CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the passing of ATJ**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Townsville
FILE NO(s):	2022/3569
DELIVERED ON:	15 October 2025
DELIVERED AT:	Brisbane
HEARING DATE(s):	10 -11 September 2025
FINDINGS OF:	T Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, passing in custody, First Nations man, risk assessment, observations, hanging points.

REPRESENTATION:

Counsel Assisting:	Ms C McKeon
Lamberr Wungarch Justice Group:	Mr A Dawes
Queensland Corrective Services:	Ms J Villanueva, Legal Strategy and Services, QCS

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Introduction

1. ATJ was a 43-year-old First Nations man who passed[1] at the Townsville Correctional Centre (TCC) on 20 July 2022.[2]

2. ATJ had been remanded in custody at TCC since 12 April 2022 in relation to offences involving domestic violence, property and weapons.[3]

3. On the morning of 20 July 2022, he was found on the floor of his cell, unresponsive, by his cellmate, William.[4] William called for help from Custodial Correctional Officers (CCOs). Attending CCOs found a ligature fashioned from a bedsheet around ATJ's neck. This was anchored to a shelf. CPR was performed by CCOs and attending Queensland Ambulance Service paramedics. ATJ was unable to be revived.[5]

4. ATJ's cause of passing was determined to be hanging.[6] As he passed while detained at the TCC, his passing was a *"death in custody"*.[7] An inquest was required under s 27(1)(a)(i) of the *Coroners Act 2003* (Qld).

The evidence

Personal History

5. ATJ was born on 14 July 1979 in Mount Isa. He was raised in the far north west of Queensland and the Mareeba area. As a young man he was always with his brothers, playing a lot of sport. He was working in industrial work and paving, and lived in north Queensland in the years before his final remand in custody.

6. ATJ had six children who were aged between 10 and 22 years of age. He became a grandfather in the year he passed. prior to his passing, ATJ had been in a relationship and had lived together with his partner in north Queensland for about a year. His children were from former partners.[8]

7. His family described him as a happy go lucky man who was not without challenges in his life.[9]

8. ATJ's partner stopped contact with him after he was arrested on 3 April 2022 and remanded in custody for aggravated offences of domestic violence.[10] According to his partner, he was affiliated with outlaw motorcycle gangs and was a regular user of alcohol, marijuana and ice.[11]

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[1] Where possible I will use the term *"passing"* or *"passed*", consistent with cultural protocols.
[2] A non-publication order is in force prohibiting the identification of the deceased and other prisoners.
[3] Ex C8 - at page 6; Ex A3- at page 3.
[4] Ex A3 - at page 3. William is a pseudonym.
[5] Ex A3 - at pages 2-4.
[6] Ex A5 - Form 30 Autopsy Certificate.
[7] *Coroners Act 2003*(Qld) s.10.
[8] Ex A2 – Form 1 at pages 5 and 10; Ex A3- at pages 12-13.
[9] Ex J1 - Community Justice Group Letter.
[10] Ex C5 - QP91.
[11] Ex C3 - DOCS referral at page 3; Ex A3- at page 11.

Correctional History

9. ATJ had a criminal history that commenced in 1999 when he was sentenced for the offences of driving an uninsured vehicle and possessing utensils or pipes.[12]

10. ATJ's offending escalated to violence and on 13 April 2006, he was sentenced in the Maryborough District Court to 6 months imprisonment, suspended for 2 years after serving 2 months for an assault occasioning bodily harm while armed.[13]

11. On 19 March 2008, ATJ was sentenced in the Hervey Bay Magistrates Court to 3 months imprisonment.[14] On 23 March 2008, ATJ told Queensland Corrective Services (QCS) that he had been thinking about harming himself.

12. He said he was feeling isolated in the prison unit and had limited contact with his family. He also reported an attempt at self-harm in the community.[15] A Notification of Concern (NOC) was completed, and he was placed on a Safety Order with conditions as per the *"at risk policy"* from 26 March 2008 to 23 April 2008.

13. ATJ was placed under 30-minute observations and was subject to an At-Risk Management Plan (*ARMP*). The order noted he had presented as depressed and had been thinking about hanging himself. It stated ATJ reported he was due for release in five weeks, had been stressed about release and was also feeling isolated as he was away from his family in North Queensland.[16]

Events Leading up to the Passing

14. On 5 January 2022, a domestic violence order was made in the Magistrates Court naming ATJ as the respondent. The order contained a single condition requiring ATJ to be of good behaviour towards his partner.[17]

15. On 14 March 2022, ATJ was sentenced to three months imprisonment suspended for 18 months for two counts of contravention of the domestic violence order, and one month imprisonment suspended for 18 months for possession of a knife and a public nuisance domestic violence offence.

16. On the evening of 3 April 2022, ATJ was involved in an argument with his partner. ATJ left but returned soon after with a can of fuel, which he poured throughout the interior of the home and on his partner. She managed to run away and call 000. When police returned to find him, they found he had poured other accelerants through the home and damaged property but had left. Police located him intoxicated on a footpath nearby with two machetes. He was arrested and held in the watchhouse to appear before court the next day.[18]

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[12] Ex C1 – at page 1.
[13] Ex C1 – at page 2.
[14] Ex C1 – at page 2.
[15] Ex D10.16.1- Self Harm Episode List March-April 2008 at page 1.
[16] Ex D10.15.1- Safety Order March-April 08; Ex I1- at pages 8-9.
[17] Ex C5, C6, C7 – QP9s.
[18] Ex C5- QP9.

