be relatively uncommon. It wouldn't be necessarily something – a level of expertise that would be readily seen in the Corrective Service at that time, although there is a caveat because that's changed. But I would also go as far as to say that the type of needs that Mr Bloomfield had would not readily be seen within Queensland Health either.*[81]

72. In his report, Dr Kovacevic largely concurred with the opinion of Dr Aboud. He considered Mr Bloomfield presented at least a moderate risk of violence to others in the future, though at the time of the assessment, he was not a high risk.[82] Dr Kovacevic opined that in addition to exploratory psychotherapy, Mr Bloomfield required longer term psychological therapy, including cognitive behavioural interventions commencing immediately, as well as anti-depressant treatment.[83]

73. Dr Madsen assessed Mr Bloomfield as presenting a moderate to high risk of violence in certain circumstances. Dr Madsen considered the risk of violence was

[78] T1 – Dr Aboud, p 52, lines 39 – 46.
[79] Exhibit C40, 10 – 11.
[80] T1 – Dr Aboud, p 52, lines 21 – 22 and 27 – 28.
[81] T1 – Dr Aboud, p 53, lines 29 – 46.
[82] Exhibit C41, 8.
[83] Exhibit C41, 8 – 9.

not imminent and appeared to be well maintained by himself and the circumstances of the custodial environment at the time.[84] Dr Madsen recommended Mr Bloomfield engage in one-on-one and group-based therapy to address his paranoid mindset and use of violence.[85] In his report and confirmed in evidence given at inquest, Dr Madsen recommended Mr Bloomfield's two violence pathways be addressed through the Cognitive Self Change Program ('CSCP'), which is a group-based therapy run through QCS, and Schema Therapy - a specific one-on-one intervention.[86]

74. Dr Madsen explained that:

> *Schema Therapy a type of psychotherapy specifically designed to work with people who have personality disorder. It's a long-term psychotherapy that's shown to have benefits in working with anti-social personalities in forensic contexts.*[87]

75. Dr Madsen further outlined in his report that:

> *Schema Therapy (ST) has been found to be more effective in the treatment of personality disordered offenders (including highly psychopathic offenders) than other types of treatment modalities. Within a ST approach, Mr Bloomfield's sadistic fantasies and thoughts would be understood as an overcompensating reaction to feelings of vulnerability, inadequacy and shame. The purpose of the treatment would be to assist him with having a greater understanding of his inner world, assist him with reducing the 'need' to rely on overcompensating responses and have better skills at having his emotional and psychological needs met in adaptive and healthy ways.*[88]

76. Consistent with the evidence given by Dr Aboud, Dr Madsen confirmed QCS would have needed to recruit a consultant with specialist expertise in the provision of Schema Therapy to work with Mr Bloomfield. Dr Madsen's evidence was that, at the time, he was occasionally engaged by QCS to deliver such services to individual prisoners.[89]

77. Upon Mr Bloomfield's sentence, the prosecution applied for an indefinite sentence. This application was dismissed by the sentencing judge, Judge Wall KC.[90] Instead, on 7 December 2015 Mr Bloomfield was sentenced to a head sentence of nine years imprisonment and declared a serious violent offender, requiring him to serve at least 80% of his sentence.[91]

78. In determining the application for indefinite sentence, Judge Wall had regard to Mr Bloomfield's young age, his background, limited criminal history and the severity of the offence.[92] Judge Wall was not satisfied that the evidence was of a high probability that Mr Bloomfield was a serious danger to the community under a finite sentence provided he received the recommended treatment.[93]

79. Judge Wall made three recommendations as to Mr Bloomfield's treatment:

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[84] Exhibit C42, [10.6].
[85] Exhibit C42, [11.2] – [11.6], [12.2].
[86] Exhibit C42, [11.4] – [11.5].
[87] T1 – Dr Madsen, p 15, lines 4 – 6.
[88] Exhibit C42, [11.6] – [11.7].
[89] T1 – Dr Madsen, p 15, lines 13 – 31.
[90] Exhibit D9 - *R v Bloomfield* [2015] QDC 339.
[91] Exhibit D9 - *R v Bloomfield* [2015] QDC 339 - Sentencing Remarks, pp 5 - 6.
[92] Exhibit D9 - *R v Bloomfield* [2015] QDC 339, [32].
[93] Exhibit D9 - *R v Bloomfield* [2015] QDC 339, [31].

(a) Mr Bloomfield engage in the CSCP;
(b) Mr Bloomfield engage in one-on-one specialist psychological treatment specifically commissioned by QCS; and
(c) Mr Bloomfield receive anti-depressant medication.

Steps taken to Implement the Sentencing Judge's Recommendations

80. The steps taken by QCS to implement Judge Wall's recommendations were considered by OIMIRG as part of the operational review.

81. While Mr Bloomfield was subject to the application for indefinite sentence, he was managed by the High-Risk Offenders Management Unit ('HROMU'). During this time, the following occurred:

(a) Mr Bloomfield was opened to the PMHS at BCC and was scheduled to attend an intake assessment on 5 August 2015. He refused to attend.[94]
(b) Mr Bloomfield was again scheduled to attend an appointment with the PMHS on 17 August 2015. He failed to attend.[95]
(c) Notwithstanding his previous non-engagement, the PMHS decided to open Mr Bloomfield to the PMHS. He refused to attend the appointment on 8 September 2015.[96]
(d) On 9 September 2015, Ms Monson, A/Principal Advisor of the HROMU emailed Ms Walton, Prison Development Manager of GEO Group and requested that psychological services attend upon Mr Bloomfield to motivate his attendance at the PMHS.[97]
(e) On 11 September 2015, Ms Walton emailed Ms Monson and confirmed that a psychologist spoke to Mr Bloomfield who advised he did not want to commence medication but would see the PMHS if they requested to see him again.[98] This information was received by PMHS Team Leader, Ms Russell on 14 September 2015.[99]
(f) Mr Bloomfield subsequently failed to attend appointments with the PMHS on 15 and 22 September 2015.[100] and
(g) Mr Bloomfield failed to attend a further three appointments with the PMHS on 13 October 2015, 2 November 2015 and 8 December 2015.[101]

82. The HROMU's involvement with Mr Bloomfield ceased when the application for indefinite sentence was dismissed on 7 December 2015. As a result, Judge Wall's sentencing remarks, as well as the pre-sentence reports obtained in relation to Mr Bloomfield, were sent to the Serious Offenders Unit ('SOU') for consideration on 21 December 2015.[102] The SOU was involved in, 'higher level delegation sentence management decisions only' as Mr Bloomfield was subject to a total period of imprisonment greater than ten years.[103]

[94] Exhibit E1.1, [8].
[95] Exhibit E1.1, [8].
[96] Exhibit C43, 2.
[97] Exhibit C28, 4; Exhibit C43, 2.
[98] Exhibit C28, 3; Exhibit C45, 4.
[99] Exhibit C28, 3.
[100] Exhibit E1.1, [8].
[101] Exhibit E1.1, [8]
[102] Exhibit C1, [93]; Exhibit C43.
[103] Exhibit C1, [95].

