QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Farrin John Vetters**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2011/3672
DELIVERED ON:	28 May 2015
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 May 2014 and 24 July 2014 Further written submissions February 2015 to April 2015
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, hanging points, management of 'at risk' prisoners.

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Mr Vetters' family:	Ms Charo Weldon (ATSILS)
SERCO Australia Pty Ltd & Ms Holly Rogers:	Ms Melinda Zerner (instructed by Corrs Chambers Westgarth)
Department of Justice & Attorney-General (Queensland Corrective Services):	Ms Ulrike Fortsecue
West Moreton Hospital and Health Service	Ms Holly Ahern

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Introduction

Farrin Vetters was 26 years of age when he died at the Borallon Correctional Centre (BORCC) near Ipswich at 9:52pm on 26 October 2011.

Mr Vetters experienced ongoing anxiety and had a tendency towards aggressive behaviour. These traits presented some difficulties for correctional and medical staff at BORCC. In the days prior to Mr Vetters' death he had, not unusually, required intensive management and had a brief stay, at his own request, in the BORCC Detention Unit.

On the day of his death Mr Vetters appeared relatively content and was alone in his usual cell when it was locked at around 6:00pm. A short time after 9:00pm, during the next routine check, Mr Vetters was found to be hanging and could not be revived.

These findings:

- confirm the identity of the deceased person, how he died, and the time, place and cause of his death;
- consider whether any third party contributed to his death;
- determine whether the authorities charged with providing for the prisoner's mental and physical health care adequately discharged that responsibility; and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

An investigation into the circumstances leading to Mr Vetters' death was conducted by PCSC Chris Hansson from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). His report was submitted to my Office and tendered at the inquest.

As resuscitation attempts were continuing on Mr Vetters, Correctional Custodial Officer (CCO) John Lewis commenced a running log. This records the arrival of several police officers shortly before 11:00pm on 26 October 2011, approximately 1 hour and 40 minutes after Mr Vetters was discovered.

The police contingent was overseen by the District Duty Officer and included a scenes of crime officer, SC John Russell. SC Russell found the area around Mr Vetters to have been secured and he commenced taking photographs of the body and surrounding scene. Detectives form the CSIU arrived at 12:55am and directed the investigation from that point. A DNA sample was taken from the outside of the knot which had been formed in the sheet used in

Mr Vetters' hanging. Various items including the sheet, a notepad and envelopes were seized from Mr Vetters' cell.

CSIU detectives later arranged the seizure of all prison and medical records relating to Mr Vetters. They conducted interviews with all other prisoners in Unit C9 at BORCC. Statements were obtained from corrective and psychological staff members at BORCC and from the paramedics who attended on the night of Mr Vetters' death.

A parallel investigation was conducted by investigators appointed by the QCS Chief Inspector. Those investigators prepared a report which was tendered at the inquest. I found this to be a thorough investigation and the report included a number of conclusions and recommendations that are adopted later in these findings.

Queensland Health's Prison Mental Health Service (PMHS) also conducted a clinical incident review immediately after Mr Vetters' death. I have also taken the conclusions of that review into account in these findings.

I am satisfied that the police investigation was thoroughly and professionally conducted and that, through the conduct of all three investigative and review mechanisms, all relevant material was accessed.

The Inquest

An inquest was held in Brisbane on 24 July 2014. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Leave to appear was granted to the family of Mr Vetters, Queensland Corrective Services (QCS), West Moreton Hospital and Health Service (the current providers of health services in the relevant region), and Serco Australia Pty Ltd, the operators of BORCC. The investigating officer, PCSC Hansson, and two staff members from BORCC gave evidence.

Following the inquest hearing written submissions were requested on several issues that arose at the inquest, including the possible recommissioning of BORCC, and the relevance of judicial recommendations on sentence for the placement of prisoners.

I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest and in subsequent submissions.

The evidence

Personal circumstances and correctional history

Farrin Vetters was born on 12 July 1985 in Mount Isa. His upbringing was traumatic. His mother died shortly after his birth and he was brought up in various foster homes before finding intermittent work on trawlers and as a station hand. Mr Vetters was in a long term relationship with Syvana Waring with whom he had a son, born in October 2010, and a step-daughter.

After Ms Waring was released from custody in October 2011 the status of her relationship with Mr Vetters appeared uncertain, causing him some frustration.

As Ms Waring was also in custody in July 2011, the care of the children fell to her mother, Ms Christie. Ms Christie would take the children to BORCC to visit Mr Vetters. She would also speak with Mr Vetters by telephone.

Mr Vetters' criminal history began at the age of 14 and resulted in four periods of imprisonment between 2003 and 2011. These resulted from a variety of offences predominantly arising from a need to fund his ongoing use of heroin and other illicit drugs. The longest period of time he had spent in the community since age 14 was six months.

After release on bail from his third period of incarceration on 20 April 2010, Mr Vetters was returned to custody on remand on 11 June 2010. On 16 March 2011 he was sentenced to four years imprisonment for various offences including one of robbery with actual violence while armed. He was given a full time discharge date of 21 May 2014 with a parole eligibility date of 16 July 2011.