17. The fresh offences were similar to those he was on concurrent suspended sentences for, and were committed during the terms of imprisonment imposed, thereby breaching the suspended sentence.[19]

18. On 4 April 2022, ATJ was remanded in custody and the charges were adjourned for mention on 8 April 2022. No pleas were entered.[20] On 8 April 2022, the charges were further adjourned for sentence on 3 June 2022. No pleas were entered on this occasion.[21]

19. ATJ was received into the TCC on 12 April 2022 and remanded on the following charges:

    a) Two contraventions of a domestic violence order (aggravated offences);
    b) Common assault, particularised as a domestic violence offence;
    c) Possession of a knife; and
    d) Wilful damage, particularised as a domestic violence offence.[22]

Medical and Mental Health History

20. Medicare and PBS records showed ATJ was dispensed diazepam in the community on 19 January 2022. The reason for this prescription was not clear, and there were no repeats of the prescription. No other mental health-related medications are recorded as being prescribed or dispensed on the PBS system.[23]

21. Townsville University Hospital records noted the following:

    a) On 2 March 2016, ATJ was voluntarily admitted to the Bundaberg Hospital adult inpatient unit after reporting suicidal ideation and auditory hallucinations. He was discharged on 4 March 2016; and

    b) On 9 March 2016, ATJ overdosed on diazepam and quetiapine, telling the Townsville Acute Care Team he did not intend to end his life and misunderstood how he took the medication. He was closed to that team on 15 March 2016.[24]

The month before his passing

22. ATJ was accommodated in cell 4 in secure unit 1. The unit contained two levels of cells and ATJ's cell was located on the ground level. This cell was a three metre by two metre dual occupancy cell. At the time of his passing ATJ shared the cell with another prisoner, William. They had been cellmates since 3 July 2022, and the cell had its own shower and toilet. [25] ATJ and William met about two months prior to ATJ's passing. They decided to share a cell together as they got along, and ATJ was physically training William. ATJ had the bottom bunk while William had the top bunk.[26]

[19] Ex C8 at page 6.
[20] Ex D11.2- IO part 2- at page 23.
[21] Ex D11.2- IO part 2- at page 22.
[22] Ex C7- QP93.
[23] Ex G2 and G3- Medicare/PBS records.
[24] Ex G5- Medical Records- THHS at page 30.
[25] Ex A2- Form 1 at page 11; Ex A3 – ; Ex D5 – Unit History.
[26] Ex A3 – ; Ex A6- Supp Form 1- CIB at page 1.

23. ATJ had not participated in any personal visits or made any personal phone calls during this period of incarceration.[27]

24. While in custody ATJ was known to regularly train in the exercise yard and in his cell. He was described as a quiet, polite, and good prisoner who was well-liked. He would train other prisoners and write letters for William, who was not able to read or write.[28]

25. During the two weeks prior to his passing, William advised that ATJ had asked for tablets from other prisoners to help him sleep. William recalled that ATJ regularly thought the people in the cells above them were talking about him, and that he would put things like toilet paper inside his ears to use as ear plugs.[29]

26. Approximately one week prior to ATJ's passing, ATJ and William were in their cell watching the news. There was a story on the news about a local man being found with child pornography on his laptop. ATJ told William he thought someone was going to *"dob"* him in for that type of offending (watching child pornography). William did not know why ATJ said this.[30]

27. On 13 July 2022, ATJ's five outstanding charges were mentioned in the Magistrates Court. That date had originally been set for sentence. No plea was entered and he was remanded in custody, with the next court date set for the callover on 22 July 2022.[31]

28. In the week leading up to his passing, ATJ also talked to William about hearing that he and another prisoner were being sent to the 'boneyard'. The boneyard was a unit where prisoners were accommodated when they needed protection.[32]

19 July 2022

29. On 19 July 2022, ATJ's unit was in lockdown and prisoners were required to stay in their cells for the day. ATJ slept, watched TV and did a little training in his cell. At one point during the afternoon a CCO told ATJ to go for a medical appointment but he declined to do so.[33]

30. At about 4:30pm, ATJ and William were delivered their evening meals. William was also delivered his evening medication, which included a sleeping tablet that he took with dinner. William sat on the top bunk, ate his dinner and watched television.

31. ATJ told William that people were talking about him and pointed to the cell above. William could not hear anyone talking about ATJ and told him not to worry about it. William thought ATJ was hearing voices, which was normal behaviour for him.[34] William later told police he felt something was 'off' about ATJ, and that he was stressed about upcoming court matters.[35]

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[27] Ex D1 – Intelligence profile report; Ex D8 – Call log.
[28] Ex B17 – Recording 1; Ex E40- PCSC HARGENS BWC; Ex E44- PCSC HARGENS BWC; Ex A6- Supp Form 1- CIB at pages 1-2.
[29] Ex B17 – Recording 1; Ex A2- Form 1 at page 10.
[30] Ex B17 – Recording 1 at 17:30 minutes.
[31] Ex D11.2- IO Part 2 at pages 3 and 18.
[32] Ex B17 – Recording 1 at 20:00 minutes.
[33] Ex B17 – Recording 1 at 12:50 minutes.
[34] Ex B17 – Recording 1 at 22:35 minutes.
[35] Ex A2- Form 1 at page 10; Ex D3- Occurrence Logbook at page 4.

32. William went to sleep around 7:30pm after taking a sleeping tablet. He woke up at about 10:30pm to use the toilet. William saw ATJ lying on the ground on his stomach in the cell. ATJ was underneath the bottom bunk with his head near the pigeonhole, a vent in the wall between cells 4 and 3. ATJ told William that they were talking about sending him to the boneyard.

33. William did not hear anyone talking about ATJ. He used the toilet and told ATJ not to worry about it and to go to bed. William went back to sleep and did not wake until the following morning.[36]

34. The occurrence logbook for nightshift shows all 84 prisoners were sighted on both headcounts.[37] The master logbook records the following after the secure check and observations conducted at 7:30pm on 19 July 2022:

    a) On the evening of 19 July 2022, secure checks being conducted at around 8:31pm and 9:37pm; and

    b) In the morning of 20 July 2022, secure checks being conducted at around 2:30am, 3:34am and 4:40am with the head count call commencing at 7:16am.[38]

Day of passing

35. CCTV depicted CCOs Hayden Smith and Nicholas Vance entering secure unit 1 at 4:30:28am. CCO Smith is depicted looking through the window in the door of ATJ's cell (number 4) at 4:30:55am. They are depicted leaving the unit at 4:32:28am.[39] CCO Smith advised when he inspected ATJ's cell, *"nothing appeared to be out of the normal…it appeared as though [ATJ] was in his bed and after a brief check I continued with the remainder of my headcount"*. [40]