83. On 22 December 2015, Mr Bloomfield was seen by Dr Elliott, PMHS Psychiatric Registrar. Dr Elliott found no evidence of mental illness and discussed the matter with Dr Schramm, who then booked Mr Bloomfield in for a further review.[104]

84. During the OIMIRG operational review, the Acting State-wide Manager advised that the SOU, '…was not responsible for decisions regarding daily management of Mr Bloomfield or for the implementation of recommended programs or treatments'.[105] Accordingly, on 24 December 2015, Ms Lyell, A/Statewide Manager, SOU emailed the information and relevant documents provided by the HROMU to the Offender Rehabilitation and Management Service ('ORMS') and to Sentence Management Services at BCC to ensure compliance with the recommendations.[106] ORMS then comprised both the Offender Intervention Unit and the Psychological Services Unit

85. On 5 January 2016, Mr Bloomfield was given a letter from the PMHS, which encouraged him to attend his next appointment. He was also informed that he would be closed to the service if he failed to attend.[107] He subsequently attended his PMHS review with Dr Schramm on 19 January 2016.[108]

86. Dr Schramm's evidence at inquest was that he did not assess Mr Bloomfield as suffering from a serious mental illness, such as schizophrenia or other psychotic or major mood disorders. However, he noted that there were features of an antisocial personality disorder present.[109] Dr Schramm's evidence was that he looked for signs of obsessive compulsive disorder ('OCD'), given Mr Bloomfield's history of ruminative violent thoughts and fantasies. However he was not satisfied he suffered from OCD.[110] Dr Schramm confirmed that, '…*given the history and given that that [SSRIs are a] medication that is usually well tolerated, the possibility of benefit, even though it would have been not great – it – it was certainly indicated to trial it, and I was willing to do that'*.[111] Mr Bloomfield declined Dr Schramm's offers for medication and a referral to a psychologist but said he would be happy for a review if the reports of Drs Aboud and Kovacevic raised any issues.[112]

87. On 27 January 2016, Mr Bloomfield transferred from BCC to Woodford. He declined to be placed on the waitlist for the CSCP on 3 February 2016.[113] A case note dated 4 February 2016 noted that the 'Senior Psych Secure 2, Principal Advisor and Senior Advisor (Offender Intervention Unit) were advised of outcome in teleconference on 03/02/2016'.[114]

88. Dr Schramm recalled at inquest that Mr Bloomfield failed to attend his scheduled appointments on 12 February 2016 and again on 4 March 2016.[115] Accordingly, an email was sent on 7 March 2016 advising Ms Lyell and the then Manager of Offender Development ('MOD'), Ms Lourigan, that Mr Bloomfield would be

[104] Exhibit E1.1, [8].
[105] Exhibit C1, [95].
[106] Exhibit C1, [96].
[107] Exhibit E1.1, [8].
[108] Exhibit E1.1, [12].
[109] Transcript -Day One – Dr Schramm, p 39, lines 14 – 20.
[110] Transcript -Day One – Dr Schramm, p 39, lines 21 – 23.
[111] Transcript -Day One – Dr Schramm, p 39, lines 26 – 29.
[112] Exhibit E1.1, 3.
[113] Exhibit C1, [50]; Exhibit C27.
[114] Exhibit C45, 8 – 9.
[115] Transcript -Day One – Dr Schramm, p 42.

closed to the PMHS if he failed to attend another appointment with the consultant psychiatrists.[116]

89. On 1 April 2016, Mr Bloomfield failed to attend his scheduled appointment and was closed to the PMHS.[117] Dr Schramm explained at inquest that he did not think there was anything more the PMHS could do. He had discussed the matter with his manager (Ms Russell) and wrote a letter to document the assessment so QCS could be formally advised. That letter was dated 24 May 2016, and Dr Schramm said he provided it to Ms Russell with the expectation that she would pass it on to QCS.[118]

90. When asked what the usual process was for closing a consumer to the PMHS, Dr Schramm explained that his usual practice is, '…that we would advise or I would ask our clinical coordinator to advise the referrer that the person had not engaged or if we'd made a decision that they didn't need to be open to us'.[119] When asked whether he was concerned about Mr Bloomfield's risk in light of his disengagement, coupled with information available in the pre-sentencing reports, Dr Schramm's evidence was that:

> *I– as I say, the chances of the risk being reduced by the medication and other intervention were not great, but it was worth trying. I did not assess him in those moments, or at the time that I saw him, to be a very high risk but, overall, a chronic high risk. So I didn't – it wasn't a situation, say, for example, of someone who had a florid psychotic illness left untreated, where you could say, "Yes, there's a risk of imminent – high risk of imminent harm to – to other persons." It wasn't that kind of situation. This was a treatment that was certainly worth trying but could not be enforced under the Mental Health Act for various reasons that I can go through…. I didn't think the risks were very, very high in those moments. But overall, this was a man who posed a chronic risk of violence to those around him, like many in prison, I suppose.*[120]

91. Dr Schramm said if he had any concerns about Mr Bloomfield's risk, those concerns could have been passed on to QCS Psychological Services. They would undertake their own assessment and decide issues of placement and observation.[121]

92. The Director of ORMS advised the following in relation to Mr Bloomfield's management at the time of Mr Schafer's murder:

> - *In relation to SSRI medication, it would not have been usual practice for ORMS to engage with PMHS regarding Mr Bloomfield's SSRI medication. This would more often occur at the centre level through regular PMHS/Centre meetings where health practitioners could share information.*
> - *In relation to court recommendations for treatment, there are a number of challenges in ensuring court recommendations are complied with. There currently isn't any trackable mechanism in IOMS for recording when an intervention is recommended by a court other than attaching transcripts of recommended interventions to support this occurring.*

[116] Exhibit C1, [99]; Exhibit C28, 1.
[117] Exhibit E1.1, [15].
[118] T1 – Dr Schramm, p 43, lines 8 – 13.
[119] T1 – Dr Schramm, p 42, lines 45 – 47.
[120] T1 – Dr Schramm, p 43, lines 27 - 38.
[121] T1 – Dr Schramm, p 43, lines 40 – 45 to p 44, lines 1 – 2.

- *Service delivery models may also not be in place to deliver on court recommendations, but where they are, best efforts are made to support this in accordance with available resources.*
- *In relation to the recommendation for intensive psychological intervention, the response would be dependent on what the intention of the recommended treatment was.*
- *If this was focussed on offending, it would have come to QCS for consideration. QCS model utilises group programs based on evidence regarding effectiveness and on the efficiencies possible. Program Delivery Officers do not engage in individual treatment as a result.*
- *Government funding was provided to QCS for individual sexual offending in 2016 focussed on community settings which could also be utilised where there was a barrier to group engagement in correctional centres to motivate them into a group, but Mr Bloomfield was not eligible for this.*
- *The offending behaviour program model in place relies on voluntary participation so will prioritise those willing to engage but efforts are made to keep prisoners informed about how to engage with treatment later.*
- *There are other mechanisms for individual intervention for a small number of high risk or high harm individuals in place now, which were not in place at the time of the offence, including the Specialised Clinical Services Unit established in approximately 2017.*
- *In relation to the CSCP referral, it is noted that this was recorded in Mr Bloomfield's Rehabilitation Need assessment in 2015. There wasn't any reference to a court recommendation for individual intervention, potentially due to the reality that there was no service delivery model available to address that and that violence needs were addressed through group programs. Mr Bloomfield was offered the program in February 2016 but declined it. When this occurs, it is standard practice that prisoners would be advised to come back for the request to be placed back on the list if they change their mind.*
- *In terms of what other mechanisms may have been available to address the court recommendation, this was limited. Staffing and experience levels of psychologists working in correctional centres is not sufficient to provide one on one psychological intervention, and the model focusses on psychological wellbeing and not criminogenic intervention. Serious mental illness is addressed through the Prison Mental Health Service operated by QHealth.*
- *There are small funding allocations made for individual intervention for prisoners with chronic self-harm which Mr Bloomfield would not have been eligible for. Noting his disengagement from his PMHS treatment provider and refusal to participate in CSCP, there is no guarantee that if any other mechanism had been available that Mr Bloomfield would have engaged in it.*
- *In the future, the complexity of Mr Bloomfield's offending risks and needs would be assessed, considered, planned for and case managed through dedicated case management units that are being implemented through the QPSR program, focussing on high risk prisoners.*[122]

93. Ultimately, Superintendent Stacey concluded in the OIMIRG Review Report and confirmed in oral evidence that there were no records in IOMS or anywhere else that indicated that specialist one-one-one psychological treatment was attempted with Mr Bloomfield.[123]

[122] Exhibit C1, [98].
[123] Exhibit C1, [100] – [101]; T2– page 9, lines 32 – 36.