In June 2011 Mr Vetters was transferred, at his request, to BORCC after brief periods at Arthur Gorrie Correctional Centre and Woodford Correctional Centre. Prior to the period of incarceration preceding his death, he had previously been a prisoner at BORCC from 4 February 2008 to 2 June 2008; and from 8 August 2008 to 16 July 2009. As a result, he was known to a number of correctional staff. He was also well known to a number of prisoners.

It is clear from the evidence that Mr Vetters retained a close bond with his extended family and was anxious to maintain contact with them while he was in custody. I extend to them my sincere condolences.

Psychiatric history and treatment

Mr Vetters was referred to the PMHS in November 2010 by a nurse at Arthur Gorrie Correctional Centre as he had asked for help in relation to panic attacks. On initial review he gave a history of having been diagnosed with Post Traumatic Stress Disorder arising from various abuses suffered as a child. He described an attempt to hang himself at age 13 while in youth detention. Mr Vetters denied any recent or current suicidal ideation and was accepted as a client for review by a psychiatrist.

Mr Vetters was first seen by a PMHS psychiatrist on 24 February 2011 and attended further appointments in March, May, June and July 2011.

According to the PMHS incident review report, Mr Vetters did not suffer from a major mental illness or depression. He was diagnosed with Mixed Personality Disorder (antisocial and borderline types), polysubstance abuse (amphetamines, cannabis), opiate dependence as well as possible Post Traumatic Stress Disorder or an Anxiety Disorder.

These conditions manifested in symptoms of anger, disturbed sleep, anxiety and unstable mood. Mr Vetters repeated his description of an attempted hanging at age 13 during the initial consultation. However, he at no other time indicated suicidal ideation to PMHS psychiatrists. The PMHS position, as put to the inquest through the tendering of its review, is that Mr Vetters was accepted as a client due to the recognition of his relative vulnerability, distress and need for support.

Mr Vetters was prescribed the antidepressant medication Fluvoxamine, which was gradually increased. He was also prescribed sedatives on occasion, predominantly Diazepam (valium).

At his interview with the PMHS psychiatrist on 5 July 2011 Mr Vetters presented as aggressive and argumentative to such an extent that the interview had to be terminated. It appears that no notification of this early cessation was given to the PMHS clinical coordinator as would normally be expected.

His next scheduled appointment proceeded on 16 August 2011. This was to be Mr Vetter's last contact with a PMHS psychiatrist. He refused to attend an appointment scheduled for September 2011 and the next appointment was listed for early November 2011, after his death.

In the August 2011 interview Mr Vetters expressed concern in relation to his father, who had been diagnosed with lung cancer. He was also worried about his partner and was attempting to complete a parole application. Family stressors were seemingly leading to increased levels of anxiety though Mr Vetters had been compliant with his medication regime. A plan was put in place for BORCC employed psychologists to continue to provide support. Mr Vetters again denied any suicidal thoughts.

Events leading to the death

Holly Rogers is a psychologist who was working at BORCC in 2011. She told the inquest that she knew Mr Vetters from his previous periods of incarceration and assessed him on arrival at BORCC in June 2011. That assessment involved her liaising with Alberta Western, the accommodation manager for BORCC.

A major consideration for these two staff members was that an Intensive Management Plan (IMP) had been imposed on Mr Vetters prior to his arrival at BORCC. The IMP had been developed by the staff at BORCC in order to facilitate Mr Vetters' desired transfer to that facility.

A case conference on 17 June 2011 by an IMP panel which included Ms Western, as well as the Senior Psychologist and the Deputy Director for BORCC, deemed the imposition of an IMP appropriate. This decision was based on a variety of recent behavioural problems exhibited by Mr Vetters, including a minor assault on corrective services staff at Brisbane Correctional Centre on 2 June 2011.

This assault occurred during a proposed one night stay while Mr Vetters was being transferred from Woodford Correctional Centre to BORCC. It resulted in his transfer to BORCC being temporarily halted. The meeting on 17 June effectively set in place the conditions necessary for Mr Vetters' ultimate transfer, which occurred on 29 June 2011.

On arrival at BORCC he underwent the usual induction process, which included an assessment of his mental health. He did not admit to having any suicidal thoughts or any thoughts of self-harm. His IMP was reviewed on 9 August 2011. His privileges were extended such that there were no limits imposed on expenditure and gym attendance, and he could attend touch football on weekends.

On 12 September 2011, his IMP was again reviewed. It was changed to a functional IMP and included a reference to participating in self-paced workbooks for anxiety and coping skills. On 24 October 2011, his IMP was again reviewed. It then became a hybrid IMP that addressed both behavioural and functional issues.

The IMP process is regulated by QCS policy. That policy calls for the IMP panel to invite representations from a Queensland Health representative (including PMHS). It mandates the inclusion of a review date which must be a maximum of three months from the date of imposition. The policy also requires a clear rationale to be provided to support the type and location of accommodation specified for the prisoner.

The IMP initially developed for Mr Vetters failed to satisfy these requirements. No PMHS representative was consulted; no review date was included; and the accommodation was not specified. The report prepared for the Office of Chief Inspector stated that the IMP was not ultimately reviewed until four months later, in October 2011.

