



CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION: Inquest into the death of Selesa Tafaifa

TITLE OF COURT: Coroners Court

JURISDICTION: BRISBANE

FILE NO(s): 2021/5437

DELIVERED ON: 29 October 2025

DELIVERED AT: Brisbane

HEARING DATES: Pre-Inquest Conference
13 June 2022 before State Coroner Ryan
6 February 2023 before Deputy State Coroner Gallagher

Inquest
9 & 11 October 2023 in Townsville
17 & 18 October 2023 in Brisbane
7 to 17 May 2024 in Brisbane

Written submissions following inquest:
September 2024 – December 2024

FINDINGS OF: Deputy State Coroner Stephanie Gallagher

CATCHWORDS: Coroners: inquest, death in custody, safety hood, spit hood, prisoner, restraint, obesity,

cardiomyopathy, coronary atherosclerosis,
mental health, human rights

REPRESENTATION:

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Qld Corrective Services:	A Freeman KC, instructed by J Franco, Crown Law
Queensland Corrective Services (QCS) Officers (CERT Leader, CCO 1 & CCO 2):	E Cooper, instructed by M Morris, Gilshenan & Luton Lawyers S Williams (9 October 2023 – 18 October 2023)
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Nurses Steer and
Pope:

Detective Sergeant J Greggery KC, instructed by C Gnech,
Marcus Edwards: Gnech & Associates

Queensland M O'Brien (6 February 2023)
Commissioner of
Police:

- ORDERS:
1. Non-Publication Order 2021/5437 of 6 February 2023.
 2. Non-Publication Order 2021/5437 of 3 October 2023.
 3. Non-Publication Order 2021/5437 of 9 October 2023.
 4. Non-Publication Order 2021/5437 of 13 May 2024.
 5. Non-Publication Order 2021/5437 of 30 November 2024.

Contents

Introduction	1
Coronial jurisdiction.....	2
Coronial investigation.....	8
Autopsy results	9
Inquest.....	11
Issues for inquest	11
Witnesses called	12
Evidence and findings on issues.....	13
Issue 1: The identity of the deceased, when, where and how she died and what caused her death	23
Issue two: the adequacy and appropriateness of diabetes and insulin management of persons in custody at TWCC.....	30
Issue three: the adequacy and appropriateness of the actions of the QCS staff on 30 November 2021	31
Issue four: the appropriateness of the use of safety hoods in QCS custody	44
Issue five: the adequacy and appropriateness of mental health care of Selesa whilst in custody at TWCC during the period of incarceration from 25 November 2020 to 30 November 2021	49
Issue six: the adequacy and appropriateness of the health management by THHS and QCS on and from 27 July 2020.....	54
Findings required by s.45 of the Coroners Act 2003	57
Identity of the deceased.....	57
How they died.....	57
Place of death.....	57
Date of death	57
Cause of death	57
Comments and recommendations	57
Schedule of Abbreviations	60

Introduction

- [1] Selesa Tafaifa, a woman of Samoan heritage, was 44 years old when she died in the Detention Unit (DU) at the Townsville Women's Correctional Centre (TWCC) on 30 November 2021, during a prolonged physical interaction with Custodial Corrections Officers (CCOs), where Selesa was restrained and handcuffs and a safety hood (also referred to as a "spit hood") were applied.
- [2] During her time in custody, Selesa was referred to as "Darcy" and "Big Mama."¹ Throughout the Inquest, she was referred to as Selesa in accordance with her family's wishes.
- [3] I acknowledge Selesa's family and their grief. Throughout the Inquest Selesa's daughter, Salote Isaako (Tafaifa), was a powerful advocate for her mother. She provided important information about Selesa to enable some reflection as to who she was as a person. In her words:

'Selesa was born in Samoa and raised by her father's parents, who we refer to as Selesa's parents. To describe the structure of Selesa's close family, I begin with my grandparents, Selesa's birth parents, Su'a Kueva Isaako and Lisa Isaako, who I call Pa and Ma. Pa is now 65 years old and one of 19 children. He is from Salelogo, one of Samoa's big islands. Ma is one of 10 children. She is from rural Siumu, on one of the smaller islands. Most of her siblings live between America and Samoa. The family bought and built a family home communally in Toamua, Samoa, between 2018 and 2021, with financial contributions from Selesa. This land and home is our family's home base, the fanua ole aiga, and belongs to the whole family – including all of Selesa's siblings, all the kids, grandkids and great-grandkids.

Selesa is the first of 10 children born to Su'a Kueva and Lisa Isaako. She is followed by her brother Taliitiga Isaako; sister Siuo Atuo Isaako, who passed away in 2009; brothers Tomasi Isaako and Ben Isaako; sister Faalelea Isaako; brother Su'a Andrew Siliva Isaako, who shares the title with his father, Su'a Kueva; sister Lisi Isaako; brother Leau Isaako, whose title is Leau; and baby brother Ata Junior Kueva Isaako. The Isaako siblings currently reside between Samoa, Australia, America and New Zealand. As the eldest, Selesa assumed a leadership role in her family, always standing alongside her siblings and ensuring their parents were taken care of. Selesa always embodied this role, regardless of her challenges with her mental health which are detailed below. She was the voice that had to lead her siblings. It wasn't just in her role as eldest that Selesa acted as a leader and caretaker; she undertook the same in the family that raised her, in which she was the youngest child. Selesa offered financial support, bought land and led this side of her family, just as she did as the eldest to her birth parents. While Selesa was the pillar of her family, she was also the clown and the person her siblings

¹ By other prisoners at TWCC.

would come to, knowing she would navigate any trouble they were in with humour. She would make her family laugh and everything would be okay again.

While Selesa struggled with being in and out of institutions and living with mental health conditions, she never wavered in her care and protection of me. She was shielding me from the extent of the hardship she experienced. When she was incarcerated, Selesa had a little ritual of making a daily phone call to her own mum. This gave her something to look forward to and kept her calm.

For our family Selesa was and remains at the heart of our lives. Selesa's daughter, sister, brother, grandmother, daughter, the whole of her family say it is impossible to convey the pain and grief of the loss of Selesa, especially the granddaughter. According to Samoan culture, she had special responsibilities for the care and leadership of her family alongside her beloved dad and late mum, her mum passing away in January of 2023. Selesa had a unique bond with her parents. ... Her phone calls with them in Samoa were her lifeline and her heart. ... It was this lifeline that she was reaching out to connect with by phone that led to the events that took her from us. Her dad still wakes every day and every night for her phone call, to hear her voice, her love, her warmth, her laughter. Her granddaughter weeps for the sudden loss of her grandmother, her future, her ancestor.

*The family hopes to expose the truths behind her death, and they fight with faith, dignity, honour, courage and persistence to ensure that what Selesa was forced to endure never happens again to anyone's mother, grandmother, sister, daughter, grandfather. They want to do what they can to ensure that what happened to their beloved Selesa never happens to any other human being.'*²

Coronial jurisdiction

- [4] Selesa's death was a reportable death under section 8(3)(g) of the *Coroners Act 2003* (Qld) (the Act) as it was a death in custody.³ The consequence of this is that an inquest is mandatory.⁴ The State Coroners Guidelines clearly articulate the seriousness of the duty of the State and Deputy State Coroner in the investigation of deaths in custody:

The investigation of deaths in police or prison custody has long been considered an important function of coroners given the vulnerability of people whose liberty is curtailed by the exercise of executive power. The Act recognises and responds to the need for public scrutiny and accountability by requiring all deaths

² Submissions of Counsel on behalf of the family dated 16 October 2024 at [18].

³ The definitions of *death in custody* and *custody* are contained in sections 10(1)(a) and 10(2)(b) & (c) of the Act.

⁴ Section 27(1)(a) of the Act.

in custody to be investigated by the State Coroner or the Deputy State Coroner and by mandating that an inquest be held into all such deaths. These requirements arose out of the extensive recommendations made in the Royal Commission into Aboriginal Deaths in Custody.⁵

- [5] To this, may be added the following statement contained within the Australasian Coroners Manual:

Deaths in custody are, of course, a fundamental human rights issue. The state has a duty of care for those whose liberty it takes. It assumes responsibility for those whom it incarcerates. Many of those in gaol or detention are vulnerable people due to social disadvantage, mental or physical illness, such as drug dependency. Independent judicial scrutiny of deaths in custody is an indispensable safeguard against abuse or neglect of persons in custody.⁶

- [6] The purpose of an inquest is to provide the public and the family of the deceased, with transparency regarding the circumstances of the death, and to answer questions that may have arisen following the death.

- [7] To this end, those granted leave to appear at the inquest (including Selesa's family) were afforded the opportunity to make submissions to the court relevant to the issues.⁷

- [8] The Queensland Human Rights Commission (the QHRC) has intervened in the Inquest. At this point it is desirable to make some observations about the QHRC's involvement. The QHRC intervened in accordance with section 51 of the *Human Rights Act 2019* (Qld) (the HR Act). This provision permits the QHRC to intervene in a proceeding before a court⁸ on a limited basis, namely, those in which:

(a) *"a question of law arises that relates to the application of [the HR] Act; or*

(b) *a question arises in relation to the interpretation of a statutory provision in accordance with [the HR] Act."*

- [9] The intervention of the QHRC raises an important issue as to the application of the HR Act to the Coroner's Court. The issue arises because by its submissions the QHRC have invited findings that various human rights of Selesa's were breached.

⁵ State Coroners Guidelines, chapter 3.

⁶ Hugh Dillon and Marie Hadley. *The Australasian Coroner's Manual*, 161 at 7.9. Submissions on behalf of the family dated 16 October 2024, at [309].

⁷ Section 36(2) of the Act entitles a person who has a sufficient interest in the inquest to make submissions about a matter which the coroner may comment under section 46(1).

⁸ Which defined in Sch 1 to include the Coroners Court.

[10] These submissions obviously invite me to find that the HR Act is relevant to my findings. Specifically, there are two submissions advanced by the QHRC.

[11] The first is that a coroners court when performing its functions of fact finding and preventive comment powers is a public entity “acting in an administrative capacity” in accordance with section 9(4)(b) of the HR Act.⁹ The consequence, so the QHRC contends, is that section 58 of the HR Act prevents the coroners court, as a public entity, from making a decision that is not compatible with human rights or fails to give proper consideration to a human right relevant to the decision.

[12] The second submission advanced is offered in the alternative. It is argued that even if the coroners court is not acting in an administrative capacity, the coroners court is required, as part of its functions, to investigate potential breaches of human rights that may have caused or contributed to the relevant death, to make findings identifying potential human rights breaches by public entities, and to make preventative comments that flow from them. This requirement is said to arise by reason of the interpretative obligation contained in section 48 of the HR Act.¹⁰

[13] I do not accept either submission for reasons that I will explain.

[14] Section 5 of the HR Act provides, relevantly:

“5 Act binds all persons

(1) This Act binds all persons, including the State and, to the extent the legislative power of the Parliament permits, the Commonwealth and the other States.

(2) This Act applies to—

(a) a court or tribunal, to the extent the court or tribunal has functions under part 2 and part 3, division 3; and

(b) the Parliament, to the extent the Parliament has functions under part 3, divisions 1, 2 and 3; and

(c) a public entity, to the extent the public entity has functions under part 3, division 4.

...”

[15] Section 5(2) contemplates that the HR Act will apply to a court in three scenarios. First, when the court has “functions under part 2.” Second,

⁹ QHRC submissions, paragraph 9.

¹⁰ QHRC submissions, paragraph 10.

when the court has “functions ... under part 3, division 3.” Third, when the court is “acting in an administrative capacity” (and thus is a public entity under section 9(4)(b) of the HR Act) and has functions under part 3, division 4.

- [16] The first submission advanced by the QHRC requires an acceptance that a Coroner is not acting in a judicial capacity when making findings in an inquest. I do not accept this as a proposition. While there is no Queensland authority that has considered the proper characterisation of the coronial process, there is authority from other States which supports the proposition that the Coroner though conducting an administrative inquiry, is carrying out a judicial function when sitting as the Coroner’s Court. I agree with this characterisation. To the extent that other coroners in Queensland have held otherwise, I respectfully disagree.¹¹
- [17] The effect of my finding is that section 58 of the HR Act does not apply because in conducting an inquest the Coroner’s Court is not acting in an administrative capacity and therefore is not a public entity within the meaning of section 9(4)(b).
- [18] The application of the HR Act can only arise to the extent that the Coroner’s Court in conducting an inquest “has functions under part 2 and part 3, division 3” of the HR Act. Necessarily, the HR Act applies to the Coroner’s Court to the extent that the court has functions under 2 and Part 3, Division 3.¹²
- [19] The proposition that the Coroner’s Court in conducting an inquest must investigate potential breaches of human rights that may have caused or contributed to the death under investigation and make findings identifying potential human rights breaches is one mandated by section 48 of the HR Act must be rejected.
- [20] Section 48, which appears in Part 3, Division 3, placed an obligation on courts when interpreting “statutory provisions” to do so in a way that is compatible with human rights. There is no issue with the interpretation of the Coroners Act that requires the Court, in compliance with section 48 of the HR Act, to interpret the provision in a way that is compatible with human rights.¹³ There is therefore no function under Part 3, Division 3 which arises.
- [21] That leaves for consideration whether, and if so to what extent, the Coroner’s Court in conducting an inquest “has functions under part 2” within the meaning of section 5(2)(a) of the HR Act. The QHRC’s

¹¹ *Inquest into the deaths of Yvette Michelle Wilma Booth, Adele Estelle Sandy and Shakaya George (“RHD Doomadgee Cluster”) 2019/4445, 2020/2244, 2020/3951*, delivered on 30 June 2023, at [125].

¹² *Wood v The King* (2022) 12 QR 101 at [74]-[75].

¹³ *Attorney-General v Grant (No 2)* (2022) 12 QR 357 at [66].

submission is necessarily inviting the Coroner’s Court to find breaches of human rights. There are several difficulties with this invitation.

- [22] The first is that the invitation does not sit comfortably with the manner in which section 5(2)(a) of the HR Act has been interpreted in Queensland in various first instances decisions of the Supreme Court. These decisions have adopted the “intermediate interpretation.”
- [23] In substance, by this interpretation the “functions” of courts under section 5(2)(a) of the HR Act are the functions of “applying for enforcing [the] human rights in Part 2 that relate to [the] proceeding.”¹⁴ The engagement of this depends upon the “scope of the right concerned and the facts and circumstances of the individual proceeding.”¹⁵
- [24] In the context of an inquest, that statutory function is conferred by subsection 45 and 46 of the Act, the relevant parts of which provide as follows:

“46 Coroner’s comments

(1) A coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to—

(a) public health or safety; or

(b) the administration of justice; or

(c) ways to prevent deaths from happening in similar circumstances in the future.

...”

- [25] The statutory function does not extend to making declarations.¹⁶ The difficulty with the QHRC’s submissions is that it is seemingly premised on the HR Act expanding the Coroner’s Court powers. That premise is wrong. The HR Act does not expand the Coroner’s Court jurisdiction. Nor does it vest jurisdiction upon the Coroner’s Court to give a remedy.¹⁷ That is precisely what the QHRC invite the court to do, to make findings about breaches of human rights.
- [26] There is another difficulty with this invitation. The statutory powers under subsection 45 and 46 of the Act are subject to an important limitation. By subsection 45(5)(b) and 46(3)(b) of the Act a coroner must not include in the findings any statement that a person is, “or may be ... “civilly liable for something.” To find, as the QHRC invites, potential breaches of human rights that may have caused or contributed to

¹⁴ *Attorney-General v Grant (No 2)* (2022) 12 QR 357 at [96].

¹⁵ *Attorney-General v Grant (No 2)* (2022) 12 QR 357 at [97].

¹⁶ *Wood v The King* (2022) 12 QR 101 at [81]-[82].

¹⁷ *Wood v The King* (2022) 12 QR 101 at [81]-[82].

Selesa's death and to make findings identifying potential human rights breaches by public entities is an invitation to do something that is expressly prohibited.¹⁸ I decline to do so.