The Making of the MSO

94. On 27 May 2019, Mr Bloomfield attempted to stab another prisoner with a 'shiv'. The victim prisoner was sitting down and Mr Bloomfield was standing behind him, about to give him a haircut. Mr Bloomfield removed the shiv from inside his pants and attempted to stab the victim prisoner twice in the abdomen. The shiv did not penetrate the victim prisoner's skin and he did not suffer any injuries.[124] Intelligence suggested that gang tensions may have precipitated the assault. [125] Accordingly, Mr Bloomfield was placed on a Safety Order ('SO') and accommodated in the DU.[126]

95. On 30 May 2019, Mr Bloomfield was transferred to the DU at BCC.[127] Mr Bloomfield's security classification was referred to Assistant Commissioner Newman ('AC Newman'), in her role as Executive Director, Specialist Operations, Woodford on 31 May 2019.[128] AC Newman's role involved making decisions in relation to prisoners' Maximum Security Classifications ('MSC'), Maximum Security Order ('MSO') requests, MSU reintegration and prison transfers.[129] AC Newman, at the time, held the requisite delegations to issue MSOs and transfer prisoners.[130]

96. In her statement, AC Newman outlined the process at the time for a prisoner to be considered for a MSC and then subject to a MSO, having regard to the 'Prisoner Accommodation Management – Maximum Security Unit' and 'The Sentence Management – MSO Management and Sentence Management – Classification and Placement' COPDs.[131]

97. On 5 June 2019, AC Newman classified Mr Bloomfield as a Maximum Security Offender and issued a MSO for a period of six months, to expire on 4 December 2019. As a consequence of the MSO, Mr Bloomfield was transferred back to Woodford and accommodated in the MSU.

98. AC Newman confirmed in her oral evidence that she made the decision on the basis that Mr Bloomfield was, '…generally a substantial threat to the security and good order of the corrective services facility'.[132] The reasons for her decision were recorded in the 'Information Notice Security Classification'[133] and the 'Notice of Placement Decision'.[134]

99. AC Newman confirmed in her evidence that as part of her decision-making, she considered the matters required by the CSA, including Mr Bloomfield's offending history. When asked whether she considered the recommendations made by Judge Wall KC, AC Newman was unable to confirm whether she specifically turned her mind to those recommendations at the time. However said was that she had access to and considered the sentencing remarks and was aware of the recommendations.[135] AC Newman confirmed that she could not recall whether

[124] Exhibit C1, [53].
[125] Exhibit C1, [55].
[126] Exhibit C1, [53].
[127] Exhibit C1, [55].
[128] Exhibit E1.3.1, [21].
[129] Exhibit E1.3.1, [21].; T2– AC Newman, p 35.
[130] Exhibit E1.3.1, [16].; T2– AC Newman, p 35, lines 26 – 30.
[131] Exhibit E1.3.1, [24].
[132] T2– AC Newman, p 39, lines 33 – 35.
[133] Exhibit E1.3.6.
[134] Exhibit E1.3.7.
[135] T2– AC Newman, p 36, lines 16 – 31.

she considered the pre-sentence reports when making the maximum security classification and placement decisions.[136]

100. On 8 July 2019, Official Visitor Burgess ('the Official Visitor') attended the MSU to interview Mr Bloomfield for the purpose of a review of the MSO pursuant to section 63(6) of the CSA. Mr Bloomfield declined to be interviewed.[137]

101. On 11 July 2019, the Official Visitor confirmed AC Newman's decision to issue a MSO for a period of six months, with a view to reintegrating Mr Bloomfield into the mainstream prison population upon its expiry.[138] AC Newman outlined that the Official Visitor was required to review the circumstances, the decision to make the MSO and then make recommendations as to whether to confirm, amend of cancel the MSO. As the delegate, she made the decision after receiving the recommendation.[139]

102. On 29 August 2019, Mr Bloomfield was again offered the opportunity to participate in the CSCP, however he declined to do so.[140] There is no record to confirm whether Mr Bloomfield was offered an opportunity to engage with the PMHS to receive the recommended medication or the specialist one-on-one psychological intervention.

Expiry of the MSO

103. During his time in the MSU, Mr Bloomfield was compliant, and progressed through the requisite MSU Management Plans.[141]

104. As part of his management, an Institutional Violence Risk Assessment and Case Formulation ('the IVRACF assessment') was commissioned by QCS and a report ('the IVRACF report') was prepared by Dr Madsen. Mr Bloomfield was interviewed by Dr Madsen on 4 September 2019. The purpose of the assessment was to identify Mr Bloomfield's '…treatment needs and intervention pathways to address any risks relevant to [his] ongoing management within the MSU'.[142]

105. In the IVRACF report, Dr Madsen assessed, in summary:

    (a) Mr Bloomfield met the diagnostic criteria for antisocial personality disorder and substance use disorder (sedatives, hypnotics, or anxiolytics), severe, in early remission in controlled context;[143]
    (b) Mr Bloomfield fell within the moderate range of psychopathy;[144]
    (c) Mr Bloomfield presented with the many of the characteristics associated with risk of violence;[145] and
    (d) Mr Bloomfield's risk of institutional violence, at that time, was moderate, though not imminent.[146]

[136] T2– AC Newman, p 36, lines 33 – 36.
[137] Exhibit E1.3.9.
[138] Exhibit E1.3.9, 5.
[139] T2– AC Newman, p 11, lines 29 – 32.
[140] Exhibit C1, [59]; Exhibit C32.
[141] Exhibit C1, [58] &[62].
[142] Exhibit C1, [59].
[143] Exhibit C33, 8.
[144] Exhibit C33, 9.
[145] Exhibit C33, p 9.
[146] Exhibit C33, p 9.

106. Dr Madsen outlined in the IVRACF report and confirmed at the inquest that Mr Bloomfield was very candid in disclosing:

(a) he was less motivated to change his behaviours;
(b) he was engaged in substance misuse (Suboxone); and
(c) he had been playing the system for a number of years.

107. When asked whether the risk of future violence should have increased, given the presence of the above factors, which were absent in 2015, Dr Madsen said Mr Bloomfield, as an individual within the prison context, would always be high risk due to his history and because of, '…how he is'.[147] Dr Madsen also said in the MSU, every individual would be a high to very high risk of offending and his role was to assist QCS in differentiating the risk between those individuals.[148] Dr Madsen went on to say, 'Saying [Mr Bloomfield] is high risk is of no value to the decision makers because they're all high risk'.[149] Dr Madsen went on to state that:

> *…what we're trying to do is saying okay, in this situation, what is – can this individual be able to function in – in a high secure prison context, despite the fact that he has all these problems and despite the fact that his risk assessment is like this. And when I – when I looked at his history within – despite everything that he told me, he had spent close to, I think, almost 8 years, I think, at this stage – or maybe it was less – but he spent a very long time in the regular prison context. And I believe that there was only five incidences of violence over that time. So the frequency of his violence in custody is very, very small. And of those five incidences, only one of them met the threshold of him actually being placed in the MSO. So what it said to me is that okay, this individual can actually be managed for long periods of time within a regular high secure prison context without him being violent successfully. So in terms of how I was trying to couch my recommendations and suggestions at that time, that is what I was paying attention to and that was what I was trying to comment on.*[150]

108. In terms of the substance misuse, Dr Madsen conceded that substance misuse would impact his risk assessment. However, he noted Mr Bloomfield disclosed Suboxone use (an opiate blocker that has a sedative quality) as opposed to methamphetamines or amphetamines, which would increase the risk perspective in a prison environment.[151]

109. Dr Madsen confirmed that Mr Bloomfield's risk of future institutional violence was not imminent. When asked by the legal representative for the Schafer family, in what situation would person have an imminent risk of violence, Dr Madsen outlined that it would be in a situation where the individual was, '…reporting it, if they [were] agitated and angry, if they [were] describing plans or intentions to do it, if they [had] means and access and opportunity'.[152]

110. Dr Madsen had recommended against Mr Bloomfield being subject to an additional MSO for a number of reasons, including:

(a) Mr Bloomfield's behaviour in the MSU being without problems;

[147] T1 – Dr Madsen, p 22, lines 17 – 19.
[148] T1 – Dr Madsen, p 22, lines 17 – 24.
[149] T1 – Dr Madsen, p 22, lines 24 – 25.
[150] T1 – Dr Madsen, p 22, lines 21 – 38.
[151] T1 – Dr Madsen, p 29, lines 7 – 25.
[152] T1 – Dr Madsen, p 28, lines 39 – 40.