However, Ms Rogers told the court that she and Ms Western would review the IMP each month although it seems no written records of their discussion or considerations was made. I accept that these reviews were occurring and note that when Mr Vetters' IMP was varied two days prior to his death, reference was made to a case conference regarding the IMP on 8 September 2011.

QCS policy requires that a prisoner with a history of self-harm should be accommodated in a suicide-resistant cell. Mr Vetters was initially accommodated in cell block B12, which met this criteria. A decision was taken later to move him to cell blocks, B5, B4 and C9 in order to be with two other prisoners he had nominated as being either family or able to provide support.

Prior to his death, Mr Vetters was housed in Block C9. This was a relatively small cell block with only 16 prisoners, a number of those prisoners being Mr Vetters' friends. His cousin Mr Craigie was also housed in the unit.

At the inquest Ms Western, the accommodation manager, explained while there were some suicide-resistant cells at BORCC, a number of factors influenced where a prisoner was placed. Mr Vetters was not assessed as being an 'at risk' prisoner. She did not consider that the larger suicide-resistant units of B13 and B14 would have been suitable as those units had a lot of long term offenders with difficult dynamics. Further, she did not consider B11, which housed more vulnerable prisoners, and first time offenders, would have been suitable.

In Ms Western's opinion, while Block C9 did not have suicide-resistant cells, Mr Vetters was suited to the environment because he was not an 'at risk' prisoner. It was a small unit and it offered him support through friends and family. Relevantly, if Mr Vetters had been found to have been 'at risk' immediately prior to his death, it is likely he would have been managed in the Detention Unit, or the Medical Centre.

In the months following his transfer to BORCC, Mr Vetters continued to present as a difficult prisoner to manage. A practice developed whereby, at Mr Vetters' request, he would be accommodated in the Medical Centre or the Detention Unit in order to have some "time out". This and other strategies appeared to be assisting Mr Vetters such that, as mentioned above, on 8 September 2011 a case conference led to a decision to vary Mr Vetters IMP. It was to be varied from a "behavioural" to a "functional support" plan. Ms Rogers described the difference as minimal, albeit that the latter provides the prisoner access to more materials to assist in the management of anxiety and required staff to consider alternative ways of dealing with Mr Vetters that may not be afforded to other prisoners.

The implementation of this change appears to have been delayed somewhat by a deterioration in Mr Vetters' conduct but ultimately occurred on 24 October 2011.

On 17 October 2011, Mr Vetters completed a Prisoner Request Form seeking a transfer to the Townsville Correctional Centre. He indicated he was from Mt Isa and all of his family support networks were in that area. His request for transfer was actioned by BORCC on 19 October 2011.

On or around 20 October 2011, Mr Vetters was seen by Mr Rick Renouf, a counsellor with 'Gallang Place' (Aboriginal and Torres Strait Islander Counselling Service). Mr Renouf formed the impression Mr Vetters was in good spirits. While Mr Vetters expressed frustration and reported he 'felt victimised by the system', was 'fed up' and that 'everything he wanted to do fell on deaf ears', he did not see any signs Mr Vetters may have been suicidal or had intentions of self-harm.

Telephone calls made by Mr Vetters in the last week of his life reveal ongoing concern about his father's health and isolation from his children. He referred to the need to 'shut out' his partner as he became too stressed when thinking about what she was doing. He was obviously mindful of his two children and distressed at being isolated from them.

Mr Vetters seemingly had a good relationship with his partner's mother, Cheryl Christie. On 23 October 2011 she brought the two children to see him at BORCC. Ms Christie later told police that Mr Vetters seemed "*really good*" during that visit. She said their conversations were forward looking and they spoke about where Mr Vetters might be transferred after the planned closure of BORCC such that he would still have ongoing access to the children.

On 24 October 2011, Mr Vetters requested an inter-unit visit with his uncle, Prisoner Michael Carr. This was facilitated and nothing untoward was noted or reported. Later that afternoon, Mr Vetters requested he spend the night in the Medical Centre. He reported it was his daughter's third birthday and he wanted to spend the night in the ward. Clinical Nurse Hooper noted Mr Vetters was highly anxious but settled following discussions about his current and past concerns.

Mr Vetters was reported to have openly communicated with CN Hooper. She arranged for Mr Vetters to receive an extra dose of Phenergan to assist him sleep. CN Hooper reported after Mr Vetters had some milk and toast he was asleep by 10:30pm. CN Hooper advised investigators she was of the opinion Mr Vetters had improved as a result of being in the Medical Unit.

On 25 October 2011 Mr Vetters presented to a corrective supervisor in a tearful state. He wanted to know the status of his requested transfer to Townsville and was missing his family. The supervisor called Ms Rogers who came to see Mr Vetters and spoke with him at length. The corrective supervisor lodged a "notice of concern" which, in any event, mandated an assessment by a psychologist.