36. CCTV then depicts CCOs Blake Treloar and Michael MacPherson entering secure unit 1 for headcount. This consisted of CCOs going to each cell door, looking through the window and checking the prisoners were in their cell prior to the doors being unlocked. CCO MacPherson checked the top level, and CCO Treloar checked the bottom level. CCO Treloar is depicted looking through the window to ATJ's cell at 7:17:01am. He later stated that from what he could see there were two people in their beds in the cell. It was normal practice not to wake the prisoners if they were asleep, and not on observations, and CCOs just ensured they were in the cell.[41]

37. The BWC of the entry to the cell demonstrated that ATJ's bedding appeared to look like someone was asleep under the blankets.[42]

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[36] Ex B17 – Recording 1 at 24:00 minutes; Ex A6- Supp Form 1 at page 2.
[37] Ex D3- Occurrence Logbook at page 4.
[38] Ex I2- Death in Custody – Attachments at pages 15-16.
[39] Ex I1- at page 12.
[40] Ex I2- Death in Custody- Attachments at page 378.
[41] Ex A3 – at pages 40-41; Ex D3- Occurrence Log at page 6; Ex I2- Death in Custody – Attachments at page 25; Ex E54.8 Treloar at 4:50; Ex E54.7- Macpherson at 7:17.
[42] Ex E8- TRELOAR BWC.

38. Around the same time, William woke up and turned the television on. He got out of bed and saw ATJ sitting against the bookcase on the ground. At that point William did not notice anything strange about ATJ's appearance and he thought that ATJ must have fallen asleep on the floor. William went to the toilet and had a quick shower, patting water on himself and returned to his bunk. William folded up his bed and told ATJ to get ready. ATJ didn't respond or move, William repeated to ATJ to get ready.[43]

39. At about 7:40am William looked at ATJ closely and realised his stomach was not moving, he noticed dribble coming from ATJ's mouth. William immediately used the intercom in his room to report to the CCOs that ATJ looked like he had passed out and was leaning against the wall and drooling.[44]

40. CCOs attended the cell within minutes. CCO Jared Day approached the cell and saw William standing by the door and what he initially thought was someone laying in the bottom bunk. The bottom bunk had been made to look like it was occupied using clothing and bedding. He directed William to take a seat on the bottom bunk, he complied with the direction and sat down.[45]

41. CCO Day noticed at this point an arm leaning out of the back of the bookshelf situated in the cell on the left-hand wall.[46] CCO Day entered the cell and walked past William to the rear of the cell. He saw ATJ in a seated position facing the rear of the cell on the ground. CCO Day saw a strip of sheeting tied around ATJ's neck and attached to the top of the bookshelf causing a tight ligature around ATJ's neck.[47]

42. CCO Day called for an officer to raise a code blue. This was broadcast at approximately 7:43am.[48] CCO Flinn entered the cell, cut the bed sheet to relieve ATJ's neck and lowered ATJ to the ground.[49] CCO Treloar escorted William to a secure interview room while CCO Wilson began CPR on ATJ.[50] 000 was called at 7:44am.[51]

43. A number of CCOs and nursing staff took turns performing CPR until paramedics arrived. Nursing staff assessed he was in cardiac arrest on arrival. They were unable to insert an oropharyngeal airway tube due to rigidity, but inserted a nasopharyngeal airway. Two rounds of 100mcg Narcan were given along with a glucagon injection. Attending nurses noted ATJ's limbs could not be moved. At 8:02am ATJ's pupils were noted to be fixed and dilated. The AED did not recommend a shock at any point during the resuscitation efforts.[52]

44. QAS arrived at the prison at 7:57am. After a short delay locating ATJ's cell, they were able to enter the cell and assess ATJ at about 8:06am. He was assessed as being in rigor mortis and presenting with obvious passing. CPR was discontinued at 8:10am and ATJ was declared deceased at 8:12am.[53]

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[43] Ex B17 – Recording 1 at 31:00 minutes; Ex A2- Form 1 at page 10.
[44] Ex B17 – Recording 1 at 33:40 minutes; Ex A2- Form 1 at page 10; Ex A3- at page 4.
[45] Ex B5, Ex B9.
[46] Ex B5, Ex B9.
[47] Ex B5, Ex B9; Ex A3- at page 6.
[48] Ex B5, Ex B9.
[49] Ex B10.
[50] Ex B10; Ex B16.
[51] Ex H3.
[52] Ex B7; Ex B11; Ex B12; Ex B15; Ex G1- QCS Medical File at page 30; Ex H2 – eARF at page 1.
[53] Ex B5, Ex B9, Ex A1 – Life extinct form; Ex H2- David- eARF at page 1.

Investigations

Queensland Police Service

45. Police who arrived on scene at 8:45am observed ATJ laying on the floor of his cell, clothed in prison issued underwear and trousers. His body had been covered by a sheet. Corrective Services Investigation Unit (CSIU), CIB and Scenes of Crime officers attended. In examining the scene, police noted the ligature used by ATJ was a white fabric, possibly a bed sheet. It was hooked over the corner of a set of metal shelves secured to the wall. The bead of silicone normally covering the corner of the set of shelves had been removed, leaving an edge that the fabric could be hooked over. [54]

46. Police also located notes in the cell in ATJ's handwriting. The main note stated:

"Love u mum your my everything the same goes for my kids an there mother I'm not that kind of person to do things like that thought the girls are the hardest well the same goes for the boys it's not easy grown your kids up bye yourself but I tried my best, hardest an I'm happy with myself I don't give a fuck wat people say but give my kids time they will tell you the truth and with this stress why I killed my self over nothing if they only knew my kids are the truth but it's a bit late now hope you find it in yourself that I didn't mean it that way I love my kids
They framed me the jealouse cunt's dog cunt's it wasen't my drinking I love my drink after hard work an growing my kids up is hard work they jealous
Love you mum
Main and blacks
See you soon busta
My kids an there mothers…..".[55]

47. Attending police interviewed William and also photographed him. No signs of injury were seen by police on William's body.[56]

Corrective Services Investigation Unit

48. An investigation into the circumstances of ATJ's passing was conducted by Detective Sergeant Steadman of QPS's CSIU. He concluded in his Coronial Report that there was nothing to suggest the hanging was suspicious. I agree with this conclusion.