(b) It being highly conceivable that he could be managed similarly in a regular prison environment, with the assistance of psychological support and institutional structure; and
(c) Mr Bloomfield's recent history (at the time) indicated that he could abstain from the use of violence for long periods of time.[153]

111. Dr Madsen also made recommendations with regards to addressing risk factors relevant to Mr Bloomfield. Those recommendations were outlined in Table 1 of the IVRACF report.[154] Dr Madsen acknowledged that Mr Bloomfield verbalised minimal motivation to change his substance use, associated criminal/antisocial mindset and broader criminal identity. However, he considered his attitude, '…may shift with a specific intervention focussed upon improving his motivation to change'. [155] Dr Madsen outlined that, 'the specifics of the individual treatment (should he become more motivated) should focus on the consequences to himself as regards to change, rather than on expecting that he develop empathy'.[156] Dr Madsen conceded at inquest that the ability for QCS to provide those recommended treatments was entirely dependent on Mr Bloomfield's willingness to engage.[157]

112. On 29 November 2019, AC Newman decided not to extend Mr Bloomfield's MSO. AC Newman assessed that the risk posed by Mr Bloomfield could be, 'adequately managed through a high security classification and placement in a secure accommodation unit, with management initially through an Intensive Management Plan'.[158]

113. In her evidence, AC Newman outlined the variety of circumstances where she may consider extending a prisoner's MSO. AC Newman said behavioural problems in the MSU were a key indicator, as well as the risk posed to the general population or specific individuals based on past incidents and behaviour.[159]

114. When asked whether Mr Bloomfield's non-engagement in the psychological/psychiatric treatment would have impacted upon the Official Visitor's recommendation that the MSO not be extended, AC Newman said she did not believe that would reach the threshold for maintaining a person in the MSU environment, particularly when his behaviour was very settled.[160] Similarly, AC Newman said Mr Bloomfield's admissions of drug use, and the increased risk that posed, would not reach the threshold for his continued placement in the MSU.[161]

115. When considering whether to extend an MSO, AC Newman, Dr Aboud and Dr Madsen all said it is was a complex decision-making exercise that required the balancing of the risk to the mainstream prison population if the prisoner is reintegrated, and the risk to the individual prisoner if their placement in the MSU is extended. AC Newman said extended periods in the MSU can have negative

[153] Exhibit C33, 11.
[154] Exhibit C33, 12.
[155] Exhibit C33, 11.
[156] Exhibit C33, 11.
[157] T1 – Dr Madsen, p 33, lines 1 – 5.
[158] Exhibit C1, [63]; Exhibit C35, 1.
[159] T2– AC Newman, p 38, lines 29 – 43.
[160] T2– AC Newman, p 45, lines 5 – 32.
[161] T2– AC Newman, p 45, lines 34 – 47 to p 46, lines 1 – 3.

psychological impacts on an individual prisoner, and those impacts can play out in different ways. For example, some prisoners turn inwardly and are at an increased risk of suicide, while others may exhibit behavioural disturbance where they act out aggressively and violently.[162]

116. Dr Madsen gave further evidence outlining risks to the individual prisoner if they remained too long in the MSU:

> *The longer you keep someone in the MSU, the risk you run is that you can actually make them mentally unwell, and I've seen that. I've seen folks who have been there for too long and have become quite psychotic, and there also is a concern about the issue of increasing risk. So some prisoners will – after they've been in there for a period of time will become so anxious and apprehensive about being transitioned back out of the MSU because then they have to have contact with other prisoners, that they will actually use violence to keep themselves in the prison – in the MS – in the MSU to avoid that. So they will threaten violence or they will try to enact violence so they get placed back there. Now, we try to really kind of have that balance where we try to keep it like you can't keep them there too long because this could happen, and we have to try to find a sweet spot to sort of be able to get them out, but we also want to – want the process to be one where you don't really want to return, right. You don't really want the experience to be one where people want to stay or return.*[163]

117. Finally, Dr Aboud said it is very difficult challenge for QCS to decide whether to extend a MSO or not; a prisoner may be placed in the MSU due to actual risk and perceived risk but, '…sometimes it's very hard to tell the difference between an actual risk and a perceived risk because in the end, risk is a perception'.[164]

Reintegration into the Mainstream Population

118. Mr Bloomfield was transferred to the DU upon the expiry of the MSO on 4 December 2019, where he was accommodated until 6 December 2019. He was then inducted into Unit N7 and reintegrated back into the general prison population.[165]

119. On 30 December 2019, Mr Bloomfield was transferred to Unit N14, where he remained until 6 May 2020.[166] This unit also accommodated Mr Schafer. Mr Bloomfield progressed through the four stages of his Intensive Management Plan ('IMP') until its finalisation on 20 February 2020.[167]

120. During the period of 30 December 2019 to 6 May 2020, Mr Bloomfield was subject to one adverse incident after providing a positive urinalysis test for buprenorphine. Mr Bloomfield pleaded guilty at the breach hearing and received a punishment of four days in separate confinement.[168] It is noted in the OIMIRG Review Report that this adverse incident occurred while Mr Bloomfield was subject to Stage 3 of his IMP, and no reference was made to that positive urinalysis result in the review and he was progressed to Stage 4. One of the goals identified in the IMP was for Mr Bloomfield to remain breach free, and at

[162] T2– AC Newman, p 53, lines 34 – 47.
[163] T1 – Dr Madsen, p 29, line 35 - 46 to p 30, lines 1 – 2
[164] T1 – Dr Aboud, p 63, lines 11 – 13.
[165] Exhibit C1, [64].
[166] Exhibit C1, [65] & [69].
[167] Exhibit C1, [66].
[168] Exhibit C1, [67].

the final review of the IMP on 20 February 2020, no reference was made to the breach.[169]

121. But for this incident, Mr Bloomfield's time in Unit N14 was incident free until he murdered Mr Schafer. No intelligence or records existed to indicate that Mr Bloomfield had any issues with Mr Schafer, or any of the other inmates accommodated in Unit N14.[170]

Enforcing Psychological and Psychiatric Treatment

122. In their assessments and at inquest, Dr Madsen and Dr Aboud were of the view that Mr Bloomfield either met the diagnostic criteria for or had traits of antisocial personality disorder. They were both of the view that Mr Bloomfield also met the diagnostic criteria for alcohol and substance misuse disorders.[171] Similarly, Dr Schramm said, while caution should be exercised in applying a diagnosis of personality disorder based on one interview, there were '…certainly features that suggested an antisocial personality disorder'.[172]

123. All doctors said Mr Bloomfield **did not** suffer from a serious or major mental illness/disease,[173] that would warrant consideration of the use of the *Mental Health Act 2016* (Qld) ('MHA').[174]

124. The 'Diagnostic and Statistical Manual of Mental Disorders' ('DSM-5-TR') is the leading diagnostic manual. Antisocial personality disorder may be defined as a personality disorder whereby an individual shows a continuing pattern of disregard for and violation of the rights of others, occurring since the age of fifteen years, with three or more of the following:

> *1. Failure to confirm to laws and social norms (repeatedly breaking laws);*
> *2. Deceitfulness (repeated lying or conning others for personal profit or pleasure);*
> *3. Impulsivity or failure to plan ahead;*
> *4. Irritability and aggressiveness (repeated physical fights or assaults);*
> *5. Reckless disregard for safety of self or others;*
> *6. Consistent irresponsibility (repeated failure to sustain consistent work behaviour or honour financial obligations);*
> *7. Lack of remorse (being indifferent to having hurt, mistreated or stolen from another).*[175]