During her conversation with Mr Vetters, Ms Rogers explored his anxiety and concerns. She found out that on the nights of 23 and 24 October 2011 Mr Vetters had spent the night in the medical centre to assist with his anxiety. He denied having suicidal thoughts but requested "time out" in the Detention Unit. Ms Rogers told the inquest that she did not consider the incident a great deal different to previous episodes of anxiety experienced by Mr Vetters and saw no reason to place him on a formal observation regime (within the "at risk" policy framework).

Ms Rogers assessed whether Mr Vetters had a current risk of harming himself by directly asking him a series of questions in relation to suicide and self-harm. She stated, "*He assured me that it was nothing like that at all and that he just wanted time out to clear his head*". He said everything could get a bit hectic in the unit and that everything was going well but he was just stressing about Townsville. She told him she would follow up that for him.

Mr Vetters' night in the Detention Unit passed uneventfully. The following day Ms Rogers contacted sentence management and confirmed that the request for transfer had been received at Townsville and was being assessed. At around 3:00pm she received a message that Mr Vetters wanted to speak to her and she went to the Detention Unit for this purpose. She passed on the news regarding the transfer to Townsville.

Ms Rogers told the inquest that Mr Vetters presented well and was cheerful. He stated that he had needed a rest and was now ready to return to his normal cell in C9. This conversation lasted around 40 minutes and ended with Mr Vetters asking whether Ms Rogers thought the Townsville application would be successful. Ms Rogers told him that she was sure it would be. She then made a case note of the conversation in which she indicated there were no indicators of self-harm.

Ms Rogers reports in her contemporaneous case note of 26 October 2011, *"He indicated today he was feeling better and it had allowed him the opportunity to calm down. He openly discussed his plans for the future and his current stressors and was informed that his request to transfer to Townsville CC had been actioned for consideration by OMT. Nil salient indicators were identified during interview".*

Mr Vetters was transferred back to his cell in unit C9. Between 4:15pm and 5:55pm he spoke to some other prisoners including Owen Craigie. Mr Craigie found a CD that Mr Vetters had asked for and says that Mr Vetters was singing when he took it into his cell. He saw Mr Vetters laughing and mucking around with another prisoner. Neither he nor any of the other prisoners spoken to were concerned with Mr Vetters' demeanour that evening.

At 6:05pm CCOs Turner and Smith commenced lock down of Units C7 and C9. This involved them manually locking each cell. CCO Turner told police that he recalls seeing Vetters alone in his cell, sitting at his desk and writing. The television was on and there was no conversation between the two. The lockdown would normally occur at 7:00pm. However, on this evening it occurred earlier to allow staff to attend a union meeting.

Mr Vetters is found deceased

Eric Fisher was in an adjacent cell to Mr Vetters and told police he recalled loud music being played from Mr Vetters' cell well after lock down. He was painting when he heard what sounded like a chair being moved around in Mr Vetters' cell. He thought it a little unusual that someone would be mucking around with a chair but didn't take a great deal of notice. A short time later he turned off his light. He estimates that he heard this sound from Mr Vetters' cell around 15 minutes before the nurses arrived that night for their regular medication run.

The medication run usually occurred at 9:00pm each evening but on 26 October 2011 it was running approximately 10 minutes late due to a late request for specific medication by one of the prisoners. This meant Mr Vetters'

cell was not reached until 9:18pm. On arrival it was noticed that Mr Vetters' cell window was covered and the door was immediately opened.

CCO Tualaulelei and Operational Supervisor Turton both saw Mr Vetters hanging from the bars above his door. They say he was facing towards the door with his feet back into the cell and touching the ground. Together they lifted Mr Vetters and Supervisor Turton attempted to cut the sheet above the knot. This was unsuccessful and ultimately the noose was able to be widened and lifted over Mr Vetters head.

In their report, investigators appointed by the Office of the Chief Inspector noted that the 'cut-down knife' used is specifically designed to safely cut the ligature from the point where it is connected to the neck rather than at the point of the knot. An inspection showed the knife was sharp and in good working order though it was noted that some of the officers involved in the initial response had "*limited or non-current*" training in the use of the knife. There is nothing to suggest that, ultimately, it made a difference to the outcome in the case of Mr Vetters.

A "*code blue*" was called and master control contacted the Queensland Ambulance Service via triple 0. Clinical Nurse Hooper, who had been present as part of the medication run, commenced CPR. A Life pack defibrillator was attached and at 9:32pm she administered adrenaline before continuing CPR. At 9:34pm paramedics arrived. They directed that Mr Vetters be moved from his cell and he was placed in the unit hallway. The two QAS officers (soon assisted by two more) continued resuscitation attempts until it became evident that Mr Vetters could not be revived. Life extinct was declared at 9:52pm.

A handwritten note found in Mr Vetters' cell appears to be a 'suicide note'. In it the writer states that he '…*carnt (sic) do this & go through this pain any more…*". He expresses his love to a number of relatives and asks to be buried "*back home*".

A document examiner with the QPS scientific section, Mr John Lau, examined the note along with three other handwritten letters and some addressed envelopes found in Mr Vetters' cell. Mr Lau formed the opinion that the writer of the letters was also the writer of the suicide note.

The DNA sample taken from the knot on the sheet used in the hanging revealed a mixed DNA profile which could be separated into major and minor DNA profiles. The major profile matched a profile obtained from the body of Mr Vetters.