- [27] That is not to suggest that if potential shortcomings are identified by a Coroner they may not be subject to comments under section 46 of the Act. Obviously, matters meeting the relevant criteria in section 46(1) of the Act then they may, appropriately, subject of comment. Coroners play an integral role in advancing concepts of "death preventability."
- [28] If a matter connected with a death relates to "public health or safety" or the "administration of justice" or "ways to prevent deaths from happening in similar circumstances in the future" then section 46 of the Act is engaged. However, to characterise such matters (as the QHRC does) as breaches of human rights and make findings consistent with this is, in my view, not appropriate and not the intended operation of section 5(2)(a) of the HR Act, even on the intermediate construction of the provision. To do so, is outside the proper remit of the Coroner's Court.
- [29] Otherwise, as is the orthodox position in the coronial jurisdiction, the focus is on determining what happened, not on ascribing guilt, attributing blame to any person or party, or apportioning liability. Thus, in accordance with section 45(5) of the Act, a 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.
- [30] Moreover, in accordance with section 37(1) of the Act, the Coroners Court is not bound by the rules of evidence and may inform itself in any way it considers appropriate. However, this does not entirely remove the requirement for the Court to have regard to the rules of evidence, particularly in terms of the receipt and weight to be afforded to evidence, during the inquiry. This includes the concept of relevance.
- [31] The relevant standard of proof for findings of the Court is the civil standard, namely, the balance of probabilities, with reference to the *Briginshaw*¹⁹ standard. The more significant the issue for determination, the clearer and more persuasive the evidence must be for a coroner to be sufficiently satisfied on the balance of probabilities that an issue has been proven.
- [32] In drawing conclusions in relation to the issues for Inquest, I must be mindful of the effect of hindsight bias.²⁰

¹⁸ The submissions of QCS have identified the relevant authorities dealing with the concepts of civil liability to which I have had regard, specifically: *Perre v Chivell* (2000) 77 SASR 282, *Bell v Deputy Coroner of South Australia* [2020] SASC 59 and *Heumann v Hutton* [2020] QSC 17.

¹⁹ *Briginshaw v Briginshaw* (1938) 60 CLR 336.

²⁰ The Australasian Coroners Manual. Hugh Dillon and Marie Hadley, Federation Press, 2015, 10.

“Hindsight bias is the tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact...It is an obvious point, but one that nonetheless bears repeating, particularly when coroners are considering assigning blame or making adverse comments that may damage a person’s reputation...”

...

Coroners should attempt first to understand the circumstances as they appeared at the relevant time to the people who were there.

...

Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. This distinction needs to be understood and rigorously applied.”

- [33] In accordance with section 48(2) of the Act, where a coroner forms a reasonable suspicion that a person has committed an offence, the coroner must give the information to the Director of Public Prosecutions (DPP). However, as the State Coroners Guidelines identify *‘the right to make submissions would be confined to Counsel Assisting and counsel for the person or organisation subject to possible referral.’*²¹

Coronial investigation

- [34] Immediately following Selesa’s death in custody on 30 November 2021, Detective Senior Constable Jess Sampson of the Corrective Services Investigation Unit (CSIU) commenced an investigation into the death. The scene of the death was forensically examined by a suitably qualified forensic scientist, and a report prepared.²²
- [35] On 13 June 2022, the State Coroner convened a pre-inquest conference (PIC), specifically to consider an application from Selesa’s family regarding the conduct of the police coronial investigation. At that time, the autopsy report was not available and there was no established medical cause of death. No coronial report had been produced by investigators. Closed Circuit Television (CCTV) and body-worn camera footage of Selesa from 30 November 2021 was available.
- [36] It is unnecessary to set out the detail of the application before the State Coroner. It is sufficient to record that the State Coroner delivered his ruling on 20 June 2022 and determined that the investigation into Selesa’s death was to be finalised by a unit other than the CSIU.²³ The

²¹ State Coroners Guidelines, chapter 9.13 Management of section 48 referrals.

²² Exhibit B24.

²³ *Inquest into the death of Selesa Tafaifa. Ruling in relation to the conduct of the Police Coronial Investigation*, at [10].

State Coroner also directed that the coronial brief of evidence be finalised by a Queensland Police Service (QPS) unit other than the CSIU by 26 August 2022.²⁴

- [37] A further PIC was listed, before me, following receipt of the autopsy report and brief of evidence to determine the scope of the Inquest.²⁵
- [38] On 4 July 2022, in compliance with the State Coroner's ruling, Detective Sergeant (Det Sgt) Marcus Edwards, Detective Senior Constable (Det S/Const) David Rolleston and Detective Senior Constable Bree Sonter of the QPS Cold Case Investigation Team (CCIT), Homicide Investigation Unit (HIU) commenced an investigative review of Selesa's death,²⁶ designated Operation Uniform Bastet.²⁷
- [39] Det Sgt Edwards provided an interim coronial brief²⁸ and a statement detailing further inquiries undertaken in respect of Selesa's death after 23 August 2022.²⁹
- [40] QCS material included the Operational Inspection and Major Incident Review Group (OIMIRG) Report,³⁰ officer reports from the CCOs,³¹ statements, body worn camera footage, CCTV, CCO training records, prisoner records, Custodial Operations Practice Directives (COPDs) and guidelines, and the Safety Hood review report.³² This material formed part of the extensive brief of evidence tendered to the court, without objection.

Autopsy results

- [41] A full external and internal examination (including postmortem computed tomography (PMCT) scan) of Selesa's body was conducted by Forensic Pathologist, Dr Jessica Vidler, on 2 December 2021, and peer reviewed by Forensic Pathologist, Dr Paul Botterill. Samples were obtained for histological and toxicological examination. Dr Vidler issued an autopsy certificate on 30 August 2022 in which she found the cause of death to be: 1(a). Not determined.
- [42] On 2 September 2022, Dr Vidler issued an autopsy report in which she re-stated the cause of death. In compiling her report, Dr Vidler had access to the body worn camera footage of the incident on 30 November 2021 at TWCC, involving CCOs and Selesa. Dr Vidler observed during her examination that Selesa's body weighed 158kg, and there was evidence of significant pre-existing natural disease

²⁴ Exhibit C21 at [4].

²⁵ *Inquest into the death of Selesa Tafaifa. Ruling in relation to the conduct of the Police Coronial Investigation*, at [44]-[50].

²⁶ Exhibit C21 at [5].

²⁷ Exhibit B63 at [3].

²⁸ Dated 23 August 2022. Exhibit C21.

²⁹ Exhibit B63.

³⁰ Pursuant to section 305(2) of the *Corrective Services Act 2006* (Qld). Exhibit D34.

³¹ Exhibit D1.

³² Exhibit D49.

including obesity, cardiomyopathy, and coronary atherosclerosis. There was no evidence of a toxicological contribution to the death.³³

- [43] Dr Vidler was unable to determine the specific cause of death and as such, it was recorded as ‘not determined.’³⁴ While no specific cause could be determined, Selesa’s death reflected a situation whereby the relative contribution of *several contributory factors* to the cardiac arrest suffered, could not be determined.³⁵ The contributory factors to the cardiac arrest included significant pre-existing natural disease and:

“Physical exertion, psychological distress, and possible intermittent mechanical asphyxia in the setting of restraint (there’s a few different types of restraint that are applied to her – the body in this case... One is physical handling by the corrective officers. Another is the positioning of handcuffs, and another is the positioning of a spit hood.”

- [44] Dr Vidler opined that there were no lethal injuries, and that the injuries observed during the autopsy were consistent with the restraint mechanisms seen in the body worn camera footage, and cardiopulmonary resuscitation.³⁶

- [45] Toxicological analysis of a sample of femoral blood revealed the presence of Ibuprofen (2mg/L), Paracetamol (6mg/L), Quetiapine (0.03 mg/L), Zuclopenthixol (0.07 mg/L), and Sitagliptin (0.16 mg/L) at non-toxic concentrations.³⁷

- [46] Blood results for levels of glucose, insulin and c-peptide level were within the normal range. In respect of Selesa’s insulin levels, Dr Vidler opined:³⁸

“There is evidence of exogenous insulin administration, which means the insulin wasn’t produced by her body. It was produced by being administered – as a medication. I haven’t found any evidence that is supportive strongly of overdose. What I have found is, which I’ve outlined in the summary of my report, that in – her insulin level was within the normal range for a post-glucose load, which means – if she’s eaten...the blood glucose level would increase in your blood because you’ve got the –sugars from the food you’ve eaten, her insulin level is within the normal range, if she had eaten recently.”

- [47] Dr Vidler gave evidence at the Inquest. This evidence, which contained further details of contributory factors to Selesa’s death, is discussed below.

³³ Exhibit A5, 20.

³⁴ Exhibit A4. Exhibit A5, 20.

³⁵ Exhibit A5, 19-20.

³⁶ Exhibit A5, 20.

³⁷ Exhibit A6. Exhibit A7.

³⁸ 17 October 2023, T1-10, L 20.

Inquest

[48] On 6 February 2023, a further PIC was convened in Brisbane. By this time the autopsy report was available. The court was again convened on 2 May 2024.

[49] The oral evidence at the Inquest was taken over three sittings: in Townsville from Monday 9 to Wednesday 11 October 2023; in Brisbane on Tuesday 17 October and Wednesday 18 October 2023; and, finally, in Brisbane from Tuesday 7 May 2024 to Wednesday 17 May 2024.

Issues for inquest

[50] Following consultation with the family and others granted leave to appear, the issues for inquest into Selesa's death were:

1. The findings required by section 45(2) of the Act, namely the identity of the deceased, when, where and how she died and what caused her death.
2. The adequacy and appropriateness of diabetes and insulin management of persons in custody at TWCC.
3. The adequacy and appropriateness of the actions of the QCS staff on 30 November 2021.
4. The appropriateness of the use of safety hoods in QCS custody.
5. The adequacy and appropriateness of mental health care of Selesa whilst in custody at TWCC during the period of incarceration from 25 November 2020 to 30 November 2021.
6. The adequacy and appropriateness of the health management by THHS and QCS on and from 27 July 2020.

Witnesses called

[51] During the Inquest, oral evidence was heard from the following witnesses:

- a. CCO Darren Cody, Townsville Correctional Centre (TCC);
- b. CCO Sarah Hauser, TCC;
- c. Registered Nurse (RN) Julie Pope;
- d. RN Hannah Steer;
- e. RN Catherine Johnson;
- f. RN Kathryn Hughes;
- g. Dr Jessica Vidler, Forensic Pathologist;
- h. Dr Stephen Rashford, Medical Director, Queensland Ambulance Service (QAS);
- i. Dr Jill Reddan, General and Forensic Psychiatrist;
- j. Dr Greg Starmer, Consulting Cardiologist;
- k. CCO 1, TCC;
- l. CCO 2, TCC;
- m. CCO Hinemoa Kopa, TCC;
- n. CCO Luke Conway, TCC;
- o. CCO Robyn McDonald, TCC;
- p. CCO Megan Tornsey, TCC;
- q. Correctional Emergency Response Team (CERT) Leader, TCC;
- r. CCO Jeannette Love, Acting Secure Supervisor, TCC;
- s. Det Sgt Marcus Edwards, QPS;
- t. Assistant Commissioner Joel Smith, Assistant Commissioner of the Southern Region for Custodial Operations, QCS;
- u. Darron Haworth, Training Coordinator, QPS; and
- v. Lee Downes.

[52] Having considered all the evidence contained in the brief, the oral evidence heard at the Inquest and the submissions of Selesa's family and those granted leave to appear, I make the following findings.

Evidence and findings on issues

[53] In examining the issues for inquest, particularly how Selesa died, relevant background events preceding Selesa's death should be articulated as they are relevant to the assessment of the events of 30 November 2021.³⁹

[54] At the time of her death, Selesa was serving a term of imprisonment at the TWCC, a high security correctional centre that accommodates sentenced and remand prisoners. This was Selesa's second correctional episode. TWCC is the only secure female correctional centre in North Queensland. It has four secure units and five residential buildings, one of which is a mothers' and babies' unit to accommodate mothers and their children.⁴⁰

[55] Selesa was sent to the TWCC after she was sentenced on 3 December 2019 in the Townsville District Court to a term of imprisonment, of four years, for armed robbery with personal violence⁴¹ and for serious assault of a person over 60. Selesa was also sentenced to a concurrent period of imprisonment for two charges of serious assault police, other assault, and property offences and convicted without further punishment for summary offences including obstruct police.⁴²

[56] On 20 July 2020, Selesa was released on parole⁴³ and returned to custody on 25 November 2020, after her parole was suspended and she was remanded in custody for a further three months. Her parole eligibility date was 9 February 2021, and her full-time release date was 4 November 2022.⁴⁴

[57] Section 12(1) of the *Corrective Services Act 2006* (Qld) (the CS Act) requires a prisoner to be classified as either high or low security upon admission to a corrective services facility. Selesa was classified a high security prisoner. The assignment of a security classification ensures prisoners are accommodated according to their assessed needs and risks, in the least restrictive environment, as is practicable in the circumstances. Prisoners classified as high security may only be accommodated in a high security correctional centre.⁴⁵

³⁹ This is consistent with Counsel Assisting's submissions. It was supported by the legal representatives acting on behalf of the QCS Officers, paragraph [4a] of submissions dated 13 November 2024.

⁴⁰ Exhibit B50 at [13] and [15].

⁴¹ Occurred on 7 January 2019.

⁴² Occurred on 9 January 2019.

⁴³ As ordered by the Parole Board Queensland.

⁴⁴ Exhibit B50 at [18] – [19].

⁴⁵ Exhibit B50 at [23] – [25].

[58] As of 30 November 2021, Selesa was housed in the DU.⁴⁶ The DU accommodates prisoners who are undergoing a period of separate confinement in the circumstances that have been found to have committed a breach of discipline and ordered to undergo a period of separate confinement, or they are subject to a safety order under the CS Act.⁴⁷ Selesa was subject to 22 safety orders during her second correctional episode. Her violation report for her custodial history noted 65 breaches, contraventions, and incidents.⁴⁸ In the months prior to her death in custody, Selesa was placed on the following safety orders:

- a. 29 April 2021 – 26 May 2021 (Selesa was reported to have assaulted staff).
- b. 15 May 2021 – 11 June 2021 (Selesa was reported to have been exhibiting aggressive behaviour including damaging her television. There were concerns over her medication compliance).
- c. 25 July 2021 – 21 August 2021 (Selesa was reported to have been involved in a physical altercation with another prisoner on 25 July 2021).
- d. 8 August 2021 – 4 September 2021 (Selesa was reported to have been involved in a physical altercation with another prisoner in the accommodation unit).
- e. 2 November 2021 – 6 November 2021 (Selesa was reported to have been making statements of self-harm and to have been found in her cell with a razor broken into pieces, she attempted to inflict a superficial cut on her arm).
- f. 22 November 2021 – 19 December 2021 (Selesa was reported to have been making threats to another prisoner and non-compliant with her medication regime).⁴⁹

[59] Selesa was subject to an Intensive Management Plan (IMP) and Safe Engagement Strategy (SES) plan to assist in management of her challenging behaviour in prison, which included threats against staff, assault, and offensive behaviour. Selesa also had a documented history of spitting towards QCS staff and property.⁵⁰

[60] IMPs may be implemented for prisoners identified as requiring higher levels of case management and/or intervention strategies or supervision. IMPs are intended to record and speak to behavioural goals for a prisoner, and the conditions that will help achieve those goals, and are developed by a panel comprised of correctional

⁴⁶ Exhibit D39.

⁴⁷ Exhibit B50 at [16].

⁴⁸ Exhibit B50 at [26].

⁴⁹ Exhibit B50 at [31]. Exhibit D40.