125. Dr Aboud said at inquest that the treatment of a personality disorder is very difficult, and the best way to try and treat the personality disorder is by trying to modify the manifestations of the disorder:[176]

> *…the manifestations would often be behavioural, but they can sometimes be psychological as well. So the – the modality of treatment for personality*

[169] Exhibit C1, [162] – [164].
[170] Exhibit C1, [69] – [70].
[171] Exhibit C40, 9; Exhibit C40, [1.6].
[172] T1 – Dr Schramm, p 39, lines 16 – 20.
[173] *Mental Health Act 2016* (Qld), s 10. During evidence, the term illness and disease were used interchangeably.
[174] T1 - Dr Madsen, p 25, lines 29 – 30; T1 – Dr Schramm, p 43, lines 21 to 22; T1 – Dr Aboud, p 50, lines 30 – 31.
[175] American Psychiatric Association. (2022.) Diagnostic and Statistical Manual of Mental Disorder, 5th Edition, Text Revision. American Psychiatric Association Publishing.
[176] T1 – Dr Aboud, p 51, lines 34 – 36.

> *disorder is typically psychological therapy. The prognosis is highly variable, and it will depend on the individual's motivation to engage and, ultimately, their response. What one can't do is change the core personality structure. What one can try and do is encourage an individual to – to adapt and behaviour in a more appropriate way if the way they've been adapting and behaving has not been appropriate.*[177]

126. Mr Bloomfield's refusal to engage in the treatment recommended by Judge Wall was not in dispute. When asked whether there was any way in which to compel Mr Bloomfield to undergo psychiatric treatment, Dr Schramm and Dr Aboud said Mr Bloomfield could not be treated involuntarily under the MHA.

127. Dr Schramm said for a person to be involuntarily treated under the MHA, a doctor must be satisfied that the ***treatment criteria*** apply and that there is no ***less restrictive way*** for the person to receive treatment and care for their mental illness.[178]

128. ***Treatment criteria*** is defined in section 12(1) of the MHA:

> *(a) the person has a mental illness;*
> *(b) the person does not have capacity to consent to be treated for the illness; and*
> *(c) because of the person's illness, in the absence of involuntary treatment, or the absence of continued involuntary treatment, is likely to result in -*
> *(i) imminent serious harm to the person or others; or*
> *(ii) the person suffering serious mental or physical deterioration.*[179]

129. A person has ***capacity to consent*** to be treated for their mental illness if the person -

> *(a) is capable of understanding in general terms -*
> *(i) that the person has an illness, or symptoms of an illness, that affects the person's mental health and wellbeing; and*
> *(ii) the nature and purpose of the treatment for the illness; and*
> *(iii) the benefits and risks of the treatment, and alternatives to the treatment; and*
> *(iv) the consequences of not receiving the treatment; and*
> *(b) is capable of making a decision about the treatment and communicating that decision in some way.*

130. Relevantly, a person may have capacity to consent to be treated even though the person decides not to receive treatment.[180]

131. When asked how psychological and personality disturbances differ to a major mental illness and whether Mr Bloomfield could be compelled under the MHA to undergo psychiatric treatment, Dr Schramm's evidence was:

> *A lot of it is by convention, that personality disorders, while they confer significant dysfunction and, sometimes, risk, are not considered serious mental diseases, and that's to do with the fact that they are often unable to be treated or very difficult to be treat. The term is usually reserved for illnesses such as the psychotic conditions, schizophrenia, schizoaffective*

[177] T1 – Dr Aboud, p 51, lines 35 – 42.
[178] T1 – Dr Schramm, p 44, lines 14 - 42.
[179] *Mental Health Act 2016* (Qld), s 14 (1).
[180] *Mental Health Act 2016* (Qld), s 14(2).

> *disorder, the major mood disorders such as bipolar disorder or major depression. A mental illness would also include other conditions, anxiety conditions, PTSD, things of that order. But it requires more than the presence of even a mental disease for someone to be treated under the Mental Health Act. It might not require a – what's – what we call in psychiatry a serious mental disease, but it – it certainly requires a mental illness, and he – Mr Bloomfield, as – he certainly had psychological issues and personality issues. They would not be what would be considered to be a mental illness. The – the other criteria to be treated under the Mental Health Act are that they do not have the capacity to consent to – treatment.*
>
> *So that can be removed by various cognitive problems, dementia, intellectual impairment; it can be removed by being in a severe psychotic state, affecting judgment. Sometimes, it can be absented by a serious mood disorder, whether it be elevated mood and mania or a depressed mood. So he certainly did not have such impaired judgment that you could say that he didn't have capacity to consent, which is basically about the ability to understand what the treatment involves, what benefits it might have, what side effects it might have. He had those capacities. So he – he didn't have – he wasn't without capacity to refuse consent under the Mental Health Act. I'm – whether or not he would've been bound to under other jurisdictions I don't know. The – the – the next criteria would – for – to be treated under the Mental Health Act is that someone – if left untreated that would result in imminent – imminent serious harm to themselves or to other or to result in serious physical or mental decline. I don't think he met that criteria. He has to meet all these criteria, by the way, not just one of them. And the last criteria is that there isn't a less restrictive way to provide treatment. So even though I believe he might've benefitted and that might've reduced risk – in other words, he might've benefitted from the treatment suggested, both psychological and pharmacological, through medication – it could not be enforced under the Mental Health Act.*[181]

132. Similarly, Dr Aboud outlined the difference between a personality disorder, such as antisocial personality disorder, and a serious mental illness. In his evidence, he stated:

> *So psychiatric disorders, very broadly, can be seen as any mental health problem at all. Within that, one can subcategorise into a group of conditions that we typically call mental illnesses. We can also subcategorise into a group of conditions that we call personality disorders. Similarly, intellectual impairment. And similarly, substance and alcohol misuse disorders. So one can see that under the broad heading of metal disorder, there are different types or different subcategories. Now, a major mental illness is really just terminology that came out of one of the diagnostic manuals which is now actually outdated. But nevertheless, what it really means is a mental illness of a greater severity. So first, one has to have a mental illness, and then a major mental illness is a more severe mental illness. So typically, that is psychotic illnesses and serious mood disorders.*[182]

133. Dr Aboud confirmed that, '…a major mental illness would include pretty much any psychotic disorder that is considered to be ***pervasive and enduring***'.[183] He confirmed that he did not believe Mr Bloomfield was suffering from a significant mood or psychotic disorder.[184]

[181] T1 – Dr Schramm, p 44, lines 8 – 42.
[182] T1 – Dr Aboud, p 50, line 42 – p, 51, line 5.
[183] T1 – Dr Aboud, p 51, lines 9 – 10.
[184] T1 – Dr Aboud, p 51, lines 20 – 21.

134. In relation to whether Mr Bloomfield could be compelled to receive psychological treatment, Dr Aboud said:

> *…it's impossible to compel somebody. They have to want to engage. So the task with a man like Mr Bloomfield would be to engage him, work with him, make an assessment, try and find out what it is that he might want out of this and ultimately work on his motivation. So I would have said those were things that – that might have been considered, but there's no guarantee that he would then choose to engage. And if he didn't, he cannot be forced. And nor can one actually force anybody to engage in psychological therapy, even people subject to the Mental Health Act. All they have to do is sit in a room and not listen and they've disengaged.*[185]

135. Mr Schafer's family submitted it was not contentious that Judge Wall's recommendations were not implemented in respect of Mr Bloomfield's psychological treatment.

136. Despite the evidence at the Inquest, Mr Schafer's family find it difficult to accept that Mr Bloomfield could not be forced to take psychiatric medication and that he was released back into the mainstream population.

137. However, the family's submission noted that, despite their frustration, the family accept it was not possible to force Mr Bloomfield to take medication or to require that he be held in the Maximum-Security Unit indefinitely.