Autopsy results

An external autopsy examination was carried out on 29 October 2011 by an experienced forensic pathologist, Dr Alex Olumbe.

A post mortem CT scan was conducted and samples taken for toxicological analysis. In his autopsy report, tendered at the inquest, Dr Olumbe noted:

> "*In the common scenario where a bed sheet has been used, one would not expect a linear abrasion as it was seen in this case.*

Dr Olumbe had access to the corrective services medical records relating to Mr Vetters. After considering these, the CT scan, toxicology report and his own observations at autopsy, Dr Olumbe issued a certificate listing the cause of death as:

> *1(a) Neck Compression*

I will address the significance of the concerns raised in the report of Dr Olumbe later in these findings.

Medical Review

A clinical incident review concluded that, in relation to Mr Vetters' contact with PMHS, there was no "*…cause and effect relationship to the outcome of this incident*." It was noted that Mr Vetter's mental health issues would have been unlikely to have warranted ongoing mental health care in the community by a public mental health service. He was not thought to suffer from a mental illness, rather suffered mental health vulnerability as a result of his mixed disorders and history of opiate dependence. The PMHS review did find areas of practice that warranted improvement. It was found that:

1. Both PMHS psychiatrists and the primary care general practitioners attending BORCC were making changes to Mr Vetters' psychotropic medication;
2. Confusion had arisen as to whether Mr Vetters had been referred to the PMHS psychological service or whether ongoing therapy was to be provided solely by Correctional psychological staff; and
3. Following a premature termination of Mr Vetters' psychiatric review on 5 July 2011, the psychiatrist should have liaised with the PMHS clinical coordinator. This did not occur.

A statement from Dr Andrew Aboud, Clinical Director for PMHS, was tendered at the inquest. Dr Aboud addressed the findings and outlined the actions taken in response.

I accept that there was no causal relationship between Mr Vetters' death and his contact with the PMHS. The three areas for improvement identified are important and details of the PMHS response are detailed later in these findings.

QCS Investigation

The investigation instigated by the Office of the Chief Inspector led to the following findings:

> *In relation to the Terms of Reference, the Inspectors hold the view that there is sufficient evidence, on the balance of probabilities, to substantiate the following findings (order does not infer significance).*

Finding 1
Inspectors do not make any adverse findings in regards to Borallon's response to the death of the Deceased Prisoner in his cell on 26 October 2011, or the rendering of medical assistance in the resuscitation attempts that followed. The overall cultural support offered to the prisoners post-incident was also appropriate.

Finding 2
Borallon failed to comply with several administrative requirements of the QCS Procedure – 'Intensive Management Plans'.

Finding 3
Borallon staff did not fully comply with the requirement for completing daily case notes for prisoners on IMPs, or the requirement to accurately record the internal movements and bed histories of prisoners when attending the internal Medical Unit.

Finding 4
Borallon staff did not follow the requirement for all NOCs to be entered onto IOMS. The QCS procedure requires that a NOC that does not result in initial response plan be entered in a prisoners case notes and not the Self Harm specific records in IOMS.

Finding 5
QCS Procedure – 'Death in Custody' contains a number of vague requirements and ought to be amended to give the document greater clarity and to ensure adherence to section 24 of the Corrective Services Act 2006 ("CSA 2006").

Finding 6
Borallon allowed a prisoner to place an external telephone call to advise his relatives of the death in custody at a time when the Deceased Prisoner's partner, family and immediate relatives were yet to be notified in accordance with the procedures.

Finding 7
Some Borallon staff had a misunderstanding of the correct use of a 'Cut Down Knife' and had not received recent training in regards to its correct use and limitations.

Conclusions

The mixed DNA profile taken from the sheet in Mr Vetters' cell can be adequately explained by a multitude of non-sinister scenarios. Its possible significance is outweighed by the evidence establishing that Mr Vetters' was locked in his cell alone on the evening of 26 October 2011 and could not have been in contact with any other person before he was found hanging later that night.

I have also given consideration to the assessment of the linear abrasion found on Mr Vetters' neck by Dr Olumbe. It is an opinion which must be considered in the context of all the evidence available at the inquest (to which Dr Olumbe was not privy). There is compelling evidence that Mr Vetters was alone in his cell when the ligature was attached around his neck. The involvement of a second person would necessarily mean an enormous and incredibly unlikely conspiracy and cover up involving corrective services officers, nursing staff and other prisoners in circumstances where no motive for the killing of Mr Vetters is evident.

The Queensland Police Service investigating officer concluded, "*that no deliberate act or omission, nor any error of judgement by any person contributed to the death of Vetters"*. Further, the investigating officer identified the numerous stressors which were impacting on Mr Vetters prior to his death. He found the staff members at BORCC were well aware of Mr Vetters' issues and his investigations revealed all that could be done was done to manage him.

I am satisfied from all the evidence that no other prisoner or member of staff at BORCC was directly involved in the death of Mr Vetters.

The Investigation by Prisoner Mental Health Services found while Mr Vetters had a previous suicide attempt by hanging at the age of 13, he did not describe suicidal ideation or intent to any Prisoner Mental Health Service staff during the period of incarceration prior to his death.