⁵⁰ Exhibit B50 at [21] – [22] and [43] – [44].

managers/supervisors, psychologists, intelligence analysts, occupational health staff and cultural liaison officers.⁵¹

- [61] SESs provide QCS staff with contemporary and contextual information regarding the management of a prisoner identified as having an increased level of risk to staff and prisoner safety, and/or to the good order of the correctional centre. The SES provides strategies to proactively mitigate identified risks, to encourage positive progression and behaviour. It also contains directions about actions required when specific decisions occur. SESs are compiled through consultation with a multidisciplinary team including psychologists and are intended to compliment IMPs.
- [62] SESs were designed to address problematic presentations by prisoners that may result from previous trauma exposure or personality pathology, which refers to a pattern of behaviour and emotion that can negatively affect a person's ability to adapt to an environment and is often characterised by self and interpersonal functioning deficits and maladaptive behaviour. SES plans aim to simplify complex personality pathology into simple behavioural indicators to assist QCS staff in dealing with a prisoner, by identifying known triggers and de-escalation techniques specific to that prisoner.⁵²
- [63] On 23 November 2021, one week before she died, Selesa reported that she was having a heart attack. A code blue⁵³ was immediately called. This required the QAS to be notified (as there was no night nurse rostered on to work). The QAS arrived within 15 minutes and following an initial assessment, paramedics decided to transport Selesa to the THHS for observation and further treatment.
- [64] On 24 November 2021, while at the TH, Selesa became abusive towards staff, requested further treatment, food, and drink, and refused to leave the TH. While CCOs attempted to move Selesa from the hospital, Selesa dropped her body weight and allegedly spat at a CCO. In response to the alleged spitting, the CCOs dealing with the incident applied a safety hood to Selesa. Selesa continued to abuse staff, threatened to spit, and bite them, and attempted to kick them resulting in the application of leg cuffs. Due to her body weight and non-compliance, CCOs used a wheelchair to move Selesa.⁵⁴ Selesa was returned to the TWCC on 27 November 2021.
- [65] On 27 November 2021, Selesa was housed in the DU and unable to attend the medical centre to receive her insulin. Health staff and CCOs attended Selesa's cell in the DU and the insulin injector was provided to her through the hatch by RN Pope. After administering her insulin, Selesa walked away from the door with the insulin injector and sat on

⁵¹ Exhibit B50 at [33] – [34].

⁵² Exhibit B50 at [35] – [39].

⁵³ Exhibit D23.

⁵⁴ Exhibit D30. Exhibit D34.14.

her bed. CCOs directed Selesa to return the insulin injector. Selesa did not comply and complained that she had not been given a phone call. CCOs watched as Selesa self-administered a second insulin dose. Selesa hid the insulin injector in her shirt, stood over the toilet in her cell and flushed the toilet. Selesa indicated to staff that she had flushed the insulin injector down the toilet. CCOs entered the cell and conducted a search but could not locate the insulin injector.⁵⁵ This incident was witnessed by CCO Sarah Hauser who provided a statement⁵⁶ and gave evidence at the Inquest. CCO Hauser's evidence was that Selesa injected herself with insulin a second time after saying "*Fuck you, Berry didn't give me another phone call.*"⁵⁷ At the Inquest, CCO Hauser's evidence was that Selesa said: "*Fuck you. I want another phone call. I'm not giving it back to you. Give me another phone call.*"⁵⁸

[66] Another CCO, Berry Tuia, presumably the person Selesa was referring to, attended and managed to gain Selesa's compliance.⁵⁹ Selesa was handcuffed through the door consistent with her SES plan and her cell was thoroughly searched by CCO Hauser and CCO Andrea Carrol who were unable to locate the insulin device. They were not able to search Selesa's person for safety reasons, namely, the existence of a potential sharps risk.⁶⁰ During the episode, Selesa was laughing and told CCOs she had flushed the insulin injector down the toilet. The nurse advised the CCOs that due to the administration of two doses of insulin, Selesa would have to go to the TH under QCS escort for observation.⁶¹ Selesa was then taken to THHS.⁶²

[67] On 28 November 2021, at 4:30am, Selesa returned to the TWCC. A Notification of Concern (NoC)⁶³ was raised, following reports from nursing staff that while Selesa was at the TH, she stated that she purposely double dosed herself to try to kill herself and she would do it again.⁶⁴ Accordingly, Selesa's SES plan⁶⁵ was replaced with an amended plan.⁶⁶ Her insulin was administered by nurses in the DU as opposed to the insulin injector being provided to Selesa, through the metal hatch to self-administer.

[68] On 29 November 2021, an Initial Assessment (IA) was completed by Psychologist Zachary Burberry in response to the two NoC. The IA noted that Selesa "*...reported that her behaviour was an attempt to*

⁵⁵ Exhibit D31. Exhibit D34.7.

⁵⁶ Exhibit B41 at [9] – [25].

⁵⁷ Exhibit B41 at [15].

⁵⁸ 11 October 2023, T3-28, L 12. T3-29, L 33. T3-66, L46. Submissions on behalf of QCS at [16]-[21].

⁵⁹ Submissions on behalf of the family dated 16 October 2024, at [112(a)].

⁶⁰ 11 October 2023, T 3-30, L 47.

⁶¹ Exhibit B41 at [21].

⁶² Exhibit D33. Exhibit D31.

⁶³ Exhibit D34.5.

⁶⁴ Exhibit D34, 37.

⁶⁵ Dated 24 November 2021.

⁶⁶ Dated 28 November 2021. The review dated of the SES plan was 28 December 2021.

*influence her chances of getting a second phone call and wanting to stay at the hospital for further treatment of her leg pain.” Selesa was maintained on 60-minute (at risk) observations.*⁶⁷

- [69] On 30 November 2021, CCO 1 saw an insulin injector device in Selesa’s cell and was able to retrieve the device from Selesa in exchange for giving her toast.⁶⁸
- [70] At 5:12pm, Selesa had handcuffs applied through the cell door and was escorted by CCOs to the ARUNTA phone room (interview room) to make a phone call. Selesa remained handcuffed throughout, consistent with her SES plan. Once in the interview room, Selesa attempted to dial out on the phone. However, the call did not connect.
- [71] At 5:14pm, Selesa again dialled the phone. The call connected to Matthew Darcy⁶⁹ and they discussed him placing funds into Selesa’s ARUNTA account to enable phone calls to be made. Selesa remained on the phone for approximately one minute and 40 seconds. Selesa dialled the phone a third time and the call would not connect. Selesa continued to attempt to make further phone calls.
- [72] At 5:17pm, CCO 1 and CCO 2, entered the room and found Selesa was visibly distressed. She was pleading to make another phone call. The CCOs explained to Selesa that the ARUNTA phone system would not allow for that many attempted calls out. This interaction was captured on body worn camera and formed part of the brief of evidence. A transcript of the body worn camera of the CCOs is contained in the brief of evidence. This includes a version with Samoan phrases used by Selesa, translated into English.⁷⁰
- [73] At 5:19pm, the CERT Leader, entered the room. Selesa was distressed and crying. CCO 1 took the phone handset from Selesa and returned it to the cradle. CCO 1 allowed Selesa to try the phone again and advised if the call didn’t connect then she would have to return to her cell. Selesa again dialled the phone. The ARUNTA system would not allow the call to be connected. Selesa sat down on the seat. She refused to leave the room and return to her cell. Selesa cried and pleaded for another phone call. The following events and exchanges then occurred:
- a. CCO 2 told Selesa: *“it will have to be tomorrow”* to which Selesa replied *“it’s always tomorrow, never...” (UI) (crying).*⁷¹
 - b. Selesa was crying, she said: *“ten more second please one second, one second please, please ... ten more second.”*

⁶⁷ Exhibit D34 at [44] – [45]. Submissions on behalf of QCS at [20].

⁶⁸ 7 May 2024, T4-71, L 6.

⁶⁹ Exhibit D34.17.

⁷⁰ Exhibit B27. Exhibit B31. Exhibit B47. Exhibit B47.1.

⁷¹ Exhibit B27, 4.

- c. CCO 2 replied: *"I can't make the phone work Selesa."*
- d. CCO 1 told Selesa that the phone was not letting her dial.
- e. The CERT Leader counted 10 seconds (out loud) and allowed Selesa another chance to make a call to see if it would connect. It did not. Selesa became more distressed when the call would not connect.
- f. The CERT Leader said: *"Darcy, go back to your cell now, come on."*⁷²
- g. CCO 1 told Selesa: *"Come on, we did what we said, I can't do anything else, you need to do what you said and go back to your cell."*
- h. Selesa responded: *"Youse always promise me a phone call everyday. But you don't want to give me a phone call (UI) ring my Mum, (UI) you promise me yesterday, you promised me the day before."*
- i. The CERT Leader directed Selesa to return to her cell. Consistently QCS officers spoke to Selesa in a calm, low tone.
- j. The CERT Leader said: *"I gave you the opportunity, we waited another ten seconds like you wanted and we tried again, there's nothing we can do now."* Selesa asked for one more minute.
- k. The CERT Leader said they were not waiting one more minute and directed Selesa: *"Darcy stand up, move to your cell. Stand up, move to your cell."* Selesa did not comply.
- l. CCOs attempted to get Selesa to stand up, however Selesa did not comply with their verbal directions and dropped her body weight.
- m. Selesa started yelling words that were incomprehensible.

[74] Around 5:21pm, a Code Yellow was called by the CCOs. Additional staff attended the interview room in response to the call. Selesa was resistant to the CCOs attempts to restrain her which resulted in the CCOs losing hold of Selesa's arms. Selesa fell backwards off the metal seat in the interview room and into the corner of the room. She appeared to strike her head against the wall as she fell to the floor. The CERT Leader, CCO 1 and CCO 2 attempted to lift Selesa to her feet. Selesa screamed, clenched her fists, and would not stand in compliance with the verbal direction given to her by CCOs. Selesa was lowered to the ground, under control of the CCOs, onto her back.

⁷² Exhibit B27, 5.

Selesa was rolled into a corner, in a prone position facing the interview room wall.

[75] In determining the sequence of events that then occurred I have been aided by the timeline contained in the report of Dr Stephen Rashford, QAS Medical Director and the timeline in the OIMIRG report.⁷³ Dr Rashford's timeline is reproduced below. I accept it accurately depicts the events by reference to the body worn camera footage that forms part of the brief of evidence.

[76] However, as QCS have submitted,⁷⁴ Dr Rashford's timeline is to be read in the context of the following matters:

- a. The timeline was developed by Dr Rashford and members of his professional standards team that reviewed the video footage carefully and methodically;
- b. The narrative contained in the timeline is that of a highly trained medical professional (Dr Rashford) and the task of review has been undertaken with the benefit of hindsight;
- c. The video footage should be supplemented and explained by the evidence of those present (such as the CCOs) directly involved with Selesa;⁷⁵
- d. At timestamp 17:22:06, Dr Rashford's oral evidence at the Inquest was that a more accurate description was an "altered level of consciousness" as opposed to a "very depressed level of consciousness;"⁷⁶ and
- e. At timestamp 17:24:06, the laboured breathing heard on the video from both Selesa and the officers involved, likely indicated that all parties were physically exerting themselves in the process of the restraint.⁷⁷

I accept the submission advanced by QCS. Dr Rashford's timetable is to be read in the context of the matters set out above.

[77] The timetable is as follows:

Footage	Camera	Time	Description
RM BWC2	2	17:21:21	The CERT leader heard "get her hands above her head".
RM BWC2	2	17:21:27	The physical struggle escalates. Selesa's hands are visible showing her palms are clearly blanched,

⁷³ See also the submissions of Counsel Assisting dated 16 December 2024, at [35] – [37]. Exhibit D34, [28] – [34].

⁷⁴ At [22].

⁷⁵ 15 May 2024, T8-63, L 14 – 39.

⁷⁶ 17 October 2023, T1-85, L 36 to T1-86, L9.

⁷⁷ 17 October 2023, T1-86, L40 to T1-87, L 25.

			indicating she is resisting. At the same time, the CERT leader can be heard directing Selesa to release the pressure on her hands.
RM BWC2	2	17:21:47	Selesa suddenly stops screaming. Breathing can be heard, sounding laboured with an expiratory wheeze. This indicates that Selesa is using a lot of force during expiration.
RM BWC2	2	17:21:50	Clear views of Selesa's face show she is less interactive and has her eyes closed (it is unclear if this is voluntary at this stage).
RM BWC2	2	17:21:57	Grunting sounds are heard. This is suggestive of significant respiratory distress.
RM BWC2	2	17:22:03	The CERT leader states, "that's alright, put her into the prone position".
7003, 7007, RM BWC2	1,2,3	17:22:06 – 17:22:13	Selesa is moved into prone position. Selesa at this point has a very depressed level of consciousness (ALOC).
7003	1	17:22:18	The CERT leader can be seen with his left knee in the middle of Selesa's back.
RM BWC2	2	17:22:27 onwards	Selesa can be heard breathing at a rate of 60 breaths per minute. An audible wheeze can be heard. There is no response to the verbal instructions.
7003	1	17:23:48	The CERT leader's left knee appears to release from Selesa's back.
RM BWC2	2	17:22:55	Selesa's legs are seen to move briefly, however there are several seconds of no movement after this. (Cannot be certain whether these moves were voluntary or not).
RM BWC2	2	17:22:56	The CERT leader states, "She's spitting and resisting". There is heavy breathing which may result in bodily fluid leaving the mouth as opposed to actively spitting at someone.
7003, RM BWC2	1,2	17:23:06	Several CCOs commence the process of applying a safety hood ("spit hood").
RM BWC2	2	17:23:06	Selesa can be heard calling out " <i>Mepasa</i> " (sic) five times. This sounds quite anguished, as if calling out to someone/thing. This was prior to the actual safety hood application.
RM BWC2	2	17:23:28	Selesa calls out several incomprehensible words, the breathing associated with this sounds very laboured.
RM BWC2	2	17:23:45	Selesa states, "I can't breathe" several times. The second time sounds fearful and increasingly laboured.
RM BWC2	2	17:23:58	A female CCO states, "It's, it's suffocating her". A male CCO replied, "It's just awkward. It's just awkward".
Various	1, 2, 3, 4	17:24:06 – 17:24:28	Selesa is physically moved to a sitting, then standing position and subsequently moved back to her cell. Selesa appears to have some control of her legs, however, a significant amount of her body weight appears to be heavily supported by CCOs. Laboured breathing audible for entire duration of move.
7008, 7004 RM BWC2	1, 2, 3	17:24:28	Selesa enters the cell with multiple CCOs.
RM BWC2	2	17:24:32	The CERT leader gives multiple commands to kneel, with nil response from Selesa. Heavy breathing heard continuing.

7008, RM BWC2, HK BWC	1, 2, 4	17:34:37	Selesa is physically placed into seated position. Over the next few seconds, she is moved into the prone position. Head is located close to wall. Figure 4 leg lock applied.
7008, RM BWC2	1, 2	17:24:49	Safety hood is re-applied.
7008, RM BWC2	1, 2	17:24:55	There are attempts to move Selesa's hand above her head (currently under stomach).
7008, RM BWC2	1, 2	17:25:01	Selesa is relocated away from the wall to the centre of the cell. During this time, some incomprehensible noises can be heard.
7008	1	17:25:12	The CERT leader's right knee is visible on Selesa's lower back while in prone position. It is difficult to hear Selesa's breathing during this time due to the heavy breathing of CCOs.
RM BWC2	2	17:25:15	There is a clear view of Selesa's hand - nil tension and nil blanching of her palm as observed earlier. I believe there is limited muscle tone.
RM BWC2	2	17:25:24	The safety hood is removed.
7008	1	17:25:53	A female CCO applied her left knee to the middle of Selesa's back.
RM BWC2	2	17:25:54	Possibly, small incomprehensible sounds are heard from Selesa.
RM BWC2	2	17:25:57	The CERT leader issues further verbal instructions to relax. There is no response from Selesa.
RM BWC2	2	17:26:04 onwards	While heavy breathing from CCOs can be heard, I cannot hear any breathing from Selesa for the remainder of the time the CCOs are in the cell. I believe that ST's breathing is ineffective or absent at this time.
7008	1	17:26:09	The female CCO removes her knee from Selesa's back.
7008, RM BWC2	1, 2	17:26:24	The CERT leader says, "Alright, roll her into the recovery position".
Various	1, 2, 3, 4	17:26:37	CCOs begin to exit from the cell.
7008	1	17:26:44	The last CCO releases physical contact, Selesa seen to slump slightly and her arm flops down indicating she is completely flaccid. Selesa is clearly unconscious at this time.
7008	1	17:26:44	All CCOs are out of cell and the cell door is closed.
7008	1	17:26:44 – 17:28:00	There is no visible movement of Selesa, including any movement of her stomach or shirt, indicating nil or ineffective breathing.
7008, 7004, HK BWC	1, 3, 4	17:26:57	A CCO is seen looking through the door window at Selesa.
7004, HK BWC	3, 4	17:27:10 onwards	Code blue is called. Visual monitoring is continued. Multiple verbal attempts to gain a response are undertaken. There are also ongoing discussions around a safe approach to cell entry.
7008	1	17:27:58	There is a small movement of Selesa's head, slumping forward noted.

[78] It is necessary to add to this timetable some matters concerning CCO Jeanette Love, who was at the time an Acting Secure Supervisor and

responded to the Code Yellow. CCO Love entered the DU at 17:23:40 with CCO Torsney entering behind her.