Findings of OIMIRG Operational Review

138. Superintendent Stacey, in the OIMIRG Review Report and in his oral evidence, confirmed the findings of the operational review relevant to Issue 2:

> *Whether appropriate policies, procedures and practices were in place for the proper assessment and continuing management of the prisoner involved and if they were adequate and complied with*
>
> - *Overall, the assessment and management of Mr Schafer following his admission to BCC and then after his transfer to WFDCC was appropriate and done in accordance with COPD requirements.*
> - *Mr Schafer's assessment and ongoing management as a PoC considered his cognitive impairment and NDIS registration. Regular welfare checks were conducted by a psychologist. He appears to have been appropriately placed in N14 (mainstream) where he reported he was happy and there were no adverse incidents recorded which involved Mr Schafer.*
> - *In December 2015, Judge Wall QC endorsed and made specific comment regarding recommended treatments for Mr Bloomfield (as proposed by independent psychiatrists and psychologists). Initial efforts appear to have been made by QCS in early 2016 regarding seeking PMHS involvement to prescribe medication and to offer the CSCP program to Mr Bloomfield; however, there is no record of attempts to arrange any 'one on one psychological intervention' treatment for him. There are no records in IOMS or elsewhere which indicate that further consideration was given to the court recommendations from March 2016 until Mr Bloomfield committed a serious prisoner on prisoner assault in May 2019.*
> - *COPDs, as they existed prior to and at the time of Mr Schafer's death, were adequate and complied with by both BCC and WFDCC.*

[185] T1 – Dr Aboud, p 55, lines 20 – 29.

- *The incident response by WFDCC staff, once they became aware of the incident, was immediate and appropriate.*[186]

Whether any intelligence or other information existed prior to the incident which might have indicated that the prisoner's death may, or was likely to occur

- *There was no intelligence, or other information, which existed prior to the incident that would have given QCS staff any indication that Mr Schafer's death may, or was likely to, occur.*
- *Mr Bloomfield's institutional behaviour in the seven years preceding the murder of Mr Schafer involved only one other incident of assault against another prisoner.*
- *Information obtained from police, regarding admissions made by Mr Bloomfield, indicates that his actions were premeditated and planned in a way that gave no indication to QCS staff, other prisoners or to Mr Schafer himself, that an assault would occur which would result in the murder of Mr Schafer.*
- *Without any prior indication of Mr Bloomfield's intended actions, via behaviour or words, QCS staff could not have reasonably predicted the incident would occur.*[187]

[186] Exhibit C1, 24.
[187] Exhibit C1 - Operational Inspection and Major Incident Review Group Review Report, p 43.

Conclusions on inquest issues

Findings required by s. 45

Identity of the deceased –	Duke Allan Wayne Schafer
How he died –	Mr Schafer was serving a term of imprisonment at Woodford Correctional Centre. Mr Schafer was located unresponsive in the laundry room of Unit N14 with a ligature tied around his neck, fashioned from a torn, prison-issue bed sheet. Resuscitation attempts were unsuccessful. Mr Schafer had been strangled by another prisoner while Correctional Officers were engaged in a muster in an adjoining unit.
Place of death –	Woodford Correctional Centre, Neurum Road, WOODFORD QLD 4514 AUSTRALIA
Date of death–	6 May 2020
Cause of death –	1(a) Ligature Strangulation

Issue 2 - Mr Bloomfield's assessment and management while in custody, including:

(i) The adequacy and appropriateness of the provision of psychological and psychiatric treatment in accordance with the court's recommendation, including but not limited to whether recommended treatment of prisoners, including medication, can be enforced and, if so, in what circumstances.

139. After considering the evidence of Dr Aboud, Dr Schramm and Dr Madsen, together with the evidence of AC Newman and Superintendent Stacey, I am satisfied that that Mr Bloomfield's assessment and management while in QCS custody, including the attempts to provide him with psychological and psychiatric treatment in accordance with the court's recommendations, were adequate and appropriate. The Custodial Operations Practice Directions (COPDs), as they existed prior to and at the time of Mr Schafer's death, were adequate and were complied with by both Brisbane Correctional Centre and WFCC.

140. Following Judge Wall's recommendations on sentencing on 7 December 2015, Mr Bloomfield was referred to and opened by PMHS to receive anti-depressant medication. However, he refused to engage on several occasions, despite encouragement. In addition, Mr Bloomfield failed to engage with one-on-one specialist psychological treatment specifically commissioned by QCS.

141. On 22 December 2015, Mr Bloomfield was seen by Dr Elliott, PMHS Psychiatric Registrar. Dr Elliott found no evidence of mental illness and discussed the matter with Dr Schramm. Mr Bloomfield eventually agreed to see Dr Schramm on 19 January 2016.

142. Dr Schramm's evidence at inquest was that he did not assess Mr Bloomfield as suffering from a serious mental illness, such as schizophrenia or other psychotic or major mood disorders. However, he noted that there were features of an antisocial personality disorder present.

143. Dr Schramm was willing to provide a trial of Selective Serotonin Reuptake Inhibitors (SSRI) anti-depressant medication, as recommended by Judge Wall. However, by January 2016 Mr Bloomfield had declined Dr Schramm's offers for medication and a referral to a QCS psychologist.

144. In his evidence, Dr Schramm explained that Mr Bloomfield had subsequently failed to attend further appointments with PMHS. Dr Schramm explained that he escalated this to his Line Manager, he wrote a letter and provided it with the expectation that it would be passed on to QCS.

145. I accept the medical evidence given at the inquest, which was consistent. All the expert witnesses as well as Dr Schramm confirmed Mr Bloomfield did not suffer from a serious or major mental illness/disease that would warrant consideration of the use of the *Mental Health Act*. Mr Bloomfield had capacity to consent to or refuse treatment.

146. The steps taken by QCS to implement Judge Wall's recommendations were outlined in detail in Superintendent Stacey's Incident Review Report. It is clear that QCS was aware of Judge Wall's recommendations and considered that the implementation of those recommendations was important.

147. By 24 December 2015, the Court's recommendations as well as copies of the relevant psychological and psychiatric reports were with the Sentence Management and the Offender Rehabilitation and Management Service.

148. Mr Bloomfield declined to participate in the Cognitive Self-Change Program when it was offered to him in February 2016 and August 2019. I accept that he was advised that he could ask to be placed back on a wait list if he wanted to participate at a later time.

149. I accept that at the time his sentence, there was limited capacity within QCS to provide specialist one-on-one psychological treatment. While there may have been a missed opportunity to re-engage Mr Bloomfield with the PMHS and one-on-one psychological intervention during his placement in the MSU, there is no evidence to suggest that had he been offered these services at any time following his 2015 sentence it would have been outcome changing.

150. While there may also have been a missed opportunity to engage Mr Bloomfield in drug intervention programs and counselling after his positive drug test on 31 January 2020, there is no evidence to suggest that it would have been outcome changing.

151. There is no evidence that Mr Bloomfield would have engaged voluntarily in any of the psychiatric or psychological treatment recommendations. When he was assessed by Dr Madsen in the MSU in 2019, Mr Bloomfield expressly indicated that he was not prepared to complete any of the recommended treatment programs and that he would not apply for parole. As he did not meet the MHA criteria there was no power to compel him to engage in treatment.

(ii) Whether the decision to reintegrate Mr Bloomfield into the mainstream prison population was appropriate.

152. I am satisfied that the decision to reintegrate Mr Bloomfield into the mainstream prison population upon the expiration of the six-month MSO was appropriate in the circumstances.

153. This decision had been reviewed by the Official Visitor who recommended that the MSO be confirmed with a view to Mr Bloomfield's reintegration. Mr Bloomfield's behaviour in the MSU was compliant and he had progressed though the required Management Plans in the MSU.