The Chief Inspector's investigation concluded, "*At no time during the Deceased Prisoner's contact with mental health personnel, centre staff, or other prisoners did there appear to be any obvious indications that the prisoner was planning a suicide attempt*".

Relevantly, the investigators stated, "*Borallon adequately assessed the Deceased Prisoner concerning: his elevated baseline; at risk assessments and his accommodation placement within the centre. Psychologists were proactively involved in managing the Deceased Prisoner, and there was no information to indicate that he was not adequately assessed given his past behavioural history and the 'coping strategies' used by both the Prisoner and the centre to attempt to minimise his levels and to maximise his level of support".*

I adopt the findings of the report conducted by the Office of the Chief Inspector.

At my request Dr Aboud examined the changes made to Mr Vetters' medication on 25 October 2011; the day prior to his death. Dr Aboud noted that during the evening Mr Vetters was noted to be very anxious, though open and communicative. Corrective services staff contacted the VMO who prescribed "*Phenergan 25mg extra*" citing "*acute on chronic anxiety and reduced sleep*". Phenergan is an antihistamine that, according to the statement of Dr Aboud, is often used to assist sleep due its sedative effect. It

is the view of Dr Aboud that this would not have had any impact on Mr Vetters' mental state and I accept this evidence.

The departure from accepted practice for the implementation of IMP's has been noted in the findings set out above. Although mindful of these it was my impression from hearing the evidence of Ms Rogers and Ms Western that both were conscientious employees who had gone out of their way to assist Mr Vetters. He was clearly a prisoner who required close attention and they had gone to great lengths to understand the issues affecting him and to formulate solutions (even though they may have been unorthodox) to try to alleviate his stress and anxiety.

I found them to be impressive witnesses who were deeply affected by Mr Vetters' death and had reflected at length on what more they might have done. I do not consider there is anything else they could have done, given the setting, to assist Mr Vetters nor was there any particular indication of his imminent suicide which ought to have been identified and acted upon.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – The deceased person was Farrin John Vetters.

How he died - Mr Vetters intentionally hanged himself using a sheet tied to exposed bars in his cell while incarcerated at Borallon Correctional Centre

Place of death – He died at Borallon in Queensland.

Date of death – He died on 26 October 2011.

Cause of death – Mr Vetters died from neck compression.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

Set out below are the recommendations made by the investigators engaged by the Office of the Chief Inspector. With the exception of recommendation 3, I consider them to be appropriate and worthwhile (an explanation regarding recommendation 3 being set out below). As a result, before the inquest I sought information from the concerned agencies as to what steps had been taken to implement them. Their responses are also summarised below.

Recommendations

As noted earlier in this report, Borallon Correctional Centre was managed by The Serco Group, a private contractor. Borallon Correctional Centre was decommissioned in early 2012 in conjunction with the commissioning of the Southern Queensland Correctional Centre. Southern Queensland Correctional Centre is also operated by The Serco Group. As both the management and staff of the decommissioned and newly commissioned prison are the same, the recommendations made in the report have been made in relation to Southern Queensland Correctional Centre. In this regard, it is recommended that:

Recommendation 1: *Southern Queensland Correctional Centre provide training to its staff about the requirements of the QCS Procedure – Intensive Management Plans.*

Recommendation 2: *Southern Queensland Correctional Centre remind all of its staff about the requirement of timely and accurate daily case notes; and the requirement to accurately record all prisoner movements within the centre that results in the prisoner being temporarily accommodated outside the prisoner's normally allocated cell.*

Recommendation 3: *Southern Queensland Correctional Centre cease its practice of not drug testing prisoners with mental health problems in individual circumstances under its targeted drug testing strategy.*

Recommendation 4: *Southern Queensland Correctional Centre provide 'refresher training' to its staff regarding: 'NOCs' and the requirement thereof of entering all NOCs onto IOMS.*

Recommendation 5: *QCS review and amend the procedures regarding 'Deaths in Custody' to ensure it reflects the requirements of section 24 of the CSA 2006, including the requirement for QCS to contact the police.*

Recommendation 6: *QCS develop a 'Death in Custody' checklist that ensures compliance with the relevant 'Procedures' (as to be amended) and the requirements pursuant to the CSA 2006. The checklist ought to be broad enough to remind staff of their 'notification requirements' and 'cultural considerations'.*

Recommendation 7: *Southern Queensland Correctional Centre review its staff training register to identify those staff members that require training on the use of a 'Cut Down Knife' and to run contingency training exercises in regards to the knife's correct use on a range of different materials commonly used in prisons as ligatures.*

Recommendation 8: *QCS consider amending IOMS so that all NOCs can be stored in, and accessed from, the Self Harm records section of the database*.

Implementation of Recommendations

Mr Peter Shaddock, General Manager – Operational Service Delivery for QCS provided a statement advising that the QCS accepted the recommendations made and considered themselves to be either responsible for, or having a role in, implementing recommendations 5 to 8.