- [79] At 17:24:00 CCO Love moved past the door to the interview room where Selesa, the CERT Leader, CCO 1 and CCO 2 were and opened the internal door between the space outside the interview room and the space leading back to the cells.
- [80] CCO Love was not directly involved in the physical restraint of Selesa.⁷⁸ CCO Love was however the most senior officer present and had consequent responsibility and authority as the “Incident Controller” or “Field Commander.”⁷⁹
- [81] It was submitted on behalf of CCO Love that she did not assume the role of Field Commander upon attending the Code Yellow as her impression was that the CERT Leader was calling out directions calmly and clearly. She was aware that as the A/Secure Supervisor she would be higher in the chain of command than the CERT Leader if she did not consider that he could handle the situation.⁸⁰ CCO Love did not however consider the CERT Leader did not have sufficient control over the situation. I accept this.
- [82] Additionally, CCO Love’s evidence was that she suffered from tinnitus. She recalled the CERT Leader was giving verbal directions to Selesa, CCO 1 and CCO 2. She did not know, nor could remember what Selesa was saying.⁸¹ CCO Love accepted that she (like other CCOs) did not recognise Selesa’s medical decline during the period of restraint. Counsel on behalf of CCO Love submitted, and I accept, that this must be understood in circumstances where:
- a. One indicator of that decline was the sudden change in behaviour from Selesa’s escalation and rapid de-escalation.⁸² Ms Love was not present for much of the period of escalation (if any) and would not have been able to identify that there had been a sudden change.
 - b. Another indicator of decline was Selesa’s lack of response after the CCOs had performed the extraction from her cell.⁸³ Like the other officers present, CCO Love identified a concern that Selesa might have pretended to be unresponsive prior to a further physical engagement upon officers re-entering the cell.

⁷⁸ Submissions on behalf of Jeanette Love dated 11 November 2024 at [5(a)-(d)].

⁷⁹ Submissions on behalf of Jeanette Love dated 11 November 2024 at [6]. Exhibit D42, 10-11. Exhibit D52. Exhibit D49. Exhibit D51.

⁸⁰ 14 May 2024, T3-9, L 4-6. Submissions on behalf of Jeanette Love dated 11 November 2024 at [10].

⁸¹ Submissions on behalf of Jeanette Love dated 11 November 2024 at [15]. Exhibit B62 at [32]. 14 May 2024, T3-16, L 23-34.

⁸² Exhibit J1, 9. Submissions of counsel assisting at [80].

⁸³ Exhibit J1, 9. Submissions of counsel assisting at [80].

- c. CCO Love was not present when Selesa asked for her puffer and did not identify that Selesa was having difficulty breathing.
- d. CCO Love's evidence is that although she does not recall exactly when she started to think Selesa might not survive, she had anxiously awaited the arrival of the nursing staff after the Code Blue had been called, because at that point she thought Selesa would get medical treatment and that she would be ok.⁸⁴ She did not have concerns for Selesa's wellbeing prior to Selesa being placed in her cell;⁸⁵ and
- e. Identifying a cardiac arrest would be very difficult for a CCO to recognise.⁸⁶

[83] It is against this background that I consider the inquest issues.

Issue 1: The identity of the deceased, when, where and how she died and what caused her death

[84] To prevent repetition, I will deal only with the medical cause of death under this heading. That issue is one which is to be decided on the basis of the medical evidence. That comprises the evidence of Dr Starmer, Dr Vidler and Dr Rashford. The balance of the matters relevant to issue one are set out above and are otherwise summarised below.

[85] So far as the medical evidence is concerned, I note counsel for Selesa's family have adopted the submissions of Counsel Assisting relating to the evidence of Dr Vidler, a forensic pathologist, as to Selesa's cause of death, particularly in respect of the contributory factors to the cardiac arrest.⁸⁷

[86] Counsel for Selesa's family invite me to attach little weight to the opinion of Dr Starmer when considering her cause of death,⁸⁸ specifically, his opinion as to the likelihood of Selesa passing away from her underlying cardiomyopathy within the four-month period after she was referred for an echocardiogram.⁸⁹ I do not accept this submission. Dr Starmer's expertise to provide such an opinion is clearly supported by his professional qualifications outlined in his CV.⁹⁰ Dr Starmer's opinion is provided in his supplementary report.⁹¹

“Ultimately, Miss Tafaifa did likely have an underlying cardiomyopathy and her mode of dying was most likely an

⁸⁴ Exhibit B62 at [40] and [44].

⁸⁵ 14 May 2024, T3-19, L 4-5.

⁸⁶ 15 May 2024, T8-60, L 43 – T8-61, L3.

⁸⁷ Submissions on behalf of the family dated 16 October 2024, at [24 a – d].

⁸⁸ Submissions on behalf of the family dated 16 October 2024, at [30].

⁸⁹ Exhibit J2, 6.

⁹⁰ Exhibit J2.1.

⁹¹ Exhibit J2.2.

arrhythmia. In someone without Ms Tafaifa's mental health history, that is, in a typical clinical trial participant, early diagnosis and initiation of medical therapy would possibly have been beneficial and may well have led to either an improvement in LV systolic function and therefore averted the need for an implantable cardiac defibrillator or resulted in early placement of an implantable cardiac defibrillator. Ms Tafaifa's complex psychiatric history is relevant however. Whilst she should certainly have been referred for an echocardiogram and a cardiology opinion following her presentation to the emergency department on the 29/07/2021, I still find it difficult to conclude, on the balance of probabilities, that there would have been a significant reduction in the likelihood of her passing away 4 months after presentation. This is a case in which the old adage [sic]"retrospect is a powerful thing" is very pertinent, as a perfect system of care and an engaged patient would have been required to potentially alter the outcome in this case."

[87] So far as Dr Vidler is concerned, I accept her evidence and reasoning as to why at the time of issuing an autopsy certificate she was unable to determine a specific cause of death in circumstances where the relative contribution of several factors to the cardiac arrest cannot be determined.⁹²

[88] In examining asphyxia as a possible cause, Dr Vidler's evidence at the Inquest was:⁹³

"Classically, the – definitions within the area of asphyxia are – not well defined. Classically, mechanical asphyxia involves the positioning of the body, so abnormal positioning of the body that would lead to - a reduced ability to breathe, as well as pressure on the outside of the body that would reduce the ability to breathe, specifically in sort of the chest and torso area.

Probably, the - most clear way to think about it was if there was just possible intermittent asphyxia by a variety of mechanisms involving the positioning of her body, forces on the outside of her body, the positioning of her arms while handcuffed, the positioning of the spit hood – all of these things have contributed to potential intermittent asphyxia."

[89] In considering whether suffocation occurred, Dr Vidler's evidence at the Inquest was:⁹⁴

"I'm not specifically talking about suffocation here, no. Some definitions of mechanical asphyxia do encompass external positioning of things on the face as well. So you know, in retrospect, I think it would've been clearer if I had just left out the word "mechanical" and just said "possible intermittent asphyxia",

⁹² Exhibit A5, 19-20.

⁹³ 17 October 2023, T1-21, L 40.

⁹⁴ 17 October 2023, T1-24, L 17.

because there's lots of different mechanisms of asphyxia that've possibly occurred in this case."

[90] I accept the submission of counsel assisting that in clarifying the use of the term "mechanical asphyxia", Dr Vidler was clear that she was not referring to the use of the safety hood,⁹⁵ but to the psychological aspects of the use of a safety hood. Dr Vidler's evidence at the Inquest was that in the lead up to the Inquest, she had done more reading and was now of the view that it may have been a "*potential contributing factor*" due to the effect that the application of the safety hood had on Selesa's hair (obscuring her face, nose and mouth).⁹⁶ Her evidence was:

*"When I rewatched the footage again in the leadup - to this inquest, I noticed specifically that her - which I didn't notice the first time, that her hair was pulled down, it would appear to be, at the front in the safety hood, which - yeah - I hadn't appreciated that the first time, so I thought that was a potentially significant occurrence."*⁹⁷

[91] Dr Vidler confirmed that the safety hood used on Selesa was not received with her body and that she had not seen a safety hood before. Dr Vidler did not "*know anything specifically about different materials*" and would not consider herself "*well-versed*" in types of safety hoods. As such she could not comment on its permeability. Dr Vidler's evidence was that there was "*no specific evidence*" that the use of the safety hood in fact played a role in Selesa's death.⁹⁸

[92] I accept the submission of counsel assisting that Dr Vidler's observations in respect of Selesa's brain as they concern the possible contribution of asphyxia⁹⁹ are of assistance:

"There can be signs of asphyxia that occur in the brain with changes to the colouration of the cells in specific areas of the brain, which is some of the very first signs of asphyxia. It does take time for these develop - to develop those. So the period of asphyxia will generally have to be, sort of, a number of minutes, sort of, getting towards the half-hour mark. So I would expect to still see a normal brain in this case even if a potential asphyxia mechanism has contributed."

[93] I have been assisted by Dr Vidler's evidence in respect of a possible contribution of asphyxia and possible contribution of restraint and psychological stress in my examination of the adequacy and

⁹⁵ 17 October 2023, T1-24, L 24. Submissions of counsel assisting dated 16 September 2024, at [48].

⁹⁶ 17 October 2023, T1-25, L 12.

⁹⁷ 17 October 2023, T1-25, L 32.

⁹⁸ 17 October 2023, T1-25, L 12.

⁹⁹ 17 October 2023, T1-6, L 3. Submissions of counsel assisting dated 16 September 2024, at [52].

appropriateness of the actions of the CCOs on 30 November 2021.¹⁰⁰ In substance, when a person becomes distressed, there is an increase in the sympathetic nervous system. To express it another way, when a person in distress gets a rush of adrenaline and that will put strain on the heart and lungs because the situation causes the heart to beat faster and can increase blood pressure. In this way, the psychological distress relating to the phone call could have increased the stress on Selesa's heart.¹⁰¹

- [94] During the restraint, Dr Vidler opined that Selesa likely experienced further psychological distress.¹⁰² Dr Vidler accepted the general proposition that psychological stress can play a role in rhythmic disturbances. Her evidence in response to a question to this effect was:

*"It can. So there's general and specific ways that psychological distress can impact a sudden cardiac death. One is just what I've described, which is just the general, sympathetic activation, which is –means, basically, there's lots of release of adrenaline and similar substances in the body that put increased stress on the heart. There's also a specific subcategory of cardiac diseases called channelopathies, in which a very –you know, a small subset of those might be activated by an acute psychological disturbance and –yeah–cause a sudden cardiac death. But that would –that's –yeah. I haven't really considered that here because that would usually be considered more in a death where there's no other reason to explain the cardiac arrest, whereas we have lots of contributing factors that'll explain it in this case."*¹⁰³

- [95] Dr Vidler's evidence was that the safety hood is something that is known to cause distress and that potentially it puts strain on (and did put strain on) Selesa's heart as well.¹⁰⁴

- [96] I accept Dr Vidler's opinion of contributory factors to the cardiac arrest and the evidence of natural disease identified during autopsy. Relevantly, her evidence was as follows:

"Neuropathology examination of the brain showed no significant abnormality¹⁰⁵ that would contribute to death', there was evidence of natural disease including severe obesity, focally moderate coronary artery atherosclerosis in the heart, heavy, dilated heart with microscopic evidence of cellular enlargement (hypertrophy) and scarring (fibrosis), consistent with

¹⁰⁰ Submissions of counsel assisting dated 16 September 2024, at [53]. 17 October 2023, T1-11, L 32.

¹⁰¹ 17 October 2023, T1-20, L 45.

¹⁰² 17 October 2023, T1-21, L33 and L36.

¹⁰³ 17 October 2023, T1-23, L 22.

¹⁰⁴ 17 October 2023, T1-11, L 45.

¹⁰⁵ Exhibit A5, 14-15.

*cardiomyopathy and fatty liver with evidence of microscopic chronic inflammation and scarring.*¹⁰⁶

...

*A heavy heart is significant because basically... a bigger heart requires more blood, more oxygenation to be supplied and to function. It also indicates that over time, the heart has probably increased in size due to abnormal haemodynamic stressors or biochemical stressors that have occurred in the body due a natural disease over a long period of time. So having a heavy heart would put someone at an increased – risk of a sudden cardiac death at any time.*¹⁰⁷

...

*Obesity is important, really, for – two main reasons. One is that – it's probably contributed to her –natural disease, such as her enlarged heart, for example. It's also important in the setting of restraint to consider that someone has obesity, particularly when obesity is –quite severe because obesity itself can inhibit breathing in terms of there's more weight on the chest and abdomen that's being carried around and when the body is put into different positions, the obesity can compress into - the abdomen, which is a soft cavity and can restrict some movement of the diaphragm, which is a muscle of breathing that sits below the chest. So – obesity is important to consider in the restraint in this case.*¹⁰⁸

[97] I have also had regard to the opinion of Dr Rashford in my consideration of what caused Selesa's death.¹⁰⁹ I was particularly assisted by Dr Rashford's evidence at the Inquest regarding statements that Selesa could not breathe. Dr Rashford's evidence was as follows:¹¹⁰

[CA] Okay. And during that period of time when the safety hood's applied to her, you recall hearing Selesa voice that she can't breathe?---

[Rashford] Yes.

[CA] Okay. What should that have indicated to the officers at that time?---

[Rashford] It's difficult for me to understand what the – what the officers would have thought of that comment.

[CA] Certainly?---

[Rashford] But people – we often hear this with people who have been restrained say they can't breathe. And people have a false

¹⁰⁶ Exhibit A5, 19.

¹⁰⁷ 17 October 2023, T1-8, L 31.

¹⁰⁸ 17 October 2023, T1-11, L2.

¹⁰⁹ Submissions of counsel assisting dated 16 September 2024, at [61]-[63].

¹¹⁰ 17 October 2023, T1-44, L 4-22.

sense of security because they think air movement is going through the vocal cords to be – actually generate the – the words. But saying you can't breathe doesn't mean you have obs – obstructed airway. It means that you feel breathless. And there's a lot of – there's a lot of different reasons for feeling breathless. And if you look at some very prominent cases that have been tried – that have been – gone through the system in the United States and here, inevitably – or universally, they all say, "I can't breathe", and – and – and it's – I – the – the reason for that, I think, is not just respiratory distress. It is actually an inability to breathe appropriately, given their underlying metabolic condition. And so certainly, it should be a warning sign for someone who's showing signs of respiratory distress to – to perhaps consider whether a safety hood is appropriate in someone in that situation.¹¹¹

...

[CA] Okay. And from a medical standpoint then, what should have been done at this time when she voiced that she couldn't breathe?---

[Rashford] I –my view–and–and I don't speak in–I speak as an emergency physician looking at this. I'm not a corrective services officer, and –and so I don't have that expertise. I think I these situations, the best thing is always to stop what you're doing, put the person into a position of mechanical advantage for breathing, which is generally sitting up, not place the safety hood and –and just call for medical assistance.¹¹²

...

[CA] Are you able to comment on the impact of that restraint had on Selesa's clinical condition?---

[Rashford] Well, you've got someone who's exhibiting–exhibiting signs of respiratory distress. They're –they're saying they can't breathe. You've placed something over their face which further makes them –it makes someone claustrophobic and potentially impairs the ability to ventilate, and then you add further restraint which sets up for significant ongoing exertion. And that exertion–in someone who particularly is not fit –and I suspect that Selesa's probably wasn't as fit as she was when she was much younger, they switch very quickly from aerobic to anaerobic metabolism. They start to develop a –develop a metabolic acidosis, and which can become very profound. And to –to compensate for metabolic acidosis, our body does two things: we –we attempt to breathe more quickly, to remove acid via carbon dioxide, or our kidneys kick in. But the kidneys is a slow version. It–it's not going to help you acutely. And so most of when we've done strenuous exercise will recognise –and

¹¹¹ 17 October 2023, T1-42, L23-41.

¹¹² 17 October 2023, T1-43, L 24.

you'll hear it when you listen to the breathing of the corrective services officers, for a very long period of time, they're breathing very quickly. They're breathing very hard. And so that's –they are compensating for the exertion that they've had to do. So Selesa has her own form of exertion, and that is resisting restraint and that–which –and –and so that's what's going on at this point. So it's certainly not ideal to do anything to impair ventilation.

[98] Dr Rashford also provided evidence regarding the points at which Selesa may have benefited from recognition of her medical decline. These included:¹¹³

- a. When she initially became breathless and had an audible wheeze (before she was removed from where the telephone was).
- b. As soon as she was placed on the floor and was unresponsive and showing signs of ineffective breathing.