154. QCS had commissioned Dr Madsen to meet with Mr Bloomfield in the MSU to assess his risk of future institutional violence. Dr Madsen recommended against Mr Bloomfield being issued with a further MSO, taking into account (among other things) Mr Bloomfield's custodial history, which indicated that he could abstain from the use of violence for long periods of time. Mr Bloomfield had engaged in violence against another prisoner on one occasion in the previous seven years.

155. I accept the evidence of AC Newman and Dr Madsen that there are risks to prisoners and others as a consequence of extended detention in the MSU. Upon release into the high security environment at Woodford, Mr Bloomfield was still progressing through an Intensive Management Plan until it was finalised in February 2020.

156. In addition, I accept the findings of Superintendent Stacey that there was no intelligence or other information prior to the incident which might have indicated that Mr Schafer's death may, or was likely to, occur.

Issue 3 - Whether any recommendations might be made that could reduce the likelihood of deaths occurring in similar circumstances, or otherwise contribute to public health and safety, or the administration of justice

157. As noted above there was limited capacity within QCS to provide specialist one-on-one psychological, as opposed to psychiatric, treatment to prisoners such as Mr Bloomfield. Superintendent Stacey and AC Newman identified that the service delivery models for psychological treatment within QCS at that time did not extend to the provision of treatment directed towards criminogenic intervention such as that recommended by Judge Wall.

158. I accept the evidence of Dr Aboud, Superintendent Stacey and AC Newman that lack of capability within QCS to provide the specialised psychological treatment such as recommended by Judge Wall, has been remedied by the establishment of the Specialised Clinical Services Unit which focuses on high-risk, high harm prisoners.

Recommendations arising from the QPS Investigation

159. DS Orchard identified two issues within Unit N14. First, there were no CCTV cameras monitoring the laundry area within the Unit. No cameras were fitted inside the laundry and no cameras were fitted externally to provide secondary monitoring.

160. Mr Bloomfield admitted he took Mr Schafer into the laundry to carry out the murder because he knew there were no cameras there. Further, throughout interviews with other prisoners, it became evident they were aware of the lack of CCTV monitoring.[188]

161. The second issue identified was the lack of prison staff patrolling Unit N14 in the period immediately following muster. Mr Bloomfield was acutely aware that in the period from when the prison officers moved from Unit N14 to Unit N15 to conduct muster, there were no officers carrying out patrols in Unit N14. He also was aware that while there was a supervisor in the officers' station, their view of the laundry was limited.[189]

162. DS Orchard recommended:

    (a) The installation of a CCTV camera in the laundry area; and
    (b) A review of staffing movements after muster to ensure a suitable number of officers are left to always manage prisoners in each unit.[190]

Findings and Recommendations arising from the OIMIRG Operational Review

163. Similarly, as a result of the OIMIRG operational review, Superintendent Stacey made the following findings:

> *<u>Any other matter(s) relevant to the events and/or which may have contributed to the occurrence of the incident</u>*
>
> - *Unit N14 is staffed by two CCOs who are assigned the roles of Unit Officer and Support Officer. The ability of two officers to effectively monitor all prisoner movements and activities within the common room, accommodation and the exercise yard areas is limited, particularly when those officers are also performing required administrative duties on the computer or attending to individual prisoner queries at the counter. This issue is exacerbated when only one officer performs those roles during muster periods or when officers are taking meal breaks.*
> - *Due to the construction and layout of N14, there are blind spots which cannot be seen by an officer seated in the officer's station. Prisoners who live in the units every day would be aware of those blind spots which can be used to conceal prohibited prisoner activities.*
> - *At the time of Mr Schafer's murder (a time specifically chosen by Mr Bloomfield), CCO Bird was the only officer present in the officer's station of N14. When interviewed, he stated he was seated at the computer completing administrative duties, attending to prisoner inquiries and also talking to CS Carter. Mr Bloomfield stated he chose the laundry to commit the murder due to its lack of CCTV coverage and due to the limited visibility from the officer's station. It is considered that*

[188] Exhibit A1, [13.2.1].
[189] Exhibit A1, [13.2.1].
[190] Exhibit A1, [13.2.1].

CCO Bird could not reasonably have seen, or been aware of, the assault taking place upon Mr Schafer by Mr Bloomfield.

- *Visibility of the laundry area from the N14 officer's station is limited by the location and structure of the officer's station within the unit. On the day of Mr Schafer's death, several items of paper were affixed to the side window of the officer's station which would have also partially blocked visibility of the laundry area by officers working in the officer's station in that unit.*
- *The construction of accommodation units in Secure 1 and Secure 2 areas are different with officer stations situated in different locations within the units. Both have advantages and disadvantages regarding daily operations, unit and prisoner visibility and staff safety. Regardless of the unit layout however, it is considered impossible, due to staffing numbers, the size of the units (including exercise yards) and the number of prisoners being supervised; for officers working in those units to view and monitor the movements and actions of all prisoners at all times.*[191]

164. Superintendent Stacey made the following recommendations in the OIMIRG Review Report to address future risks. These recommendations, relevant to the inquest issues, are as follows and are numbered in accordance with which they appear in the Review Report:[192]

> *<u>Recommendation 1</u>*
> *The Assistant Commissioner, Specialist Operations should ensure that effective systems exist across the state to monitor compliance with court recommended programs and treatment for prisoners.*
>
> *<u>Recommendation 2</u>*
> *Deputy Commissioners, Custodial Operations, and Community Corrections and Specialist Operations, should remind all staff that all relevant information regarding implementation of court recommendations, attempts to do so, or the rationale for determinations not to provide recommended treatments, should be recorded in IOMS.*
>
> *<u>Recommendation 3</u>*
> *The General Manager, WFDCC, ensure all windows which provide visibility from WFDCC officer's stations into prisoner accommodation areas should be kept clear of all paper or any other item which may obstruct the view of officers working in those areas.*
>
> *<u>Recommendation 4</u>*
> *The General Manager, WFDCC, reinforce the expectation that during musters in Secure 2 where only one Custodial Correctional Officer (CCO) is left to supervise a unit (while all other CCOs conduct muster in the adjoining unit), CCOs prioritise observations of prisoners in the units over the completion of routine administration tasks.*
>
> *<u>Recommendation 6</u>*
> *The Assistant Commissioner, Central and Northern Region Command give consideration to whether supervision capacity of prisoners residing in accommodation areas at WFDCC can be improved, such as by increasing the number of CCOs rostered to work in those units or by modifying daily routines and task allocation.*

[191] Exhibit C1, 47.
[192] Exhibit C1, 3.

165. Assistant Commissioner Hamlett ('AC Hamlett') and Superintendent Stacey provided evidence to the Court in relation to the consideration and implementation of the recommendations set out in the OIMIRG Review Report and the QPS investigation report.

Recommendation 1

166. AC Hamlett told the inquest implementation of Recommendation 1 had commenced and the case management process, known as End-to-End ('E2E') case management, has been in development since 2016. This process arose from the Queensland Parole System Review ('QPSR'), '…which contained recommendations designed to provide a clear path towards reform, underpinned by the Government's core objective of ensuring safe communities'.[193] A key component of the E2E case management process is the Engagement Plan which, '…is the tool used to capture any court based recommendations and the ability of QCS to address such recommendations'.[194]

167. AC Hamlett confirmed that the E2E case management program has been implemented in Townsville, Brisbane Women's, Southern Queensland and Numinbah correctional centres. An external evaluation was completed in January 2024 and AC Hamlett confirmed that there was a plan to continue its roll out.[195]

Recommendation 2

168. AC Hamlett outlined that implementation of Recommendation 2 had been completed. Correspondence was issued by the Deputy Commissioner, Community Corrections and Specialist Operations to the Leadership Team (including Offender Development; and Sentence and Case Management Services) on 12 April 2024.[196]

169. AC Hamlett also said at inquest that directions exist in the current COPDs in the sentence management services assessment and planning custodial offender practice directives.[197]

Recommendation 3

170. AC Hamlett confirmed Recommendation 3 had also been implemented. Monitoring remains ongoing, and strategies exist to ensure visibility is not obstructed. Such strategies include reminders at daily briefings, supervisors conducting random inspections and ongoing monitoring of the environment through weekly inspections.[198].