I accept from the statement of Mr Shaddock that adequate steps have been taken to implement each of these recommendations. In the case of recommendation 7 QCS implemented a training module which has now been incorporated into the CPR phase of the "Apply first aid" course required to be completed by all custodial staff.

As set out in the recommendations BORCC was, and now the Southern Queensland Correctional Centre is, operated by a private company, the Serco Group. The Director of SQCC, and an employee of Serco, Mr Mark Walters provided a statement setting out the steps taken to implement recommendations of the QCS Chief Inspector's report.

Again, I am satisfied that adequate steps have been taken by SERCO. In this regard, I note the objection taken to the wording of recommendation 3. Mr Walters points out that mental health status is not an exclusion criteria for determining whether a prisoner will be tested for illicit substance use, nor was it at the time of Mr Vetters' death. There was and remains a policy of checking positive results against any medication prescribed to that prisoner to determine whether that medication may explain, influence or invalidate the result. If so the test is not relied upon as evidence that the prisoner has used illicit drugs. Accepting this, as I do, renders Recommendation 3 redundant though not invalid.

PMHS Clinical Incident Report

I accept that the PMHS and other Queensland Health agencies have responded adequately to the concerns raised in the PMHS instigated clinical incident review. In his statement Dr Andrew Aboud set out the following changes which have occurred since Mr Vetters' death in response to the review:

1. A workplace instruction is now in place clearly setting out the delineation of responsibility for the prescription and management of a prisoner's psychotropic medication between PMHS psychiatrists and visiting medical officers;
2. As recommended by the clinical incident review, the process for referral to a psychologist has been examined. The review called for an exploration of correctional services' capacity to provide psychological support to prisoners. Dr Aboud noted that psychologists in the corrective services field are utilised for assessment of risk and that this takes up almost all their capacity. The availability of psychologists for support of prisoners is extremely limited. In his statement of 19 May

2014 Dr Aboud says the prison population in the West Moreton Health and Hospital Board area of responsibility had continued to grow and had risen 37% in the previous 12 months. No further psychological or psychiatric resources had been provided for a number of years and an application to government for increased funding in the 2014-15 financial year had been unsuccessful;

3. There is now a formal workplace instruction requiring notification to the PMHS co-ordinator of situations where prisoner interviews are prematurely terminated.

Ultimately, Mr Vetters was fortunate to have received quite intensive psychological support in the days leading up to his death. This was no doubt because Ms Rogers put other matters on hold to attend to his needs.

According to data released by the Australian Bureau of Statistics[1], as at 30 June 2014, the number of adult prisoners in Queensland prisons was 7,049, an increase of 16% (973 prisoners) from 2013. The adult imprisonment rate was 192.9 prisoners per 100,000 adult population, an increase from 169.0 prisoners per 100,000 adult population in 2013. This represents the highest number of prisoners and the highest imprisonment rate since 2004. The average daily number of prisoners had increased to 7,194 in the December 2014 quarter.[2]

It is an accepted principle that prisoners should receive health care equivalent to that available in their community, without discrimination based on their legal situation. Rates of the major mental illnesses, such as schizophrenia and depression, are between three and five times higher in offender populations than those expected in the general community.[3][4] Prison provides an opportunity for these health issues to be addressed.

It is clearly not possible for those responsible for providing mental health services to prisoners to maintain adequate levels of service delivery within current resources in the face of the recent growth in prisoner numbers.

I acknowledge that public funds are limited and it is the role of the government to allocate those funds according to its priorities. However, given the record number of prisoners in Queensland, I consider that a formal recommendation needs to be made with respect to resourcing in this area, noting the concerns of Dr Aboud and commending the utility and quality of the work done by correctional and PMHS staff.

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[1] ABS 4517.0 - Prisoners in Australia, released 11 December 2014

[2] ABS 4512.0 - Corrective Services, Australia, December Quarter 2014

[3] Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons E B Heffernan, K C Andersen, A Dev and S Kinner, Med J Aust 2012; 197 (1): 37-41

[4] The Identification of Mental Disorders in the Criminal Justice System. Trends and Issues in Crime and Criminal Justice, no. 334. Canberra: Australian Institute of Criminology. Ogloff, J.R.P., Davis, M.R., Rivers, G. & Ross, S. (2007).

Recommendation
I recommend that the Queensland Government review the allocation of resources to the Prison Mental Health Service and Queensland Corrective Services to ensure that the capacity of staff in those agencies to respond to the mental health needs of prisoners is established at an appropriate level, and can then be adjusted to respond to fluctuations in the prison population.

Closure of BORCC
The inquest heard that the decommissioning of BORCC which had been planned at the time of Mr Vetters' death was subsequently completed. Prisoners were moved to a newly built facility near Gatton known as the Southern Queensland Correctional Centre.

I acknowledge that the construction of Southern Queensland Correctional Centre is an important step in the slow and expensive process of ultimately removing hanging points State-wide.

In this context, it was concerning to hear at the time of the inquest that it was then QCS policy to recommission BORCC as a high security prison. The recommissioned facility was anticipated to cater for 492 prisoners with 244 to be housed in existing unmodified cells.