[99] However, notwithstanding these matters, Dr Rashford opined that by this point, Selesa was either in peri-arrest or cardiac arrest:

“Given the cause is either hypoxia, or low oxygen, or it is an abil – inability to mount a response to that acidosis, both of those – once you go into cardiac arrest, the chances of survival are quite – can be quite slim, particularly if you’ve got other things – when you add the other – well, the house of cards for Selesa is not a very strong house of cards, like, lots of comorbidity. The chances of survival are slim to start off with, and they rapidly go off. So, you know, once she entered into a peri-cardiac arrest or cardiac arrest state, the chances of survival were – were negligible.”

[100] Counsel Assisting has submitted, and I find that the following points should be considered when considering Dr Rashford's evidence:¹¹⁴

- a. Dr Rashford's opinion was given from the perspective of a highly trained emergency physician, not that of a corrective service officer.
- b. Dr Rashford could not, for obvious reasons, comment upon the state of mind of the CCOs as to what assessment, if any, they made of Selesa's words that she could not breathe when the safety hood was applied.
- c. It is not uncommon for people who have been restrained to say they cannot breathe, and the complaint alone does not necessarily mean a person has an obstructed airway. Rather, it

¹¹³ 17 October 2023, T1-98, L 13-37.

¹¹⁴ Submissions of counsel assisting dated 16 September 2024, at [64(a) – (f)].

can also mean that a person is breathless, and there are several reasons why a person may feel breathless.

- d. From a medical perspective the application of a restraint, in the form of a safety hood, and further exertion in a person who has a poor level of fitness can cause the development of metabolic acidosis to which the body has two possible reactions: to breathe more quickly, to remove acid via carbon dioxide, or, the kidneys will compensate, albeit the kidney response will be slow and will not assist acutely.
- e. The best chance of survival for Selesa was if her decline in the peri-arrest stage was recognised; and
- f. Once Selesa was in peri-arrest or cardiac arrest, the chances of survival were, to adopt Dr Rashford's words, "slim" or "negligible" by reason of the presence of her medical comorbidities.

[101] Ultimately, while the cause of death is listed as 'not determined,' I find, on the basis of the medical evidence I have set out above, that Selesa suffered a cardiac arrest, in the context of several contributory factors, where the relative contribution of each cannot be determined, but which include physical exertion and restraint, where a safety hood (spit hood) had been applied which caused her hair to be held across her face. I also find that Selesa's significant pre-existing natural disease (obesity, cardiomyopathy, and coronary atherosclerosis), contributed to the cause of death.

Issue two: the adequacy and appropriateness of diabetes and insulin management of persons in custody at TWCC

[102] Issue 2 was formulated prior to the finalisation of the brief of evidence and in circumstances where Dr Vidler at the time of issuing the autopsy certificate was unable to determine Selesa's cause of death. Selesa was a diabetic, type 2 insulin dependent. As part of her treatment for this condition she was prescribed mixtard insulin – three times a day: morning 50 units mixtard 30/70, lunchtime 46 units mixtard 30/70 and afternoon 46 units mixtard 30/70.¹¹⁵

[103] As I have set out above, there were issues encountered with Selesa's administering insulin. However, at Inquest, the medical evidence concerning Selesa's cause of death made clear that the management of Selesa's diabetes (and the condition itself) did not have any connection with the cause of death. In such circumstances, I do not consider it necessary to further address this issue.¹¹⁶

¹¹⁵ Exhibit I2.

¹¹⁶ This submission was supported by Counsel for the family at [31]-[33], and Counsel for the QPS at [24]-[25].

Issue three: the adequacy and appropriateness of the actions of the QCS staff on 30 November 2021

- [104] As the time of Selesa's death, the Control and Restraint Manual (CRM) was in effect.¹¹⁷ It set out the situational response model. Since Selesa died that manual has been replaced by the Tactical Options Manual (TOM) which contains, in place of the situational response model, the TEN-R model.
- [105] Notwithstanding the change, it remains the position that it is the situation response model against which the actions of the CCOs who interacted with Selesa are to be assessed. Mr Darron Haworth, a training coordinator with the Queensland Police Service, provided a report to me on the use of force by the CCOs. His report was prepared on the basis that the TOM was in force at the relevant time. This was identified during the course of the Inquest so oral evidence was given by Mr Haworth as the application of the CRM.
- [106] In dealing with the third issue there are, as Counsel Assisting submits, three relevant events, each of which are uses of force, and which occurred sequentially, to consider:
- a. First, the decision to apply the safety hood to Selesa;
 - b. Second, the movement of Selesa from the interview room to her cell; and
 - c. Third, the cell extraction performed by the CCOs to return Selesa to her cell.¹¹⁸
- [107] In considering these issues it is necessary to consider the circumstances that preceded the initial use of force. This is necessary, in part, because the legal representatives for Selesa's family submit, in substance, that Selesa died after she was refused a phone call and she was forcibly restrained by officers, including via the use of a spit hood; and that the use of force by CCOs, during these events occurred in circumstances where Selesa did not pose any significant risk to person or property.¹¹⁹
- [108] The legal representatives for the CERT Leader, CCO 1 and CCO 2 submit that this is a flawed evidentiary premise.¹²⁰ I agree with that submission.

¹¹⁷ Exhibit D34.41, 81 (Version 07). Submissions of counsel for the QCS at [29]-[32].

¹¹⁸ Submissions of counsel assisting dated 16 September 2024, at [74]

¹¹⁹ Submissions on behalf of the family dated 16 October 2024, at [3(b) & (d)].

¹²⁰ Submissions on behalf of QCS Officers at [7]-[9].

[109] In doing so I also accept the submission that in considering the actions of the CCOs on 30 November 2021, including the use of force, the following facts are relevant.¹²¹

- a. Selesa was accommodated in the DU, this meant that she had been non-compliant with directions and was displaying poor behaviours. The DU has several constraints on a prisoner, including restrictions upon leaving, out of cell time and communication.¹²²
- b. Selesa was subject to an IMP and a SES plan. The evidence of the CERT Leader, CCO 1 and CCO 2 was that they were required to be aware of the SES and it was to be followed during their interactions with Selesa.¹²³
- c. Relevant to the actions of the CERT Leader, CCO 1 and CCO 2, the SES plan detailed that:
 - i. Conversation will encompass clear concise direction and expectations of behaviour.
 - ii. Selesa is always required to display compliant polite and respectful behaviour to staff and prisoners.
 - iii. Selesa is not permitted to threaten abuse or intimidate staff members at any time.
 - iv. Only one staff member to communicate with Selesa at any time.
 - v. Staff must be vigilant and ensure the [sic] always have a reactionary gap with Selesa.¹²⁴
- d. When in a highly elevated state, Selesa's ability to follow instruction is likely to be impaired. Short, clear, focus directions in calm and measured tone will be of benefit.
- e. There was to be a minimum of 1 x CERT team leader, 2 x CCO present at all times when the cell door is opened, or there is no physical barrier between the staff and Selesa (consideration is to be given with the use of a shield for a physical barrier for staff to complete intercom check safely without the risk of spit from Selesa).

¹²¹ Submissions on behalf of QCS Officers at [11]-[24].

¹²² 8 May 2024, T5-24, L16-19.

¹²³ 7 May 2024, T4-9 L34-39 (CCO 1); T4-78 L5-6 (CCO 2); 9 May 2024, T6-45 L35-40 (CERT Leader).

¹²⁴ Exhibit D9, 3.

- f. Consideration to place a safety hood on Selesa whilst conducting phone calls in the DU interview room due to her history of staff assaults (spitting).
- g. All interactions to be captured by body-worn camera.¹²⁵

- [110] In these circumstances, it is reasonable that CCOs were not going to allow Selesa to remain in the unsecure interview room and not return to her cell.¹²⁶ CCO 1 explained that this was important in the context of being accommodated in the DU, because the DU is a unit where non-compliant prisoners may be housed. The evidence of CCO 1 was that a lot of prisoners will become non-compliant until they get what they want.¹²⁷
- [111] Selesa was not refused a phone call. That evidence supports the submission made on behalf of the CCOs, that 17:00h was not the usual time for prisoner phone calls. Selesa had mentioned phone calls earlier in the day, but there had been no money in her Arunta account and that prevented her being able to use the phone.¹²⁸
- [112] CCO 1 later identified that money had been transferred to Selesa's Arunta account and the CERT Leader chose to facilitate Selesa making a phone call, despite it not being the usual time of day for such things.
- [113] This was also despite the other duties required to be undertaken by CCOs in the DU around that time (facilitating the medication round, providing evening meals, removing rubbish from the cells and topping up any necessities).¹²⁹
- [114] Selesa was compliant when she was taken out of her cell in the way prescribed by the SES. She appeared happy, in circumstances where the CCOs were allowing her to make a phone call.¹³⁰
- [115] Selesa attempted a call, before she was able to connect to Matthew Darcy. They spoke for 1 minute and 40 seconds. Selesa then dialled the phone a third time and the call did not connect. She continued to attempt to make further phone calls.
- [116] CCO 1 and CCO 2 entered the interview room to find Selesa visibly distressed and pleading to make another phone call. The CERT Leader then entered the interview room. CCO 1 allowed Selesa a further opportunity to make a phone call and told her if it did not connect she would have to return to her cell. Selesa attempted to

¹²⁵ Exhibit D9, 4-5.

¹²⁶ 7 May 2024, T4-50, L21-25 (CCO 1).

¹²⁷ 7 May 2024, T4-73, L15-23 (CCO 1).

¹²⁸ 7 May 2024, T4-86, L15-22 (CCO 2).

¹²⁹ 8 May 2024, T5-4, L28-41 (CCO 2).

¹³⁰ 9 May 2024, T6-57, L21-24 (CERT Leader).

make the call but it did not connect. Selesa cried and pleaded for another call. The CERT Leader then counted 10 seconds and allowed Selesa a further chance to make a call. That call did not connect.

[117] Only after CCOs had allowed Selesa multiple attempts to make a phone call, did the officers move forward to get Selesa to stand up and prepare to physically escort her back to her cell. This practice was consistent with previous experiences with Selesa when she became non-compliant.¹³¹ Selesa then dropped her body weight.

[118] I also accept the submission that multiple attempts to de-escalate the situation were made by the CCOs, prior to the first application of force.¹³² Relevantly, at the Inquest, the CERT Leader's evidence (which I consider in further detail below) was that his experience with Selesa guided his approach of giving her opportunities to attempt to make calls, and that this was in, and of itself, a means of de-escalating her state of distress.¹³³ Other methods of de-escalation employed by the CCOs were explained by the CERT Leader as:

- a. Ensuring Selesa had privacy while making phone calls;¹³⁴
- b. Presence and proximity of the CCOs to Selesa while she was in the interview room;¹³⁵
- c. Using a compassionate tone and offering suggestions to try to assist in identifying the problem;¹³⁶
- d. Audibly counting ten seconds to try to give Selesa a grasp of time and assist her to calm down and realise that she was being given the time she had asked for, as opposed to making her go back to her cell straight away.¹³⁷

[119] Counsel Assisting submitted that the events of 30 November 2021 involved the unplanned application of a safety hood to Selesa in circumstances where Selesa was non-compliant with directions given by CCOs and had spat at CCO 1.¹³⁸ I accept that submission. ‘

[120] It is also relevant that Selesa had a documented history of behaviours (including prior incidents of spitting and non-compliant behaviours) and that those documented behaviours informed how the CCOs involved made decisions on 30 November 2021. This included the fact that, due to Selesa's previous behaviours, a safety hood had previously been applied to her without known adverse consequences.

¹³¹ 7 May 2024, T4-19, L34-40.

¹³² Submissions on behalf of QCS Officers at [24].

¹³³ 13 May 2024, T7-64, L5-29 (CERT Leader). Exhibit D25, 6.

¹³⁴ 13 May 2024, T7-15, L43-46 (CERT Leader).

¹³⁵ 13 May 2024, T7-16, L4-14 (CERT Leader).

¹³⁶ 13 May 2024, T7-16, L8-11 (CERT Leader).

¹³⁷ 13 May 2025, T7-16, L33-37; T7-17, L607 (CERT Leader).

¹³⁸ At [78(a) – (h)].

[121] The process for application of a safety hood to a non-compliant prisoner is detailed in the CRM:¹³⁹

[122] The CRM also contain guidance for the removal of the safety hood.

[123] Mr Haworth's report contained the following opinion¹⁴⁰ in respect of the use of the safety hood on Selesa:

It is my opinion, that the obvious distress signs (visible and audible) displayed by the prisoner should have been a consideration under section 17.14 as to the requirement to remove the spit hood due to the signs of difficulty in breathing and that as required, the CCO's should have requested an assessment by the Q Health nurse before continuing with the intended escort back to the prisoner's cell. In support of this opinion, CCO 2 is heard to say, 'it's, it's suffocating her'. This is an indication, that at the time the spit hood was being applied, CCO 2 was aware of the obvious distress signs (visible and audible) displayed by prisoner TAFAlFA.

Furthermore, during the application of the spit hood CCO 2 can be heard saying, 'I can't get that on' which is believed to be in reference to her attempt to apply the spit hood to the prisoner. I note, that prisoner TAFAlFA has a large volume of hair of which she was not wearing up or secured with a hair scrunchie or similar hair tie device. Again, under section 17.14 it could be argued that there was a need to discontinue the attempt to apply the spit hood due to the difficulty encountered given her hair volume and/or head being too large.

Also, of note at this stage of the incident is the comment made by CCO 1 in his officer report provided whereby he states, 'I was controlling Prisoner DARCY's hands at this point. Prisoner DARCY spat on my right hand, glove and arm. A spit hood was then applied as best as possible, however due to the Prisoner DARCY's long hair being everywhere and her active resistance, it was just placed over the top of her head'. If this was CCO 1's assessment at the time, again under section 17.14 it could be argued that there was a need to discontinue the attempt to apply the spit hood due to the difficulty encountered given her hair volume and/or head being too large.

In summation of this section of my report, I would expect that the CCO's [sic] involved at this time of the control and restraint (including the application of the spit hood) phase of the incident would be able to articulate and justify their respective actions referencing the QCS Tactical Options Model framework (QCS TOM V2 2021 SECTION 17 – Safety Hood), including the threat assessment process and that their actions were in accordance with the guidelines of the Use of Force COPD Version 3 (Implementation date: 06/01/2022 – Review date: 2023)¹⁴¹ in that they have satisfied the procedural and legislative requirements of being:

- a) reasonable in the circumstances;
- b) necessary; and
- c) proportionate to the seriousness of the circumstances.

¹³⁹ Version 07. Exhibit D34.41, 81.

¹⁴⁰ Exhibit J4, 14.

¹⁴¹ In evidence, Mr Haworth acknowledged that the correct QCS policy was the Control and Restraint Manual. Prior to giving evidence, Mr Haworth reviewed this manual and gave evidence that it did not change his opinions: see transcript, 15 May 2024, T8-54, L10-26.

[124] Counsel Assisting submits that there are some limitations as to the weight that may be assigned to some of Mr Haworth's opinions. As Mr Haworth acknowledged in his report, that he was unable to comment on individual CCOs threat assessment, articulation or justification during respective control and restraint stages of the incident in question.¹⁴²

[125] In his oral evidence Mr Haworth accepted that¹⁴³ the incident involving Selesa was spontaneous, and, necessarily, consisted of the dynamic and evolving application of restraint. He also accepted his opinion was formed with the benefit of being able to consult manuals and guidelines and a proper consideration of the options available to CCOs and there is a significant risk in hindsight bias, and knowing what in fact occurred, which could have influenced the exercise he undertook, that is, an assessment of the uses of force deployed towards Selesa.

[126] It is also relevant to record that the incident and the uses of force applied to Selesa were spontaneous and while CCOs receive some training in medical conditions that may present in prisoner during a use of force, identifying a cardiac arrest would be very difficult for a CCO to recognise.¹⁴⁴

[127] Mr Haworth expressly acknowledged the significance of the CCOs assessment of risk in the context of the use of force:

[CA] Now, in the paragraph commencing, "Furthermore", Mr Haworth, I won't ask you to read it again, but you say it should be argued that there was a need to discontinue the attempt to apply the spit hood, due to difficulty encountered due to her hair volume and/or head being too large?---

[Haworth] Yes.