Recommendation 4

171. Recommendation 4 has been achieved. Staff are briefed each morning (prior to unlock) regarding competing priorities for the day. During this briefing, they are reminded that administration tasks are to be undertaken periodically throughout the day. Prisoner supervision is to be prioritised when other

[193] Exhibit E1.4, [11] & [22]; T2– Eloise Hamlett, p 63, lines 22 – 25.
[194] Exhibit E1.4, [22].
[195] T2– Eloise Hamlett, p 63, lines 25 - 30.
[196] Exhibit E1.4, [27] – [29].
[197] T2– Eloise Hamlett, p 66 lines 9 -13.
[198] T2– Eloise Hamlett, p 67, lines 4 – 10; Exhibit E1.4, [31] – [34].

CCOs are conducting muster, meal breaks and medication parades in the adjoining unit.[199]

172. AC Hamlett also said the importance of undertaking dynamic observations is:

> *…constantly reinforced through training at the academy called observations skill training, through our mentoring and coaching of CCOs via the correctional supervisor… their role is, particularly during periods of high activity such as muster, medication, parade, their role is to maintain visual observations of the unit. The process has further been strengthened by securing, now, areas of vulnerability…which assists to reduce the likelihood that we've got people in blind spots that makes it more challenging for the CCO to perform the observations.*[200]

173. AC Hamlett also explained that the area supervisor is to conduct random audits of musters and unlocks from the control room. Where a deficiency was identified, the supervisor was to attend the unit and directly address the officers involved.[201]

Recommendation 6

174. AC Hamlett advised that Recommendation 6 could not feasibly be implemented for two reasons. AC Hamlett explained:

> *The Woodford staffing model does allow for staff to supervise prisoners. In particular, the Secure 2 accommodation unit staffing model is comparable to/higher than other correctional centres at a similar bed state. This is an optimal staffing level to maximise prisoner supervision while maintaining staff safety.*[202]

175. AC Hamlett's view was that a further increase in staff would not have mitigated the risk. However, securing the areas of concern and controlling movement would.[203] She said additional staff could act as a distraction as opposed to a single person focussed on observing the unit.[204]

QCS response to QPS recommendations

176. In the OIMIRG Review Report, it was noted that following the death of Mr Schafer, Superintendent McHaffie undertook a review of the laundry practices in Secure 2 and other correctional centres around the State.

177. Superintendent McHaffie found that prior to 2017, the laundry areas in Secure 2 were always locked. Prisoners were required to request access from unit officer. This changed in April 2017 when prisoner numbers increased to fifty-one inmates (the unit was designed for a capacity of thirty-five prisoners) and the laundry was approved to be left open to facilitate more opportunities to wash their clothes.

178. The Schafer family's submission noted that reviews had been conducted by the QPS and OIMIRG. However, they expressed their criticism of the poor system of

[199] Exhibit E1.4, paras [35] – [38].
[200] T2– Eloise Hamlett, p 70, lines 1 – 5.
[201] Exhibit E1.4.1, [14].
[202] Exhibit E1.4, [48].
[203] T2– Peter Stacey, p 2, lines 18 – 44; T2– Eloise Hamlett, p 68, lines 1 – 9.
[204] T2– Eloise Hamlett, p 69, lines 22 – 26.

prisoner control and the failure to identify obvious safety risks present in Unit N14 prior to the death of Mr Schafer. Those risks were well known to prisoners and were exploited by them. They were not remedied in a timely manner. Mr Bloomfield stated that the weakness in the safety system motivated his decision to take Mr Schafer into the laundry before killing him.

179. I accept the submission from the Schafer family that the April 2017 change to give open laundry access did not take into account the risks that resulted from the change.

180. Superintendent McHaffie also found that fifty percent of correctional centres left laundries unlocked while the other fifty percent kept them secured.[205] Superintendent McHaffie determined that the laundries in Secure 2 (and therefore Unit N14) would return to being locked at all times.[206]

181. Both Superintendent Stacey and AC Hamlett said the current laundry procedure at Woodford was that the laundry remains locked and a prisoner must first be granted access by correctional officers. Once granted, a prisoner will remain under observation by a correctional officer standing at the door. The laundry is never to be unsecured without direct supervision. Additionally, only one prisoner is allowed to use the laundry at a time. While doing so, the laundry remains secure.[207] Effectively, as AC Hamlett stated at inquest:

> *…it's just controlling the movement of prisoners to mitigate the risk of having more than one person in that area at any time or having the area unsecured without appropriate staff supervision.*[208]

182. When asked whether the change in policy achieved the same outcome as putting CCTV in the laundry by stopping unsupervised access, Superintendent Stacey said:

> *It probably provides better protection than a CCTV camera would in that it stops prisoners walking in there unsupervised and of their own volition. It is the case that they have to be granted access, but while they're in there, they're actually under physical observation of the CCO, so anything that they're doing in there that's incorrect can be actioned straight away to stop it, whereas a camera, you're – you're looking at someone having to be looking at the camera at the exact time something is happening to them, realise some action has to be taken. And other than that, a camera would be good to record an incident for later review and potential evidence.*[209]

183. Superintendent Stacey's view was that direct observation of prisoners provided better scrutiny of what was happening in the laundry than having a camera installed.[210]

184. While the Schafer family submitted that I should recommend that all prison laundry and kitchen areas be fitted with CCTV cameras, I accept Superintendent Stacey's evidence that direct observation by a CCO who is physically present provides a superior level of supervision.

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[205] Exhibit C1, [206] – [210].
[206] Exhibit C1, [206] – [211].
[207] Exhibit E1.4.1, [11]; T2– Eloise Hamlett, p 71, lines 4 – 19.
[208] T2– Eloise Hamlett, p 71, lines 17 – 19.
[209] T2– Peter Stacey – p 71, lines 4 – 14.
[210] T2– Peter Stacey – p 71, lines 15 – 20.

185. AC Hamlett confirmed that a proposal was due to be considered by the Officer Safety Committee in relation to a statewide review of laundries and kitchenettes to determine what additional measures could be put in place to reduce the risk of a similar incident from occurring in the future.[211] The approach taken in other centres, and being investigated at Woodford, is the introduction of a centralised laundry. This would allow unit laundries to cease operation.

Delay in provision of OIMIRG Report to Operational Oversight Committee

186. It was acknowledged by QCS that in this matter, there was an administrative oversight in providing the OIMIRG Review Report to the Operational Oversight Committee for recording progressive action of the recommendations. However, Superintendent Stacey said despite this:

> *…the reports are consulted through the agency. The General Manager at Woodford saw the report, the recommendations, the talk about clearing windows, off and that sort of thing, so the ability for the agency to take action back when the report was written was there anyway, regardless of whether the Operational Oversight Committee did or didn't record them.*[212]

187. Superintendent Stacey also confirmed that since becoming aware of the administrative oversight, a review of all Death in Custody Operational Review Reports has been undertaken to ensure that all recommendations have been referred to the Operational Oversight Committee.[213] Further, a process has now been developed that results in the Operational Oversight Committee's director and secretariat being notified of the recommendations at the same time the Commissioner approves the recommendations.[214]

188. In this matter, both the QPS and OIMIRG suggested recommendations to address and mitigate potential future risks.

189. The delay in providing the OIMIRG Review Report to the Operational Oversight Committee, while undesirable, has now been rectified.

190. In the circumstances, I consider that no further recommendations are required. The recommendations already made and actioned in response to Mr Schafer's death are adequate and appropriate.

191. I extend my condolences to Mr Shafer's family.

192. I close the inquest.

Terry Ryan
State Coroner
BRISBANE

[211] Exhibit E1.4, [55] – [56].
[212] T2– Peter Stacey – p 32, lines 34 – 38.
[213] Exhibit E1.2.1, [9] – [10].
[214] T2– Peter Stacey – p 33, lines 12 – 18.