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[54] Ex A2- Form 1; Ex A6- Supp Form 1 CIB at pages 2-3; Ex F3- SOCO photos at page 51-52, 80, 87, 90-96.
[55] Ex F1- Images of Notes at page 10.
[56] Ex A6- Supp Form 1 CIB at page 3; Ex F2- SOCO photos.

49. After being notified of the passing, CSIU officers attended the TCC with SOC officers and CIB. The cell was inspected, and no suspicious circumstances were identified. A fingerprint examination confirmed ATJ's identity. Recorded interviews were conducted with next of kin, prisoners in ATJ's unit. CCOs involved in the incident were interviewed and provided Officer Reports or statements. QAS, QCS, DOCS, PBS and Medicare records relating to ATJ were obtained. Correspondence from the Community Justice Group *(CJG)* assisting the next of kin was obtained and considered. [57]

50. DS Steadman's investigation included the following relevant points:

    a) ATJ's final term in prison was his fourth custodial episode;[58]

    b) During this term there were no recorded QCS incidents;[59]

    c) QCS records revealed no previous self-harm or attempted suicide incidents, and no incidents of poor behaviour or aggression towards QCS staff or other prisoners;[60]

    d) Of the prisoners who agreed to be interviewed:

        i. ATJ's former cellmate advised ATJ would walk up and down the cell and talk to himself, thought people were talking about him and would sit at the desk in the cell looking around, which he thought was strange;[61]

        ii. Prisoner S advised ATJ was stressing about court and his partner on the outside but still described him as being "*good*" the day before his passing;[62]

        iii. Prisoner W recounted that the day prior to ATJ's passing, ATJ had asked him about getting medication to help him sleep. Mr W told ATJ that he did not know where he could get medication. Mr W described ATJ as not seeming "*worried*" at the time he asked;[63] and

        iv. Other prisoners described ATJ as acting 'normal and happy' the day before his passing. They described him as training in his cell, which was normal behaviour for him, and being happy about starting his job as a cleaner in the unit.[64]

    e) No evidence was identified that ATJ had disclosed any plans to self-harm to any prisoners;

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[57] Ex A3.
[58] Ex A3- at page 3.
[59] Ex A3- at page 3.
[60] Ex A3- at page 10.
[61] Ex A3- at pages 17-18.
[62] Ex A3- at page 20; Ex E54.5 at 6:00 minutes.
[63] Ex A3 – at page 24.
[64] Ex A3 ; Ex E47; Ex E42; Ex E40.

f) William's records showed that he had recounted the same version to his friends and family that he told police. In one of the conversations William told his friend that he could not see the noose around ATJ's neck because his "*neck was down*" and he was a *"big boy"*. William appeared to police to be upset when initially recounting his version of events to officers and sounded emotional in his phone conversations about the incident;[65]

g) ATJ appeared to have been supervised by CCOs in accordance with QCS procedures and requirements;[66]

h) No official concerns were raised about ATJ's mental health during the last period of incarceration;[67]

i) CCTV footage from the 48 hours before ATJ's passing did not identify any unusual behaviour. It depicted ATJ and the other inmates living their normal day to day life in custody. The cell itself did not have internal CCTV;[68]

j) DS Steadman was of the view that ATJ had not raised concerns with staff about his stress, health or mental health;[69]

k) ATJ was not prescribed medication for stress or mental health issues during his final term of incarceration;[70] and

l) All attempts are made to remove hanging points in prison cells but in this instance the silicone was removed from the corner of a set of shelves, exposing a hanging point. It is unclear who was responsible for removing the silicone.[71]

51. In terms of the preventability of the passing, DS Steadman concluded:

a) ATJ was treated satisfactorily and adequately while remanded in TCC;

b) All policies and procedures relating to ATJ's custody and supervision appeared to have been complied with;

c) ATJ used material provided to him by QCS (bedsheets) to fashion into a ligature to self-harm which led to his passing. While efforts were made by QCS in the design of prisoners' cells to reduce hanging points, in this case it appeared ATJ had removed silicone from the top of a set of metal shelves allowing ATJ to hook the ligature over it; and

d) ATJ used his knowledge of the "*procedures and observations*" of TCC staff to "*commit suicide without being discovered until a later stage".*[72]

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65 Ex A3 – at pages 28-29; Ex E58-E76; Ex B17- Recording.
66 Ex A3- at page 42.
67 Ex A3 - at page 42.
68 Ex A3 – at page 42; Ex E10-E37.
69 Ex A3- at page 42- this conclusion was not correct.
70 Ex A3 - at page 42.
71 Ex A3 - at page 42.
72 Ex A3 – at page 44.

52. Ultimately, DS Steadman adopted the conclusions expressed by Dr Williams that ATJ's passing was caused by hanging, there were no suspicious injuries to ATJ and that ATJ had no significant natural disease.[73]

53. No evidence to warrant initiation of criminal proceedings against any person, including QCS and Queensland Health staff, was found.[74]

Critical Incident Review and Inspection Group

54. A parallel investigation was conducted by the Critical Incident Review and Inspection Group (CIRIG) in QCS. Those investigators prepared an Operational Review Report that was provided to the Court. This investigation included reviews of QCS records, policies and procedures, CCTV, recorded interviews with prisoners and CCOs.[75]

55. The Report noted that when ATJ entered custody at the TCC on 12 April 2022, he underwent an Immediate Risk Needs Assessment (IRNA) which saw him referred for a further risk assessment by a psychologist. The psychologist assessed his presentation on the day and concluded ATJ did not require ongoing psychological support or observations. It noted there was no evidence to suggest ATJ was experiencing mental health concerns during his final term of custody at TCC.[76]

56. COPDs relating to At Risk - At Risk Management, Daily Operations (Night Shift), Incident Management (Death in Custody), Incident Management (Incident Management Process), and Incident Management (Management of Evidence and Seized Property) were considered in the review.