[CA] Pausing there. When you say it could be argued, is there a contrary argument available?---

[Haworth] Yes. There is. So what I was saying in the report or referring to in the report is section 17.14 of the TOM, which I was given. Where it talks about reasons for discontinuance or the consideration of discontinuance of a spit hood, all right, which include that it can't physically fit over the head of the prisoner, gurgling and gasping sounds, respiratory distress and so on. The argument to the other side of that, which is why I say it could be argued, would be the officer's own threat assessment at that time.

¹⁴² Exhibit J4, at [12]. 15 May 2024, T8-64, L36-48.

¹⁴³ 15 May 2024, T8-59, L20-33.

¹⁴⁴ 15 May 2024, T8-60, L43 to T8-61, L3.

- [128] Necessarily, the evidence of the CCOs involved must be considered to assist in understanding their state of mind on the day, alongside the body worn camera footage and CCTV.¹⁴⁵ In considering this evidence I am of the view that the CCOs that provided evidence at the Inquest were honest witnesses. This includes the CERT Leader who gave oral evidence over two days,¹⁴⁶ and was examined at length by counsel on behalf of Selesa's family.
- [129] The actions of the CCOs are to be considered by reference to the events outlined above. This includes the fact the CCOs permitted Selesa multiple attempts to make a phone call and the fact that Selesa was distressed and the CCOs allowing multiple attempted phone calls was an attempt to assist her.¹⁴⁷
- [130] It was only after multiple failed attempts to make a phone call Selesa was then directed to return to her cell. She did not comply with this direction. Thereafter, CCOs attempted to stand her up at which point Selesa became actively resistant, non-compliant, and dropped her body weight.¹⁴⁸
- [131] At the point of non-compliance, and noting her distress, there was one other potential option (other than using physical force) open to the CCOs. They could have permitted Selesa to remain in the interview room until her distress abated. There was no identifiable policy that specifically outlined this as an approach in the precise situation which presented that afternoon. However, permitting Selesa to remain in the interview room was not a practical option having regard to nature of the interview room and the operational needs at TWCC at the particular time. This included the fact that the interview room was not a secure room.
- [132] In addition, the CERT Leader identified in oral evidence further relevant considerations:¹⁴⁹

[CERT Leader] The goal of our response to codes is to return the complex to normality, so normal operations. With Ms Darcy outside of her cell, we weren't able to return any part of the prison back to normality. There were then potentially prisoners stuck in air locks in different parts of the prison and not able to unlock we would have had interruptions to the centre-wide operations. The other thing that I had considered was the fact that it was getting on towards shift handover. We had operational requirements of conducting musters and lock-aways. We had operational requirements to also pass information on to oncoming night shift officers. So coming into that time period I don't believe we had even facilitated medication to the units, although it

¹⁴⁵ Submissions of counsel assisting dated 16 September 2024, at [100] and [101].

¹⁴⁶ The CERT Leader remained under oath over a weekend.

¹⁴⁷ 13 May 2024, T7-16, L4-14.

¹⁴⁸ 9 May 2024, T6-61, L13-15.

¹⁴⁹ 9 May 2024, T6-76, L30-50, T7-77, L1.

does normally happen that time of day. I'm not hundred per cent sure if it had been done yet, but those things would have been going through my head while I was making those decisions.

- [Freeman] And in terms of the medication rounds, particularly in the DU, they are done by nurses; is that right?---
- [CERT Leader] Yeah and I have them.
- [Freeman] But you would escort the nurses?---
- [CERT Leader] Well we had them as a result of the code blue during the incident as well.
- [Freeman] Yes, yes. But if the code blue wasn't happening, in the usual day?---
- [CERT Leader] Mmm-hmm.
- [Freeman] When the nurses are dispensing medication they need to be escorted, don't they?---
- [CERT Leader] Correct.
- [Freeman] Yes. And so at this particular time it's about what, between 5 and 5.30 in the afternoon and you've got four officers in the activity room with the Selesa?---
- [CERT Leader] That's right.
- [Freeman] And so as I – okay, sorry. In terms of the location of this particular interview room as well, am I right in understanding that it's immediately on the left of that main entry to the DU, the first air lock that you walk through to get into the detention unit?---
- [CERT Leader] Yes ma'am.
- [Freeman] And then there is another air lock beyond the interview room that goes into the unit proper?---
- [CERT Leader] Yeah, so the first door at the entry to the detention unit allows you access into the entry air lock which does include the interview room. The interview room door also doesn't lock, so it's just a regular door handle door. It is isn't an air lock door. So with us in that air lock, we were largely prohibiting any entry of anyone else into the detention unit while Ms Darcy wasn't – correction, while Ms Darcy was on the phone in that room.
- [Freeman] So the interview room itself is not a secure room?---
- [CERT Leader] No, it is to the area lock as well, incorporating that room and the air lock as a secure room.
- [Freeman] Okay. Is there a viewing panel into the interview room?---

[CERT Leader] Yes.

[Freeman] Okay. In terms of that interview room on this particular day, was it a sustainable containment option for you long-term in relation to controlling Selesa's behaviour?---

[CERT Leader] Absolutely not.

[Freeman] Why not?---

[CERT Leader] For starters there's no running water. There's no toilets. There's no access to her Ventolin. There's plenty of reasons why you would not leave – it wouldn't be humane to leave a person in a room like that.

[Freeman] Would the telephone itself pose any particular risk potentially?---

[CERT Leader] Absolutely.

[Freeman] Is that because there's a cord on it, for example which might be used for self-harm attempts, for example?---

[CERT Leader] Also edges, Ms Darcy had a particular behaviour trait of head banging or head-butting objects or walls. The potential risk of the device that – that you hung – that you hang the phone on, the hooks that come out of the actual device would have been quite a difficult situation to manage had she been – utilised that.

[133] At some point during the initial use of force Selesa spat at CCO 1, with the spit likely landing on his arm.¹⁵⁰ This prompted the CERT Leader to give a direction that Selesa be put in the prone position (a face down position) used to decrease the safety risk to CCOs.¹⁵¹ The CERT Leader then gave a direction to apply the safety hood. The decision was made by the CERT Leader because he observed Selesa spit (and noting that there had been other occurrences of spitting by Selesa). This action by Selesa he described as an assault on officers.¹⁵²

[134] The CERT Leader's evidence and understanding as to the circumstances in which safety hoods were to be used and his personal assessment of Selesa included the following:¹⁵³

[CA] All right. Now, from your training, what was your understanding of how – I know it's artificial but try and take your mind back to 30 November 2023 – what was your understanding as to when a safety hood should not be used?---

¹⁵⁰ 9 May 2024, T6-63, L 13-23.

¹⁵¹ 9 May 2024, T6-62, L38-43.

¹⁵² 9 May 2024, t6-65, L3-6.

¹⁵³ 9 May 2024, T6-54, L41 to T6-55, L38.

[CERT Leader] Our key indicator from when a safety hood should not be used is if that person is in respiratory duress.

[CA] All right. Now when you say – did you say “duress”?---

[CERT Leader] Duress.

[CA] What do you understand respiratory duress to mean?---

[CERT Leader] Anything that is outside of the baseline for that prisoner.

[CA] All right. How does one assess ---?---

[CERT Leader] With respect to breathing, sorry.

[CA] I understand, yes. How does one assess the baseline of prisoner?---

[CERT Leader] Through experience and observation.

[CA] Was there anything, to your knowledge, in the SES plan about Selesa’s baseline?---

[CERT Leader] So her baseline was identified with contact with the prisoner, observing that prisoner over – for myself a number of years from before this event

[CA] All right. So just pausing there. Your interactions and observations, how many interactions and observations did you make of Selesa, to the best of your knowledge?---

[CERT Leader] Hundreds.

[CA] And as at 30 November 2021, what would you have assessed he baseline as ---
...

[CA] That’s all right. So far as her respiratory condition was?---

[CERT Leader] It fluctuated.

[CA] Did she have any known respiratory issues to you?---

[CERT Leader] Only through my own observations, she was provided with what appeared to be Ventolin. I’m not privy to her medical incompetence [sic] so I – we aren’t told actual medical conditions per se. Through my observations I’ve identified at times, especially when she was combative with other prisoners, she would be out of breath, she would have a couple of hits on the Ventolin device and her baseline – that was included in her baseline essentially for us through our observations.

- [135] The CERT Leader had considerable experience in applying safety hoods having applied them “many times”.¹⁵⁴ Ordinarily, owing to this experience and familiarity with them, the CERT Leader would apply the safety hood.
- [136] On this occasion however he did not do so as he wanted to maintain control over Selesa who, in a semi-prone position. This involved keeping, or attempting to keep, one of Selesa’s hips and shoulders elevated. The CERT Leader was actively involved in this. In fact, he was responsible for maintaining the attempt to keep one of Selesa’s hips and shoulders elevated. He achieved this by using the bottom part of his leg as a “chock” to prevent her from rolling upwards.¹⁵⁵
- [137] CCO 2 was the officer who applied the safety hood. She is also the officer who can be heard to say, shortly after the safety hood was applied, “it’s suffocating her”. In evidence, CCO 2 explained her state of mind when she made these remarks. In doing so, her evidence was that she did not observe anything that led her to believe that Selesa was being suffocated but, rather, she was “scared of suffocation.”¹⁵⁶
- [138] The CERT Leader was conscious that Selesa’s was breathing heavily and requesting her puffer. However, the CERT Leader’s assessment was that her heavy breathing was within her “baseline”.¹⁵⁷ He was also satisfied that Selesa was not in respiratory duress.¹⁵⁸
- [139] After the safety hood was applied, the CERT Leader continued to assess Selesa’s wellbeing. He recalled Selesa saying words, repeatedly, “I can’t breathe, I can’t breathe” but considered that “there [were] no signs of respiratory duress outside her baseline.”¹⁵⁹ Consistent with this, the CERT Leader gave evidence that at times Selesa “had a tendency to get quite elevated” which included screaming “over and over again” which would cause her to “get quite out of breath.”¹⁶⁰
- [140] Selesa was then taken back to her cell in the escort position, with the safety hood remaining on her head. The CERT Leader made a further assessment of her baseline. By this point the CERT Leader considered that Selesa was “exhausted” and “didn’t want to continue to engage in her non-compliant behaviour”. His assessment was informed by his experience with Selesa.¹⁶¹

¹⁵⁴ 9 May 2024, T6-56, L6-7.

¹⁵⁵ 9 May 2024, T6-64, L5-25.

¹⁵⁶ 8 May 2024, T5-28, L1-6 and L26-31.

¹⁵⁷ 9 May 2024, T6-66, L15-19.

¹⁵⁸ 9 May 2024, T6-65, L13-15.

¹⁵⁹ 9 May 2024, T6-65, L30-34.

¹⁶⁰ 9 May 2024, T6-62, L29-30.

¹⁶¹ 9 May 2024, T6-66, L45 to T6-67, L6.

[141] Mr Haworth also considered the movement of Selesa, by CCOs, from the interview room to her cell and considered that it was within the guidelines of [the CCOs] operational practices:¹⁶²

... it is my opinion that the control and restraint tactics utilised including the transition of the handcuffed prisoner from the horizontal to the vertical stabilised positions and the subsequent escort to the cell were conducted within the guidelines of the Use of Force COPD Version 3 (Implementation date: 06/01/2022 – Review date: 2023) in that they satisfied the procedural and legislative requirements of being:

- a) reasonable in the circumstances;
- b) necessary; and
- c) proportionate to the seriousness of the circumstances.

[142] Once back in her cell, Selesa was placed in the prone position. During this process the safety hood was dislodged from her head and the CERT Leader informed others that “we don’t need that again”. The safety hood was however reapplied immediately prior to the CCOs exiting the cell, by CCO 1. The CERT Leader identified that it was not reapplied correctly but could not recall whether he knew this at the time or having reviewed the BWC.¹⁶³

[143] To exit the cell the CCOs performed a dynamic (or modified dynamic) cell extraction. As executed, it consisted of the handcuffs that had been applied to Selesa being removed and all officers departing the cell and then locking the door. The extraction was deployed in this manner because once the handcuffs had been removed from Selesa officer safety was reduced. The extraction was undertaken to reduce the risk of assault to officer. As part of this process, the officers were contemplating the risk that a prisoner was pretending to be compliant.¹⁶⁴

[144] The safety hood did however remain on Selesa’s head when the extraction took place. It should not have. The fact that it remained on her head was contrary to the guidance contained within the Control and Restraint Manual. However, and consistent with the medial opinions set out above, there is no evidence that this played any role in Selesa’s death.

[145] Once the cell door was shut, the CERT Leader called a code blue. This occurred about 30 seconds after the cell door had been shut. The CERT Leader called the code blue because Selesa had not responded to questions asked of her. It was also the CERT Leader’s experience that it was out of character for Selesa to be quiet and non-responsive in similar instances.¹⁶⁵ Usually, Selesa would have reacted once her cell door was shut. That she was quiet and non-

¹⁶² 15 May 2024, T8-56, L15-18. Exhibit J4, 16.

¹⁶³ 9 May 2024, T6-67, L27-34.

¹⁶⁴ 9 May 2024, T6-67, L27-34.

¹⁶⁵ 9 May 2024, T6-68, L30-44.

responsive was considered by the CERT Leader to be “unusual circumstances”.¹⁶⁶

[146] The CERT Leader then made the decision to open Selesa’s cell door. His evidence as to this was:¹⁶⁷

[CA] And then the cell door was opened. Who’s decision was it to open the cell door?---

[CERT Leader] Mine.

[CA] Why did you make that decision?---

[CERT Leader] So gathering all the information that I had on hand and what had just occurred, my initial instinct was that she was trying to pretend until we regained entry into the cell and that she would assault officers. At that stage, I developed a plan to utilise the Perspex shield to enter as a defensive tool to keep the officers safe as they entered the cell.

[147] Upon entering the cell, it was apparent that Selesa was non-responsive, and first aid was administered but Selesa could not be resuscitated.

[148] Mr Haworth provided the following opinion regarding the cell extraction:¹⁶⁸

With an understanding of the physical dynamics that the CCO’s encountered with the cell insertion of prisoner TAFIFA in this incident including the position whereby the prisoner’s head was facing the doorway to the cell during the handcuff removal and subsequent CCO exit from the cell, it is my opinion that the CCO actions were a reasonable response given the complex dynamics at the time. They may not have been an example of ‘best practice’, but they were still tactically sound and effective within a range of correctness without being excessive in my opinion.

Concern could be raised as to the CCO’s possible lack of acknowledgment and lack of immediate action in relation to the non-responsive behaviour of prisoner TAFIFA when the CERT Leader verbally engages with the prisoner on two (2) occasions and there is no verbal or physical response. In close review of the BWC and CCTV footage provided this nonresponsive behaviour is evident for the approximately forty (40) seconds prior to the CCO’s exiting the cell.

[149] In all the circumstances, having regard to the evidence of the CCOs and Mr Haworth I make the following findings:

¹⁶⁶ 9 May 2024, T6-69, L10.

¹⁶⁷ 9 May 2024, T6-69, L25-34.

¹⁶⁸ Exhibit J4, 24.

- a. The CCOs directly involved with Selesa were unaware of and therefore did not properly recognise her medical decline during the period of restraint, which included the use of the safety hood.
- b. Despite not recognising Selesa's medical decline, the CCO's were acting in a manner broadly consistent with the procedures set out in the CRM.¹⁶⁹
- c. The way CCOs moved Selesa from the interview room back to her cell was adequate and appropriate in the circumstances of her non-compliance and, accepting that the cause of Selesa's death was cardiac arrest, the actions of the CCOs as part of the cell extraction were, in the circumstances, adequate and appropriate.

[150] However, I am of the view that after the safety hood had fallen off Selesa's head, when she had returned to her cell, it should not have been reapplied. That was not best practice and was not in accordance with the CRM. What should have occurred, when the cell extraction was performed and Selesa was alone in her cell, was that the safety hood should have been removed. However, for the reasons considered under issue two (2) this did not cause Selesa's death.

[151] Further comment regarding the appropriateness of the use of the safety hood and the need for associated training is provided under issue four.

Issue four: the appropriateness of the use of safety hoods in QCS custody

[152] The approved safety hood for use by CCOs was trademarked as the Safariland TranZport Hood (Model 8320),¹⁷⁰ described as having a bacteria-filtering medical-grade fabric on the lower portion of the hood. Importantly, the fabric is intended to be a breathable (permeable) substance. A hood of this type was tendered at the Inquest.