A significant proportion of the existing cells at BORCC contain hanging points. These cells were said to represent 28% of the State's unmodified infrastructure and the cost of modifying BORCC to meet the new standard for Correctional Centres in the State was estimated to be $250 million[5].

The death of Mr Vetters is analogous to many deaths confronted by coroners which show that even well designed and applied risk management processes cannot predict or prevent every suicide attempt. Suicidal ideation may only be fleeting or periodic and barring access to a ready means of suicide should be paramount in any prevention strategy.

The representative for Queensland Corrective Services has indicated that it is not yet known whether the current Government proposes to recommission BORCC. As a consequence, the extent of any capital works that might be carried out to modernise parts of the facility to address the presence of hanging points in existing cells was unclear.

Recommendation 165 of the Report of the Royal Commission into Aboriginal Deaths in Custody was in the following terms:

> *165. The Commission notes that prisons and police stations may contain equipment which is essential for the provision of services within the institution but which may also be capable, if misused, of causing*

[5] Exhibit B30

> *harm or self-harm to a prisoner or detainee. The Commission notes that in one case death resulted from the inhalation of fumes from a fire extinguisher. Whilst recognising the difficulties of eliminating all such items which may be potentially dangerous the Commission recommends that Police and Corrective Services authorities should carefully scrutinise equipment and facilities provided at institutions with a view to eliminating and/or reducing the potential for harm. Similarly, steps should be taken to screen hanging points in police and prison cells. (3:291)*

The State Government at the time accepted that recommendation and committed to its implementation. It is tragic that Mr Vetters had ready access to a hanging point more than 20 years after their removal was recommended by the Royal Commission.

I was assured that if BORCC were to recommence operations the custodial operations Practice Directive entitled "Risk of Harm to Self" would be applied to all accommodation decisions for prisoners in the centre. This directive provides that prisoners with demonstrated histories of at risk behaviour would not be placed in non-hanging point resistant cells, unless extenuating circumstances exist.

In addition, the practice directive outlines that in circumstances where a prisoner with previous at risk behaviour is placed in a non-hanging point resistant cell, the accommodation decision would only be made with due regard to the assessed risk to each prisoner.

This policy was not in existence at the time of Mr Vetters' death and may serve to minimise the risks of death occurring where a prisoner is assessed as being "at-risk".

While I accept that it may be necessary to recommission BORCC to respond to the increasing prisoner population, recommissioning cells with hanging points would appear to be a regressive step in the long, slow progress that has been made to date in this area. This should be done as a last resort and only after all other reasonable options have been considered.

Access to Prisoner Medical Files

In the context of the potential recommissioning of BORCC and the application of the "Risk of Harm to Self" Practice Directive, ATSILS submitted that all those responsible for identifying suitable accommodation for a prisoner should be given access to the prisoner's medical file, which may contain information in relation to previous suicide attempts. The inquest heard that the BORCC accommodation manager did not have access to Mr Vetter's medical files, which included a reference to his reported attempted suicide at age 13.

The ATSILS submission was not supported by the West Moreton Hospital and Health Service, which is responsible for the State-wide management of medical records for all Queensland prisoners.

WMHHS noted that it is obliged to maintain confidentiality with respect to those records under the *Hospital and Health Boards Act 2011*, and that information sharing with QCS occurs in the context of a memorandum of understanding, which is currently undergoing review. There are also existing mechanisms for sharing information with those responsible for managing "at risk" prisoner-patients.

Given the existing mechanisms for the exchange of information and the current review of the memorandum of understanding, I do not consider that a recommendation is required in response to the ATSILS' submission at this time.

Placement of Prisoners

In sentencing Mr Vetters on 16 March 2011, His Honour Judge O'Brien recommended that QCS consider accommodating Mr Vetters at Townsville Correctional Centre. At the inquest I asked QCS what was done in relation to this and what systems, if any, are in place to consider such recommendations.

The Executive Director, Specialist Operations for QCS, Ms Samantha Newman, provided a statement which was tendered subsequent to the inquest date. It helpfully sets out the policy in place requiring the delegate of the Chief Executive to consider a range of nominated issues in determining placement. These include "*the prisoner's personal circumstances including access to family and primary social supports"* and "*any other relevant factor*".

There can be no doubt that a judge's sentencing remarks constitute a relevant factor. Under the policy they must be considered. In the case of Mr Vetters, the initial decision on his placement was made before sentencing while he was on remand in 2010. It is relevant that Mr Vetters' partner and child were based in south-east Queensland. It is also relevant that, until sentenced, Mr Vetters was required to attend court in Brisbane.

There is no indication that Mr Vetters' geographical placement was re-considered after his sentencing in March 2011. Mr Vetters was perhaps torn as to where he wanted to be housed. This saw him request a transfer to BORCC via a request dated 1 June 2011. It was only later that he requested another move to Townsville. In both cases his requests were treated seriously and actively facilitated.

Ms Newman stated that since 2012 the QCS has moved the decision making process on location of prisoners from individual prisons to a central body which deals with all prisoners state-wide.

In the circumstances where Mr Vetters' transfer requests were agreed to, and because there is no indication that the judicial recommendation was ignored, I do not consider a recommendation on this issue is warranted.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
28 May 2015