57. In considering ATJ's at-risk management, the Report stated:

    a) ATJ's final term was his seventh correctional episode;[77]

    b) While Counsellor McMaster did not acknowledge ATJ's Self-harm episode history (SHEH) flag, and deemed him not to be an acute risk of engaging in self-harm or suicidal behaviours at the time of assessment, given a suicide/self-harm question response had been endorsed (recent loss of loved ones), she did refer him for risk assessment by a psychologist;[78]

    c) ATJ was seen by psychologist Joshua Miller on 12 April 2022. He assessed his responses as normal, citing ATJ was future-focused and denied any current suicidal or self-harm ideation, plan or intent. He was considered suitable to be accommodated in a unit with no observations necessary;[79]

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[73] Ex A3 - at page 44.
[74] Ex A7- Cover Report DIC.
[75] Ex I1- Death in Custody- Report; Ex I2- Death in Custody- Attachments.
[76] Ex I1- at pages 4-5 and 15 ff.
[77] Ex I1- at page 8.
[78] Ex I1- at pages 9, 12 and 13.
[79] Ex I1- at page 9.

d) Through this term of incarceration, there were no case notes to evidence concerns for ATJ's welfare at the TCC, aside from on 1 May 2022, when he reported experiencing possible COVID-19 symptoms. The supervisor case note audit completed on 2 June 2022 specifically mentioned the SHEH flag and stated *"nothing in case notes during this audit period indicate that the prisoner is at risk of self-harm"*;[80]

e) When interviewed by CIRIG Inspectors and asked about how much weight should be given to self-harm episode from 2008, Mr Miller advised that any attempt 10 years old and older is considered historical, and that weight is also a matter for professional judgement. He further advised that ATJ's behaviour described by William (listening through the vents and thinking people were talking about him) would not be expected to be picked up by psychological services unless it was noticed and reported by custodial staff, an inmate or ATJ himself; and[81]

f) William advised Inspectors at interview that ATJ had not made any comments or done anything leading up to his suicide that made him believe ATJ was vulnerable or needed help.[82]

58. In this respect, the CIRIG findings were to the effect that ATJ was referred to a psychologist following his IRNA. The psychologist identified the previous self-harm episode and made a thorough assessment of ATJ's risk. This assessment was that he was not presenting at risk of suicide or self-harm. While ATJ's cellmate had observed him listening through the vent and stating people were talking about him, this was not observed by or reported to QCS staff.[83]

59. In reviewing the incident in the context of the Daily Operations (Night Shift) COPD, the report discussed the 4:30am check of ATJ's cell conducted by CCO Smith and noted that the COPD acknowledges that it is difficult for a CCO to determine apparent good health during a headcount on a night shift, and that officers must be vigilant for unusual behaviours or occurrences. The Report mentioned CCO Smith's statement that *"it had appeared as though the prisoner was in his bed and after a brief check, I continued with the remainder of my headcount"* and noted this belief correlated with other CCOs.[84]

60. Body worn camera (BWC) footage of the bedding on entry to the cell objectively looked like someone was laying underneath the blankets. However, the Report did not deal in any way with the check conducted at 7:16am when, having regard to the fact that he was noticed some 10-20 minutes later and was already in rigor mortis, he would have almost certainly been sitting on the floor of the cell hanging during this check.

61. At interview with Inspectors, CCO Day's advice was that he could see ATJ's arm and his figure behind the bookshelf through the window before he opened the door, and that as a result despite seeing William and what looked like a body lying in ATJ's bed, it looked like three people were in the room so *"something's obviously wrong at this point in time".* [85]

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80 Ex I1- at page 9.
81 Ex I1- at page 14.
82 Ex I1- at page 14.
83 Ex I1- at pages 14-15.
84 Ex I1- at page 15.
85 Ex I2- Death in Custody- Attachments at pages 234-236.

62. Section 8 of the Incident Management - Death in Custody COPD re-iterates the requirements of s 24 of the *Corrective Services Act 2006* (Qld) which requires that if a prisoner is First Nations, the following entities/people must be notified:

- *an Aboriginal or Torres Strait Islander legal service representing Aboriginal or Torres Strait Islander persons in the area in which the prisoner died; and*
- *if practicable, an elder, respected person or Indigenous spiritual healer who was relevant to the prisoner.* [86]

63. The Report acknowledged these cultural notifications were not made.[87]

64. The Report found that the responding CCOs acted promptly in providing life-saving measures to ATJ and did not cease their efforts until life was declared extinct by a paramedic.

Family concerns

65. On 20 July 2022, the QPS spoke with ATJ's mother. She advised the QPS ATJ had seen a doctor for voices in his head regarding *"evil"*, he was always "*hearing things"*, was possibly schizophrenic, and had depression but was unsure if this had been clinically diagnosed. She was also unsure if ATJ was diabetic or had any cardiac history.[88]

66. There was nothing recorded in the medical records to suggest ATJ had been formally diagnosed with or treated any mental health disorders with any recency, including depression or for "*hearing things*".

67. ATJ's partner also told police that ATJ was always hearing voices. This occurred on a daily basis and was worse when he drank alcohol. She said ATJ wore ear plugs all the time and would sleep with them in, telling her he wore them so that he would not be disturbed by anyone.[89]

68. The Coroners Court received a letter from the Lamberr Wungarch Community Justice Group (CJG). The letter advised there were concerns about:

    a) The final hours of ATJ's life;
    b) His incarceration within the prison;
    c) His monitoring in his cell;
    d) The response to the suicide by TCC staff;
    e) The contents of the note he left; and
    f) The suicide being out of character, with the family being of the view that he had never exhibited any suicidal ideation before, and had never attempted to self-harm.[90]

69. On 28 July 2022, the Court released the notes found in ATJ's cell to his mother and the CJG.

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[86] Ex I1- at page 16.
[87] Ex I1- at page 16.
[88] Ex A2- Form 1 at page 11; Ex E56 – Video recording.
[89] Ex A3- at pages 11-12.
[90] Ex J1- Community Justice Group Letter.