[153] I accept the submission of counsel assisting that there is a greater need for CCOs to receive further training specifically designed to better educate officers who deploy safety hoods to recognise signs of medical distress experienced by prisoners. This is particularly so where CCOs are not medically trained professionals, and the application of safety hoods may occur in highly dynamic situations involving vulnerable prisoners, with significant underlying medical comorbidities, such as in Selesa's case.

[154] The need for such training is supported by the expert opinion of Dr Rashford who identified several occasions where Selesa's clinical deterioration should have been recognised.¹⁷¹ Dr Rashford also

¹⁶⁹ Version 07. Exhibit D34.41.

¹⁷⁰ Exhibit D34.41, 76. Exhibit D11.

¹⁷¹ Exhibit J1, 9.

identified the relevant human factors that should be considered in situations of this kind. Relevantly:

“I have no doubt that a sudden change in a person’s behaviour or physical activity should prompt at least a re-evaluation of the approach being taken to the situation. In this particular case, there were several occasions where Ms Tafaifa’s clinical deterioration should have been recognised but unfortunately this did not occur. That being said, there are significant human factors to consider for this situation”.

“The CSOs [CCOs] involved had witnessed a period where Ms Tafaifa became escalated and then rapidly de-escalated, leading to the assumption that the presentation was most likely behavioural in nature. The CSOs were also heightened from the period of physical restraint provided. I would draw attention to a comment made by [the CERT Leader] during the video recording I have provided labelled ‘Debrief’, where he describes Ms Tafaifa as, ‘Already escalating as normal Darcy’. This indicates to me that there was the belief this fluctuation in behaviour was a somewhat ‘normal’ event for Ms Tafaifa. I would also highlight my observations of the actions taken during re-entry to the cell. Despite no physical movement for several minutes, there are still tactical plans being made to respond to a threat from Ms Tafaifa. This indicates that the CSOs were concerned that the lack of response may have been a ruse and another physical engagement was likely. However, the objective evidence and physical status of Ms Tafaifa did not support this concern”.

[155] I accept the submission of counsel assisting that while Dr Rashford accepted that Selesa’s clinical deterioration should have been recognised, there were, as he indicated, other factors at play, namely: the CCOs had witnessed a period where Selesa escalated and then rapidly de-escalated, which led to an assumption that her presentation was most likely behavioural in nature and, to an extent, normal for her; the CCOs were also heightened from the period of physical restraint; and the CCOs made tactical plans when re-entering the cell, indicating, that the CCOs were concerned that the lack of response from Selesa was a ruse.¹⁷²

[156] Counsel for the QCS accepted that the evidence before the Court suggested there was an inconsistency in how QCS officers were trained in the use of safety hoods and any subsequent refresher training that is provided. This was also identified in the 2023 Safety Hood Review.

[157] I accept the submission of the QHRC that the Safety Hood Review acknowledged that a human rights assessment had not been conducted for the use of safety hoods and would be required if they remain in operation. It further noted that since the introduction of Safety hoods in QCS, ten years ago, the prisoner population has

¹⁷² Submissions of counsel assisting dated 16 September 2024, at [81].

changed with prisoners having higher rates of mental health illness and cognitive impairment, making it more difficult to safely manage the risk of spitting and biting.¹⁷³

[158] QCS Academy (QCSA) has undertaken work to ameliorate inconsistencies identified in training the application of safety hoods. The Custodial Officer Entry Program now includes competency-based assessment on the practical application of safety hoods, prisoner safety considerations and management post-deployment. The QCS Custodial Delivery Command is further liaising with the QCSA to consider sequencing refresher training for current officers.¹⁷⁴

[159] Noting that a proper consideration of the issue is relevant to recommendations that may be made, I note the following submissions of counsel for the QCS:¹⁷⁵

- a. QCS introduced the use of safety hoods as an approved safety/security item in 2013.¹⁷⁶ This was in response to an increase in Hepatitis within the prisoner population in 2011 and concerns from the workforce at that time around transmission of disease.¹⁷⁷
- b. A safety hood features a bacteria-filtering medical-grade fabric that helps to contain contaminants and makes attempts at biting ineffective. A secure-lock tab and elastic neckband allow for application and prevents self-removal without limiting the wearer's range of vision. The intended purpose of the safety hood is to reduce the risk of communicable diseases being transferred when a prisoner is biting or spitting.¹⁷⁸
- c. Section 143 of the CS Act permits the use of a safety hood by CCOs by virtue of it being a use of force, when considered reasonably necessary to (amongst other things):
 - i. compel compliance with an order given or applying to a prisoner; or
 - ii. restrain a prisoner who is attempting or preparing to commit an offence against an Act or a breach of discipline; or
 - iii. restrain a prisoner who is committing an offence against an Act or a breach of discipline.

¹⁷³ Submissions of counsel for the QHRC at [163]. Exhibit D49, 22.

¹⁷⁴ Submissions of counsel for the QCS at [103].

¹⁷⁵ Submissions of counsel for the QCS at [90]-[97].

¹⁷⁶ Exhibit D49, 6.

¹⁷⁷ 15 May 2024, T8-7, L22-26. Submissions of the QHRC at [159].

¹⁷⁸ Exhibit D48, 6.

- d. The *COPD – Use of Force* provides further information regarding the application of s 143 The CS Act and the use of force, including the requirements to exercise use of force, considering available options and reporting the use of force.
- e. The deployment of safety hoods must be carried out by appropriately trained officers.¹⁷⁹
- f. During the financial years 2020/2021 and 2021/2022, there were 163 reported assaults on officers where a prisoner deliberately struck an officer with their bodily fluids. Of the 163 incidents, 133 involved an officer being spat on or bitten.¹⁸⁰
- g. A safety hood was used in approximately three percent of all use of force incidents for 2020/2021 and four percent for 2021/2022.¹⁸¹
- h. QCS has a duty of care to ensure the health and safety of its employees whilst in the workplace and QCS staff in correctional facilities are required to respond to difficult situations which include interacting with and managing prisoners who may spit and bite.
- i. The transfer of bodily fluids such as spit or blood exposes officers to the risks of communicable diseases which has the potential to result in ongoing and harmful effects on the officer's health.¹⁸²

[160] At the Inquest, AC Smith gave oral evidence regarding the effects on CCOs that are spat on and organisationally how it is dealt with:

“It really depends on the incident and there’s a continuum, so at the lower end an officer might be spat at, say, where there’s no contact with the skin, it might just be on their clothes. In that scenario, the impacts – that’s still evident in the form of psychosocial risks. But, generally speaking, that’s far easier to manage through. And then the opposite end of that continuum, an officer might be spat at to an orifice in their face, so their eyes or their mouth. And if there is also open wounds, if there’s been an assaultive situation or an injury during the use of force, then that requires the staff member to undertake blood tests and follow up tests over several months. There are particular precautions that they must take in that scenario to avoid intimate contact with others and in that circumstance I have seen staff experience significant psychological distress and some

¹⁷⁹ Exhibit D49, 15.

¹⁸⁰ Exhibit D49, 9.

¹⁸¹ Exhibit D49, 10.

¹⁸² ExhibitB50 at [50].

*have actually resulted in ill-health retirement outcomes and personal issues and psychological issues.*¹⁸³

[161] For reasons of prisoner healthcare confidentiality, information regarding whether a prisoner has a communicable disease is not readily available to QCS staff and as such, they must take appropriate universal precautions and treat each interaction with prisoners as if they may have such a disease, particularly when there are incidents of spitting or biting in the custodial environment.¹⁸⁴

[162] Submissions on behalf of the QCS noted¹⁸⁵ alternative methods of personal protective equipment do not stop a prisoner's ability to continue to spit¹⁸⁶ and the safety hood is the only accoutrement available to CCOs to protect them against a prisoner who was spitting.

[163] At the Inquest, AC Smith gave evidence that alternative tactical options to address a prisoner that was spitting included balance displacement:

*"In the instance of where a prisoner has spat or where there is a reasonable belief that there is a risk of a prisoner spitting at an officer, in absence of the safety hood, the other forms of tactical options used might balance displacement of the prisoner, which effectively means tilting the prisoner's head on a 45-degree angle and bending them over such that they can't direct their spit towards the staff, but of course that manoeuvre itself poses potentially some health risks to the prisoner from a positional asphyxia perspective given that obviously its not easy to breathe in that scenario, if you're bent over with your head crooked at 45-degree angle."*¹⁸⁷

[164] Mr Haworth's evidence is also relevant to this issue. Mr Haworth agreed that in the incident involving Selesa on 30 November 2021, there was no other option open to the CCOs to protect themselves from being spat on.¹⁸⁸ Specifically, his evidence was that the alternative of wearing a polycarbonate face shield (as is utilised in watchhouses in Queensland) places the officer in a position where they have to protect themselves rather than using something that stops the spitting or biting from occurring in the first place and this only protects the face and no other parts of the body like exposed skin on the legs and arms of an officer.¹⁸⁹

[165] I accept the submission on behalf of QCS that from an organisational perspective, the discontinuation of the use of safety hoods within QCS

¹⁸³ 15 May 2024, T8-8, L8-9. Submissions of counsel for the QCS at [98]. Submissions of counsel for the QHRC at [168].

¹⁸⁴ Submissions of counsel for the QCS at [99].

¹⁸⁵ Submissions of counsel for the QCS at [100] – [104].

¹⁸⁶ Exhibit B50 at [51].

¹⁸⁷ 15 May 2024, T8-58, L27-31.

¹⁸⁸ 15 May 2024, T8-61, L5-10.

¹⁸⁹ 15 May 2024, T8-58, L15-37. Submissions of counsel for the QCS at [100]-[101].

facilities is not a simple task and could not be immediately achieved. The likely process would include a risk assessment in accordance with obligations under the *Work Health and Safety Act 2011* (Qld) and an analysis of what alternatives are available and their efficacy to control to the same degree, if not better, the mitigation of risk that safety hoods provide to employees in relation to contracting communicable diseases; a consultation process with the workforce and other stakeholders including the engagement of any dispute resolution processes (including via the Queensland Industrial Relations Commission) should agreement not be reached; briefing to the executive on the findings of those processes before making a final determination; and subsequent implementation and change impact analysis.¹⁹⁰

[166] While the use of safety hoods has ceased in some states, the Northern Territory, Western Australia, Victoria, and New Zealand continue to use safety hoods in a correctional setting.¹⁹¹ As submitted by the QHRC, corrective services in New South Wales, the Australian Capital territory and South Australia do not use safety hoods and Tasmania planned to cease using them from January 2023.¹⁹² South Australia has legislatively banned the use of safety hoods in all custodial detention or police settings.¹⁹³ New South Wales has also followed suit.¹⁹⁴ Police services in Victoria and Tasmania do not use safety hoods and in Western Australia their use is restricted to the Perth Watchhouse.¹⁹⁵

[167] I accept that the course of action taken in other Australian jurisdictions indicates that there may well be possible alternatives available to the ongoing use of the safety hoods in QCS custody.¹⁹⁶ However, in the circumstances, and having regard to the evidence before the Inquest the submissions of the parties, I am not prepared to find that the continued use of safety hoods is in appropriate in QCS.

Issue five: the adequacy and appropriateness of mental health care of Selesa whilst in custody at TWCC during the period of incarceration from 25 November 2020 to 30 November 2021

[168] In considering this issue for inquest, I have been assisted by the expert opinions of Consultant Forensic and Clinical Psychologist, Dr Michael Davis¹⁹⁷ and Consultant Psychiatrist, Dr Jill Reddan.¹⁹⁸

¹⁹⁰ Submissions of counsel for the QCS at [102].

¹⁹¹ Exhibit D49, 14.

¹⁹² *Statutes Amendment (Spit Hood Prohibition Act) 2021 (SA)*.

¹⁹³ Exhibit D49, 13-14.

¹⁹⁴ *Detention Legislation Amendment (Prohibition of Spit Hoods) Act 2024 (NSW)*.

¹⁹⁵ Submissions of counsel for the QHRC at [172].

¹⁹⁶ Submissions of counsel for the QHRC at [180].

¹⁹⁷ Exhibit J5.

¹⁹⁸ Exhibit J3.

- [169] I accept the submission of counsel assisting that there is indeed a public safety issue in respect of the management of vulnerable persons such as Selesa, in custodial settings, who experience co-occurring medical and mental health co-morbidities, and that there is a need for the detaining authority to be vigilant of the need for holistic treatment and care of persons in custody.¹⁹⁹
- [170] Selesa had been subject to a Treatment Authority (TA) under the *Mental Health Act 2016 (Qld)*²⁰⁰ since 20 April 2018 and in receipt of psychiatric treatment and care. The category of the TA was community category.²⁰¹
- [171] At the time of her death, Selesa was receiving the following medication:
- a. Mixtard 30/70, 50 units in the morning, 46 units at midday and 46 units in the evening;
 - b. Metformin XR;
 - c. Atorvastatin 40mg at night;
 - d. Magnesium 500mg at night;
 - e. Panadol Osteo two tablets twice a day;
 - f. Quetiapine XR 200mg in the morning and 400mg at night;
 - g. Vitamin D 1000 units daily;
 - h. Zuclopenthixol 300mg IMI second-weekly (it had been last administered on 23 November 2021);
 - i. Ibuprofen 400mg twice a day as required;
 - j. Symbicort two puffs twice a day; and
 - k. Ventolin two puffs as required.
- [172] Dr Reddan noted in her report that it was unclear whether Selesa was still being prescribed Sitagliptin 100mg in the morning. It appeared that the Lithium, 450mg twice a day, had been ceased. It is unclear exactly when it was ceased and why.
- [173] I accept the evidence of Dr Jill Reddan in respect of Selesa's mental health diagnosis and management, and that on the available material, it is probable that Selesa suffered from Bipolar 1, with a rapid cycling subtype. It is unclear, the extent to which substance abuse (including alcohol, cannabis and particularly methamphetamine) use was

¹⁹⁹ Submissions of counsel assisting dated 16 September 2024, at [139].

²⁰⁰ Exhibit G1, 76-85.

²⁰¹ *Mental Health Act 2016 (Qld)*, Schedule 3 - *in relation to the category of a treatment authority – the person subject to the authority may live in the community while receiving treatment and care*. Sisters Inside NGO were listed as a nominated support (amongst others).

contributing to, exacerbating, or possibly leading to the rapid cycling. However, Dr Reddan opined that, it was more probable than not that, it played a role.²⁰²

[174] Relevantly, Dr Reddan opined that:

'The management of rapid cycling Bipolar Disorder and polysubstance abuse is very difficult and rapid cycling is an inadequately studied phenomenon.'

To complicate matters further, there is some evidence to suggest that Ms Tafaifa probably manifested personality problems, although in my opinion, a diagnosis of Antisocial Personality Disorder is not necessarily supported by the material so far available.

...Subsyndromal mood disturbance and rapid cycling does impact on personality functioning. There are some patients who cycle so rapidly and who are rarely euthymic that it can be almost impossible to determine the relative contributions of all these possibilities.²⁰³

[175] I accept Dr Reddan's opinion that although there were some gaps in understanding Selesa's case, there is no evidence that Selesa's psychiatric management whilst she was in the TWCC was inappropriate or unusual. There were some major challenges facing the Prison Mental Health Service (PMHS) in managing Selesa.²⁰⁴ Whether Selesa may have benefitted from a prolonged admission to the medium secure unit in Townsville (an admission of six months for example) is unclear and there is no evidence that that was considered. Dr Reddan considered that there may well have been very good reasons for that however, it is by no means certain that a long admission to the medium secure unit would have necessarily altered the longer-term trajectory in Selesa's case, particularly in view of her increasing medical problems.²⁰⁵

*'The side effects of the various biological treatments (that is medications) for her condition can be very significant. Ms Tafaifa was overweight and her weight increased from 2018 and this may well have been a side effect of various medications she was being prescribed.'*²⁰⁶

[176] I accept the submissions on behalf of QCS that:

- a. There are various mechanisms in place that operate to ensure QCS staff are able to effectively and safely manage prisoners in accordance with their risk and needs. These include

²⁰² Demonstrating more than four episodes of serious mood disturbance per year.

²⁰³ Exhibit J3, 12.

²⁰⁴ Exhibit J3, 14.

²⁰⁵ Exhibit J3, 13.

²⁰⁶ Exhibit J3, 14.

legislative tools such as safety orders and internal management strategies such as IMPs and SES plans.