Autopsy Results

70. On 22 July 2022, Dr Rebecca Williams conducted an autopsy consisting of an external and internal examination of the body. The ligature was received with ATJ's body.[91]

71. The external examination showed a linear abrasion on ATJ's neck consistent with hanging caused by material. There were no other external injuries identified and no internal injuries identified. No evidence of natural disease was identified.[92]

72. The toxicology results showed ATJ had the following drugs present in his system:

    - "*Amitriptyline (anti-depressant): present at concentration less than usual therapeutic range.*
    - *Nortriptyline (anti-depressant): present at low level.*
    - *Mirtazapine (anti-depressant): present at low level*".'[93]

73. ATJ had not been prescribed or dispensed anti-depressants at TCC by health staff.

74. Dr Williams concluded that the cause of death was hanging.[94]

The Inquest

75. As this was a death in custody, an inquest was required by s 27(1)(a)(i) of the *Coroners Act*. In accordance with s.45(2) of the Act, the Coroner is required, if possible, to make the following findings at the conclusion of this inquest:

    a) the identity of the deceased;
    b) how he passed;
    c) when he passed;
    d) where he passed; and
    e) what caused his passing.[95]

76. The inquest is intended to provide the community and the family with an explanation of the circumstances of the passing, and to answer any questions which may have been raised following the passing. The Coroner is not able to blame individuals or find that any of those who interacted with a person who has passed are criminally or civilly liable for a crime or a civil wrong.

77. At a pre-inquest conference on 26 March 2025, the Court was advised by ATSILS that the family no longer wanted to remain actively involved in the Inquest. Leave to appear was granted to QCS. The Lamberr Wungarch Justice Group was also granted leave to appear on public interest grounds under s 36(2) of the *Coroners Act*.

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[91] Ex A4 - Form 8 Autopsy Report at page 3.
[92] Ex A4 – Form 8 Autopsy Report at page 8.
[93] Ex A4 – Form 8 Autopsy Report at page 8.
[94] Ex A4 – at page 8.
[95] s.45(2) *Coroners Act 2003* (Qld).

78. Following the pre-inquest conference, it was determined that the following issues were to be investigated at the inquest:

    a. The findings required by s 45 of the *Coroners Act*;

    b. whether the initial risk assessments in respect of self-harm conducted during ATJ's final term of incarceration were adequate and appropriate; and

    c. whether the supervision of ATJ was adequate and appropriate during his final term of incarceration at the Townsville Correctional Centre; and

    d. whether the furnishings within cells at the Townsville Correctional Centre adequately mitigate the risk of exposure of hanging points.

79. The inquest was held in Brisbane with some witnesses appearing by video link. All statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. I accepted the submission from counsel assisting that all evidence be tendered and that oral evidence be heard from five witnesses, namely:

    - Former Custodial Counsellor McMaster;
    - Former QCS Psychologist Miller;
    - CCOs Smith, Treloar and Day (QCS);
    - Inspector Mumby, CIRIG (QCS); and
    - Assistant Commissioner Thomson, Infrastructure Command (QCS).

80. I consider that the evidence tendered in addition to the oral evidence from these witnesses was sufficient for me to make the requisite findings.

Conclusions on Inquest Issues

Findings required by s. 45

81. I am required to find, if possible, the medical cause of death, who the deceased person was and when, where, and how he came by his death. After considering all the evidence I make the following findings:

Identity of the deceased –	(redacted)
How he died –	ATJ had been remanded in custody for three months for domestic violence offences. He was assessed on entry to prison as not being at risk of self-harm and not requiring an increased level of observations. He later expressed concern to his cell mate that he was being spoken about by others in the unit. After leaving a note professing his innocence, he fashioned a ligature from a bed sheet and intentionally hanged himself from a shelving unit in his cell. Silicone had been removed from the point the shelves joined the cell wall, creating a hanging point.
Place of death –	Townsville Correctional Centre, 22 Dwyer St STUART QLD 4811 AUSTRALIA
Date of death–	20 July 2022
Cause of death –	Hanging

Whether the initial risk assessments in respect of self-harm conducted during ATJ's final term of incarceration were adequate and appropriate.

82. On reception to the TCC on 12 April 2022, ATJ was medically assessed and reported he had no medical history or conditions and was on no medication. A mental health and risk screening was also conducted and he denied current mental health issues and any previous or current self-harm, suicide attempts or ideation.[96]

83. According to the Immediate Risk Needs Assessment (IRNA) conducted by Custodial Counsellor McMaster on 12 April 2022:

    - *"There was no information provided from the transporting officer, arresting officer or watch house records that indicated that [ATJ] was at an increased of suicide or self-harm"*;

    - *"[ATJ] denied any previous attempts to complete suicide and there was no collateral information to suggest otherwise. Further, at the time of the assessment, he did not present with any observable evidence of a history of or recent suicidal behaviour";*

[96] Ex G1- QCS Medical File at pages 8-16.

- *"[ATJ] denied any history of engaging in self-injurious behaviours and there was no collateral information to suggest otherwise. Further, at the time of the assessment he did not present with any observable evidence of a history of or recent self-injurious behaviour";* and

- *"[ATJ] denied any current thoughts of suicide or self-harm and stated he had not experienced such thoughts in the week prior to the current assessment. He reported that he would notify officers if this were to change. The at-risk process was explained to [ATJ] which he acknowledged. Further, the shopfront process was explained to him if he needs any further assistance from assessment services during his time in custody";*

- *"[ATJ] reported his cousin sister, aunty and good friend have all passed away in the past two months. [ATJ] was advised of the process of shopfront and how to contact staff groups including assessment services and the Cultural Unit should he require assistance throughout his incarceration. He acknowledged";*

- *"[ATJ] denied any knowledge of any significant others that may have completed suicide or attempted suicide";*

- *"[ATJ denied any current feelings of helplessness or hopelessness and stated he was accepting of his current circumstances. He presented appropriately throughout the assessment and there was no evidence that he was experiencing helpless or hopeless thought patterns";*

- *"[ATJ] denied feeling sad or depressed at the time of the assessment. Furthermore, he did not present with any overt symptoms of depression";*

- *"[ATJ] denied experiencing any feelings of anxiety, shame, fear or anger that were disproportionate to his current circumstances. There was nil observed evidence to refute this";*

- *"[ATJ] reported that his offences had not caused public outrage in the media or community and further denied any possibility of repercussions from other prisoners at [TCC]";*

- *"[ATJ] denied seeing a Counsellor or Psychologist for any reason recently";*

- *"[ATJ] denied being admitted to a psychiatric unit within the past six months. Further, he denied any history of psychiatric admissions"; and*

- *"[ATJ] presented in a stable mood with congruent affect. He did not present with any overtly odd or bizarre behaviour. He interacted appropriately throughout the assessment and easily engaged in conversation. [ATJ] appeared orientated to time, person and place and no perceptual disturbances were observed or reported".* [97]

[97] Ex D10.1.1- IRNA Custodial Assessments- at pages 3-17; Ex D10.5.1- Case notes at pages 3-4.

84. Custodial Counsellor McMaster's case notes concluded that ATJ presented in a stable mood with congruent effect. His hygiene was assessed as appropriate and he engaged well throughout the assessment. His speech rate and volume were within normal range and he was observed to maintain appropriate eye contact. His psychomotor activity was unremarkable and his insight and judgement appeared intact.

85. ATJ was not observed to attend to any external stimuli throughout the assessment. He reported having both internal and external supports, identified suitable short and long term goals, and denied any current suicidal or self-harm ideation, plans or intent. He was not deemed to be at an acute risk of engaging in self-harm or suicidal behaviours at the time of the assessment.[98]

86. There was no mention of ATJ's SHEH flag in this assessment. This flag was related to disclosures he made to QCS staff during a term of imprisonment in March and April 2008. Following those disclosures, he was placed on observations, made subject to an At-Risk Management Plan (ARMP), routinely assessed and he improved during April. Observations were stepped back and then removed on 16 April 2008 with the ARMP discontinued.

87. During ATJ's 2022 reception to TCC, Custodial Counsellor McMaster noted that because ATJ endorsed one or more suicide/self-harm questions during the IRNA, QCS Custodial Operations Practice Directives (COPD) required that he be referred for a further risk assessment to be completed by a psychologist.[99] The relevant endorsement in his IRNA was the recent loss of loved ones.[100]

88. ATJ was also seen by the Cultural Team on 12 April 2022. Among other things, they checked on ATJ's wellbeing and noted they had no concerns.[101]

89. ATJ was then seen by QCS psychologist Joshua Miller on 12 April 2022. His case notes confirm there were no hygiene issues observed, he made appropriate eye contact and displayed appropriate facial expressions and body posture. ATJ was observed to demonstrate unremarkable psychomotor activity and he spoke with appropriate tone, rate and volume. He presented in a stable mood with appropriate affective expression.

90. ATJ denied experiencing auditory or visual hallucinations and was not observed to respond to any external stimuli at the time of his assessment. No insight or judgement deficits were noted and ATJ appeared to be orientated to time, person and place.

91. The psychologist's case notes also state that ATJ reported having both internal and external support and identified socialising as a coping strategy he believed would be effective in custody. He was future focused towards seeing his family within the centre, before returning to the community. ATJ denied any current suicidal or self-harm, ideation, plan or intent. No other concerns were raised.[102]

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[98] Ex D10.5.1 - Case notes at page 4.
[99] Ex D10.5.1 - Case notes at page 4.
[100] Ex I1 - at [6] on page 9.
[101] Ex D10.5. 1- Case notes at page 4.
[102] Ex D10.5.1 - Case notes at pages 4-5.

92. Ms McMaster and Mr Miller both had limited recall of their interactions with ATJ during oral evidence given the passage of time that had elapsed since they both reviewed him on 12 April 2022. However, their evidence was consistent with their contemporaneous notes.

93. Having regard to the passage of time, I accept that their recall of their interactions with ATJ is limited and the best evidence of the initial assessments conducted remains the contemporaneous notes made by Ms McMaster and Mr Miller in the QCS system, namely the IRNA notes and the case notes.

94. When questioned about the nuances regarding assessments of First Nations inmates, Mr Miller demonstrated an appropriate understanding of how a review should be tailored. He was also able to identify culturally appropriate aspects of his assessment of ATJ, such as his consideration of socialisation with other inmates, and expressions of feelings of connection to family and community as protective factors for him.

95. Ultimately, as a result ATJ was deemed suitable to be accommodated in a shared cell in a unit with no observations regime necessary. His placement in a secure unit was as a reception unit only. He would be required to progress to secure units 1, 2 and 3 before being able to progress to residential accommodation.[103]

96. Inspector Mumby told the Court he considered Mr Miller's assessment of ATJ to have been adequate and appropriate. Inspector Mumby noted that despite the fact Ms McMaster missed seeing the SHEH flag, ATJ was referred to a psychologist immediately and this oversight was not outcome changing.

97. Throughout this term of incarceration, there were no case notes to evidence concerns for ATJ's welfare at the TCC, aside from on 1 May 2022 when he reported experiencing possible COVID-19 symptoms. The supervisor case note audit completed on 2 June 2022 specifically mentioned the SHEH flag and stated "nothing in case notes during this audit period indicate that the prisoner is at risk of self-harm".

98. When interviewed by CIRIG Inspectors and asked about how much weight should be given to self-harm episode from 2008, Mr Miller advised that any attempt 10 years old and older is considered historical, and that weight is also a matter for professional judgement.

99. He further advised the behaviour described by William (ATJ listening through the vents and thinking people were talking about him) would not be expected to be picked up by psychological services unless it was noticed and reported by staff, an inmate or ATJ himself. The evidence was that no person noticed or reported any concerns during ATJ's term.

100. William advised QCS Inspectors at interview that ATJ had not made any comments or done anything leading up to his suicide that made him believe ATJ was vulnerable or needed help.

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[103] Ex I1- at [6] on page 9; Ex D10.5.1- Case notes at pages 5-6.

101. I accept the CIRIG findings that ATJ was referred to a psychologist following his IRNA. The psychologist identified the previous self-harm episode and made a thorough assessment of ATJ's risk. This assessment was that he was not presenting at risk of suicide or self-harm. While ATJ's cellmate had observed him listening through the vent and stating people were talking about him, this was not observed by or reported to QCS staff, hence psychological services were unable to identify and act on it.

102. Apart from his disclosures in April 2008, QCS records indicate ATJ had no previous self-harm or attempted suicide incidents, and no incidences of poor behaviour or aggression towards staff or other prisoners. No concerns were raised about ATJ's mental health by other prisoners or staff during his final term.