- b. IMPs are multipurpose plans, implemented for prisoners who have been identified as requiring a higher level of supervision, case management and/or intervention strategies. IMPs are developed by a panel of QCS staff such as correctional managers or supervisors, intelligence analysts, psychologists, cultural liaison officers and occupational health staff.
- c. Selesa was subject to both an IMP and an SES plan during her time at TWCC and she was open to the PMHS during her incarceration and was regularly seen by a Queensland Health (QH) psychiatrist whilst at TWCC. Selesa also received medical care from the onsite health facility operated by QH at TWCC for her medical issues.
- d. While QCS does employ psychologists and correctional counsellors to provide psychological services that promote mental health, wellbeing and safety of individuals in QCS facilities, the QCS psychological services are responsible for supporting prisoners' progression through their time in custody, and to assist in desistance from future offending and promote successful reintegration into the community.
- e. This is contrasted with mental health services delivered by QH, which focuses on providing examinations, treatments and services for prisoners with mental health issues or diagnoses.
- f. QCS also has processes in place where prisoners may be assessed as a Prisoner of Concern which is a joint assessment and treatment process where either QCS or QH have raised particular concerns around the mental health of a particular person, particularly mental health issues that are chronic as opposed to episodic.
- g. Selesa was identified on 11 March 2021 as being a Prisoner of Concern as she was subject to a TA and had Schizophrenia which impacted upon her insight, judgement and decision-making and her behaviour was noted as being volatile at times.
- h. There is also the Elevated Baseline Risk process as a subset of the at-risk management process, where a person who is considered to have chronic enduring self-harm issues that places the prisoner at a higher risk of those behaviours, will be assigned a person to case manage them and provide therapy to assist them in a more proactive sense to avoid returning to a heightened risk of suicide or self-harm.
- i. QCS also has a system of providing specialist units such as safety units, crisis support units and maximum-security units at

facilities where there is a psychologist assigned to case manage those particular prisoners who require those services.

- j. QCS and QH have a collaborative relationship and a shared interest in ensuring prisoners receive effective health care services and are managed safely.
- k. From 14 July 2023, QCS and QH have an updated information sharing agreement in place to ensure that appropriate information sharing occurs between the two agencies and to encourage a culture of collaboration.
- l. QCS acknowledges that health, safety and wellbeing of prisoners is paramount, and it requires relevant information to make informed decisions on prisoners' risk management strategies, accommodation, monitoring and other aspects of their management.
- m. In recognition of this, working groups between QH and QCS which include senior executives from each agency meet fortnightly to discuss health policies and strategic issues. Furthermore, QH clinicians have regular meetings with QCS psychologists to share relevant information about prisoners who are connected with the PMHS. There may also be occasions where a case conference is instigated by QCS upper management in a centre if there are particular concerns about a prisoner's welfare or challenges concerning their management because of their mental health.²⁰⁷

[177] Submissions on behalf of the family refer to Selesa's placement in the DU and seek to rely on the evidence of Ms Lee Downes. I do not accept these submissions, nor do I accept the evidence of Ms Downes in respect of this issue for inquest noting a lack of relevance to the issues for determination and Ms Downes lack of relevant qualifications and expertise to provide such an opinion.²⁰⁸ I will some other brief comments about Ms Downes' report, which extends beyond the placement of Selesa in the DU, below.

[178] The QHRC accepted and adopted the submissions of counsel assisting that the evidence would lead to the finding that Selesa's mental health and medical health care by THHS and/or QH while located at TWCC was generally appropriate and adequate within current resources.²⁰⁹ Overall, I accept those submissions as correct and make that finding.

²⁰⁷ Submissions of counsel for the QCS at [106]-[107].

²⁰⁸ Submissions of counsel for the family at [34]-[45]. See also submissions on behalf of QCS at [119]-[126].

²⁰⁹ Submissions of counsel for the QHRC at [12c]. The QHRC noted issues subject to resource considerations at [13].

Issue six: the adequacy and appropriateness of the health management by THHS and QCS on and from 27 July 2020

- [179] I accept the submission of counsel assisting that while Selesa was undoubtedly a vulnerable prisoner in the context of her mental health and medical morbidities, the management of Selesa’s health by THHS and QCS on and from 27 July 2020 was adequate and appropriate.
- [180] Dr Starmer opined that Selesa had frequent presentations to the THHS Emergency Department (ED) from at least September 2018 – several for shortness of breath and intermittent chest pain. The majority of those presentations were related to an exacerbation of asthma with smoking as a contributing factor and/or intercurrent respiratory tract infection. Dr Starmer noted that symptoms resolved following the administration of corticosteroid, Prednisolone, and inhaled Salbutamol.²¹⁰
- [181] In his first report, Dr Starmer opined that the most relevant presentation occurred on 29 July 2021 (four months prior to Selesa’s cardiac arrest). Dr Starmer noted that Selesa was correctly referred for an echocardiogram, however, should have also been simultaneously referred to a cardiologist, where, had a finding of left ventricular systolic dysfunction been confirmed, it is highly likely treatment for heart failure would have been instituted. However, an unstable psychiatric state is a contraindication to therapy and it is highly unlikely Selesa would have received treatment within the four-month time frame between identification of left ventricular systolic dysfunction and her death.²¹¹
- [182] Dr Starmer noted in his addendum statement that the diastolic dysfunction seen on the echocardiogram was *‘not uncommon in a person of this age with type 2 diabetes’* and while the echocardiogram was *“reassuringly normal”*, left ventricular systolic function is subject to change.²¹²
- [183] Counsel for the family made no submissions in respect of this issue for inquest.²¹³ As noted above, the QHRC accepted and adopted the submissions of counsel assisting that the evidence would lead to the finding that Selesa’s mental health and medical health care by THHS and/or QH while located at TWCC was generally appropriate and adequate within current resources.²¹⁴ I find accordingly.

²¹⁰ Exhibit J2, 3.

²¹¹ Exhibit J2, 5.

²¹² Exhibit J2.2.

²¹³ Submissions of counsel for the family at [54]-[55].

²¹⁴ Submissions of counsel for the QHRC at [12c]. The QHRC noted issues subject to resource considerations at [13].

The report of Lee Downes

[184] I have already referred to one aspect of Ms Downes. Counsel for the QCS objected to substantial parts of the report on the basis that they were irrelevant to the issues to be determined at Inquest. Specifically, objection was taken by reference to three topics contained within the report:

- a. First, the review of previous incidents captured on video prior to 30 November 2021 and the opinion as to the appropriateness of measures utilised by QCS staff in relation to Selesa on those days, including whether reasonable force was used;
- b. Second, the appropriateness of the CERT Leader in relaying his version of events to all staff who attended a debrief before police arrived;
- c. Third:
 - i. Whether there were alternatives to placing Selesa in the DU during the period from 25 November to 30 November 2021;
 - ii. The appropriate practice for the placement and treatment of incarcerated people with significant physical, mental health and behavioural challenges;
 - iii. Whether the conditions and restrictions that applied to Selesa whilst in the DU affected her wellbeing, behaviour and capacity to respond to correctional officers and comply with directions;
 - iv. Whether the safety orders made in relation to Selesa were made by persons with the appropriate delegations.

[185] As to the first topic, I accept the submission advanced by the QCS the appropriateness of measures employed by QCS staff in relation to Selesa's behaviour on 18 March, 4 April and 29 April 2021 is not relevant to issues to be determined in the Inquest.

[186] So far as the second topic is concerned, I find that it is unnecessary to delve into the CERT Leader's actions during the debrief. There is nothing that requires the issue to be determined as part of the inquest. Any contention that his actions somehow contaminated the investigation into Selesa's death is without substance in circumstances where the incident was recorded on multiple body cameras, with audio, and captured on CCTV without audio.

[187] As to the third topic, QCS submit that the matters are irrelevant to the issues to be determined at the Inquest. I have had regard to this submission and accept it. There are other limitations as to Ms

Downes' report, and her qualifications, advanced by the QCS. In the circumstances, it is not necessary to consider those submissions. The fact that the matters I have outlined are not relevant is sufficient.

Referral to the DPP

- [188] Pursuant to section 48(2)(a) of the Act, a coroner must give information (not coercively obtained pursuant to section 39(2) of the Act to the DPP if the coroner reasonably suspects a person has committed an indictable offence. Consistent with principles of common law, there must be a factual basis to reasonably ground such a suspicion.²¹⁵
- [189] Submissions were made on behalf of Selesa's family that while the oral evidence of the CCOs obtained pursuant to section 39(2) of the Act could not be used, some evidence before the court could form the basis of a reasonable suspicion that the CERT Leader, CCO 1 and CCO 2 had committed the indictable offence of manslaughter and as such a referral should be made to the DPP.²¹⁶
- [190] Consistent with the State Coroners Guidelines, the family do not have standing to make such a submission. No submission was made by counsel assisting in respect of any referral to the DPP, nor any other relevant disciplinary body.
- [191] Counsel for the QCS submitted that Selesa's family do not have standing to make such a submission, particularly in circumstances where Counsel Assisting did not raise the possibility of any such referral being open on the material, and that such submission ought to be disregarded. It was further submitted that no referral should be made in this case, particularly given the medical evidence regarding the cause of death, where no single cause could be established.²¹⁷
- [192] Counsel for the CERT Leader, CCO 1 and CCO 2 submitted that the submission that the officers be referred to the DPP should be set aside and not considered by the court,²¹⁸ and that the family do not have proper standing to make such a submission as per the State Coroners Guidelines.²¹⁹ It was submitted that:
- a. Counsel assisting has made no such submission which is an appropriate position in light of the evidence before the court;

²¹⁵ *George v Rockett* (1990) CLR 104.

²¹⁶ Submissions on behalf of the family dated 16 October 2024, at [304] – [307].

²¹⁷ Submissions on behalf of the QCS dated 20 December 2024, at [137] – [139].

²¹⁸ Submissions on behalf of QCS Officers at [3iii].

²¹⁹ Submissions on behalf of QCS Officers at [77].

- b. The death had been the subject of an investigation by the QPS and resulted in no charges being laid against any person in connection with the death; and
- c. Consistent with the approach of the Court of Appeal in the case of *R v Legradi & Lombardi* [2010] QCA 364 Selesa's case is one where the forensic pathologist has given evidence that the heavy heart was a significant finding and was something that could have potentially caused cardiac arrest at any time, including by way of Selesa conducting her day-to-day activities and without the application of force or restraint.²²⁰

[193] On all the evidence before me, and specifically the medical evidence, I am of the view that there is no basis upon which a referral to the DPP should be made in respect of any person involved with the restraint of Selesa on 30 November 2021.

Findings required by s.45 of the Coroners Act 2003

[194] I make the following findings:

Identity of the deceased: Selesa Tafaifa.

How they died: Selesa died at the TWCC following a physical interaction with CCO's, in circumstances where a safety hood was deployed.

Place of death: TWCC, 1 Dwyer Street, Stuart, Qld, Australia.

Date of death: 30 November 2021.

Cause of death: While the cause of death is listed as 'not determined.' I find Selesa suffered a cardiac arrest, in the context of several contributory factors (where the relative contribution of each cannot be determined) including physical exertion and restraint, where a safety hood (spit hood) had been applied, causing her hair to be held across her face. Selesa had significant pre-existing natural disease (obesity, cardiomyopathy, and coronary atherosclerosis), which also contributed to the cause of death.

Comments and recommendations

[195] As I have observed above, in accordance with section 46 of the Act, a Coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest which relates to

²²⁰ 17 October 2023, T1-10, L 41-46. T1-11, Line 1. Submissions on behalf of QCS Officers at [82].

public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. Comments may take the form of recommendations to government or to agencies to make or consider systemic changes or amendments to existing policies or procedures.

Terminology in training manuals

[196] I accept the submission of counsel assisting as to the utility of the recommendation of the State Coroner in the *Inquest into the death of GLT*, regarding the use of terms such as “excited delirium” and “positional asphyxia” in training manuals.

Recommendation one

- a. Accordingly, I recommend that the QCS review the use of such terms in QCS training manuals in consultation with the QAS to ensure the terminology used and training provided to QCS staff is accurate and reflective of best medical practice.²²¹

Phone calls

[197] I accept the submission of the QHRC that the available evidence shows that prisoners such as Selesa must arrange funds to make private phone calls to loved ones, and that there are technological limits to making consecutive calls, which have since been addressed in the DU.²²²

[198] Issues associated with Selesa’s ability to make phone calls and there not being sufficient funds in Selesa’s account, were considered during the Inquest. Selesa’s inability to communicate with her loved ones on the day of her death was a source of psychological distress for her, and the catalyst in her escalating and non-compliant behaviour that may have contributed to her physical distress.

[199] The utilisation of a phone system that is not reliant on a prisoner having funds in their account, to maintain connection with their loved ones, during a custodial sentence, would likely have the two-fold benefit of promoting the mental welfare of prisoners, enabling them to maintain contact with loved ones, and assisting QCS staff to manage prisoners.

Recommendation two

- a. I recommend that QCS consider implementing a phone system that allows prisoners to make free phone calls to loved ones. I acknowledge that the day-to-day operation and management of phone calls is a matter for QCS (for example to determine when

²²¹ 17 October 2023, T1-51, L 41. Submissions of counsel assisting dated 16 September 2024, at [149].

²²² Amended submissions of the QHRC dated 21 October 2024, at [72] – [74].

and how many phone calls are allowed per prisoner and when) and is dependent on several operational factors.

Safety hoods

- [200] As noted above, there is a greater need for CCOs to receive further training specifically designed to better educate officers who deploy safety hoods to recognise signs of medical distress experienced by prisoners. This is particularly so where CCOs are not medically trained professionals, and the application of safety hoods may occur in highly dynamic situations involving vulnerable prisoners with significant underlying medical co-morbidities, such as in Selesa's case.
- [201] Selesa's family are seeking a recommendation to the effect that the QCS prohibit the use of safety hoods in all correctional facilities and that the Qld Government consider legislating this ban.²²³ However, I am cognisant of the limitations of the evidence in respect of the contribution of the spit hood to Selesa's cause of death and I do not make that recommendation.
- [202] However, the fact that other jurisdictions have ceased the use of safety hoods is a basis upon which, if it has not already occurred, QCS should consider whether its operational needs require the devices to continue to be used. I acknowledge that it is a matter for QCS to determine what constitutes appropriate equipment to provide staff in the conduct of their duties. The availability of viable alternative devices which protect officers is, of course, a relevant consideration.
- [203] At the very least however, it would be desirable that a review be undertaken of training provided to QCS officers regarding the deployment of safety hoods and monitoring of persons subject to the use of safety hoods, in consultation with the QAS.

Recommendation three

- a. I recommend that QCS consider undertaking a review of training provided to QCS officers regarding the deployment of safety hoods and monitoring of persons subject to the use of safety hoods, in consultation with the QAS.

I close the Inquest.

Stephanie Gallagher

Deputy State Coroner

BRISBANE

²²³ Submissions of counsel for the family at [293]-[294].

Schedule of Abbreviations

The Act	<i>Coroners Act 2003 (Qld)</i>
The CS Act	<i>Corrective Services Act 2006 (Qld)</i>
The HR Act	<i>Human Rights Act 2019 (Qld)</i>
CCO	Custodial Corrections Officer
CCIT	Cold Case Investigation Team
CCTV	Closed Circuit Television
CERT	Correctional Emergency Response Team
COPD	Custodial Operations Practice Directive
CSIU	Corrective Services Investigation Unit
Det S/Const	Detective Senior Constable
Det Sgt	Detective Sergeant
DPP	Department of Public Prosecutions
DU	Detention Unit
ED	Emergency Department
HIU	Homicide Investigation Unit
IA	Initial Assessment
IMP	Intensive Management Plan
NoC	Notification of Concern
OIMIRG	Operational Inspection and Major Incident Review Group
PIC	Pre-inquest conference
PMCT	Postmortem computed tomography
PMHS	Prison Mental Health Service
QAS	Queensland Ambulance Service
QCS	Queensland Corrective Services
QCSA	Queensland Corrective Services Academy
QH	Queensland Health
QHRC	Queensland Human Rights Commission
QPS	Queensland Police Service
RN	Registered Nurse
SES	Safe Engagement Strategy
TA	Treatment Authority
TCC	Townsville Correctional Centre
THHS	Townsville Hospital and Health Service
TWCC	Townsville Women's Correctional Centre
TOM	Tactical Options Manual