103. Ultimately, I accept Counsel Assisting's submission that the initial risk assessments in respect of self-harm conducted in April 2022 were adequate and appropriate.

104. While Mr Dawes placed some emphasis on the fact that ATJ had asked to be placed on Diazepam on 16 May 2022 and had not seen a doctor at TCC, the evidence was that he did not have a current prescription for this medication in the community. There was also no evidence to indicate the reason he had been given a single prescription for Diazepam in January 2022.

Whether the supervision of ATJ was adequate and appropriate during his final term of incarceration at the Townsville Correctional Centre

105. Counsel Assisting submitted it was open to me to conclude that the supervision of ATJ was generally adequate and appropriate during his final term of imprisonment. However, Mr Dawes submitted that the observations made in the lead up to ATJ's death were superficial.

106. There was no evidence before the Court to support the conclusion that ATJ should have been subject to closer supervision or management.

107. The recall of CCO Smith and CCO Treloar, in oral evidence, of their observations of ATJ's cell was limited given the passage of time since they conducted their respective headcounts at 4:30am and 7:17am on 20 July 2022.

108. Neither officer could recall sighting ATJ sitting on the floor next to the shelves. Both advised the Court that they understood they were required to sight inmates in their bunks through the cell window. They were both of the view that what they observed appeared to be the two inmates asleep in their bunks.

109. Both CCOs stated that it was not a requirement to open the door and enter the cell, rather, just to check through the window. With respect to the 4:30am check, CCO Smith stated he understood CCOs were to shine torches onto the roof of the cell, not throughout the cell. These requirements are understandable from the perspective of the human right to privacy, and the need to enjoy a proper night's sleep. This was agreed to by Inspector Mumby in his evidence.

110. Both CCOs stated that while they did not see any limbs or skin while observing what they believed was ATJ in his bunk, it was common for inmates to completely cover themselves with blankets so they would not be disturbed.

111. The evidence does not satisfy me to the requisite standard that ATJ had hanged himself before the 4:30am headcount.

112. With respect to the 7:17am headcount, it is difficult to establish that ATJ was hanged and not seen by CCO Treloar at that time. However, as stated by Inspector Mumby in oral evidence, it is possible he was missed.

113. I am unable to determine on the evidence before me exactly when ATJ hanged himself. It may have been before or after the 7:17am headcount.

114. I consider that the headcounts conducted during the night before ATJ was found unresponsive complied with QCS Policy in force at the time. The policy required that officers satisfy themselves that each prisoner was in "apparent good health". I accept that during the night shift officers need to exercise "good sense and sound judgement" and that it is difficult for an officer to determine the good health of a prisoner who appears to be asleep through a cell window. I agree that it is not necessary to wake prisoners for this purpose.

Whether the furnishings within cells at the Townsville Correctional Centre adequately mitigate the risk of exposure of hanging points

115. Exploration of this issue was required by the fact that the sealant between the top of the metal shelves and the wall of ATJ's cell had been removed, allowing ATJ to anchor a bed sheet fashioned into a ligature from the exposed gap.

116. The evidence of Assistant Commissioner Thomson was that it is not possible to completely eliminate prisoner self-harm and suicide by infrastructure measures alone.

117. In 2022-2023, a state-wide program to address ligature points within detention units was commenced by QCS. AC Thomson's evidence was that 92.9 % of all secure cells in Queensland now have a safer cell design, and every high security correctional centre has safer cell designs. The opening of the Lockyer Valley Correctional Centre will increase the percentage of safer secure cells to 93.5%.

118. AC Thomson advised the Court that ATJ's cell was of a safer cell design at the time he passed. His evidence was that part of the standard for a safer cell design is that all joins between fixtures and fittings to walls and ceilings are to be sealed using a non-pick sealant, which provides a higher degree of resistance to being picked.

119. AC Thomson said that the non-pick sealant is not impenetrable and an implement could be used to remove the sealant over time. Therefore, as part of daily operations, visual inspection of prisoner accommodation cells is required, with particular attention to potential hanging points, including whether the integrity of the non-pick sealant has been compromised. This enables maintenance works to proceed to restore the integrity of the sealant.

120. AC Thomson said this precaution had been in place since 1996. Where issues are identified prisoners are removed from the defective cell and housed elsewhere until the sealant had been re-applied and hardens.

121. As noted by AC Thomson, while safer cells minimise ligature points, it is not possible to completely eliminate all risks of prisoner self-harm and suicide through infrastructure alone. He advised the Court that prisoner self-harm and suicide were complex issues, and a range of factors contribute to risks, “including individual, situational, environmental psychosocial stressors, as well as a person’s mental health and wellbeing, along with other vulnerabilities”.

122. AC Thomson stated that in order to manage this issue, QCS also employs best practice suicide and self-harm policies to mitigate risk. These include individual case management involving assessing and identifying risk factors on admission, placement in suitable accommodation, observation and management regimes, and continual assessments of risk.

123. With respect to First Nations prisoners, AC Thomson advised that QCS had given consideration to the overrepresentation of First Nations people within prisons, and measures were being implemented to ensure facilities incorporated more culturally appropriate designs.

124. These included increased access to nature, improved lighting, appropriate meeting and socialising spaces, and allowances for visiting elders to be accommodated nearby.

125. I am satisfied that the furnishings in the safer cells at the Townsville Correctional Centre combined with regular cell inspections adequately mitigate the risk of exposure of hanging points.

126. However, the regime of regular cell inspections to identify hanging points did not effectively mitigate the risk of exposure at the time of ATJ’s passing. As Mr Dawes noted, it would have been necessary to use some type of tool over a period of time to create the hanging point.

Comments and recommendations

127. Section 46 of the *Coroners Act* provides that a coroner may comment on anything connected with a passing that relates to public health or safety, the administration of justice or ways to prevent passings from happening in similar circumstances in the future.

128. Several recommendations related to business improvement were made in the Operational Review Report of CIRIG outside the scope of the issues considered in this inquest.

129. I am satisfied that there are no further relevant comments or recommendations required.

130. I close the inquest.

Terry Ryan
State Coroner