OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Tracey Lee Inglis**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Townsville
FILE NO(s):	COR 2010/3221
DELIVERED ON:	9 December 2011
DELIVERED AT:	Townsville
HEARING DATE(s):	6 September 2011; 7 - 9 December 2011
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, suicide, management of pain relief

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Ms Janet Inglis:	Mr Anthony Collins (ATSILS)
Department of Community Safety:	Mr Michael Nicholson
Queensland Health:	Mr Kevin Parrot
Prisoners Legal Service and Sisters Inside:	Mr Andrew Hoare

Table of contents

The *Coroners Act 2003* provides in s47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Tracey Lee Inglis. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

On 19 August 2010, 37 year old Tracey Inglis commenced a term of imprisonment at Townsville Women's Correctional Centre (TWCC). She had a complex medical and psychiatric history that included Hepatitis C, intermittent suicidal ideation, depression and chronic pain from injuries suffered in a motor vehicle accident. Although these had been well documented on her previous stay at TWCC which had ended only eight months earlier, a series of systemic failures meant that only the last of these was noted when she was received by the prison on this occasion.

In the early hours of 18 September 2010 Ms Inglis was found on the floor of her cell, unconscious, with no vital signs and in a pool of blood. Sadly, attempts to resuscitate her were unsuccessful.

These findings:

- confirm the identity of the deceased, how, where and when she died and the medical cause of her death;
- examine the adequacy of the medical care she received while imprisoned at TWCC, including the adequacy of the processes designed to channel prisoners into appropriate services when they are received;
- examine the extent to which changes have already been adopted at TWCC and elsewhere in response to or subsequent to the death of Ms Inglis; 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

Ms Inglis' death was reported to the Corrective Services Investigation Unit (CSIU) and the investigation carried out by Detective Senior Constable Rudi Knaggs.

Senior Constable Knaggs attended TWCC with another CSIU investigator on the afternoon of 18 September 2010, arriving at 2:30pm. He told the inquest he was satisfied the scene had been adequately secured; exhibits preserved prior to his arrival and a running log had been kept by a correctional officer.

General duties QPS officers arrived at 2.00am and from that point the scene was secured and under QPS control.

Prior to the arrival of CSIU investigators specialist police had been sent to the scene including two detectives from Townsville CIB. Those officers directed a constable from the scenes of crime (SOC) unit to take a number of photographs of the cell and surrounds and to make other examinations including the taking of swabs for DNA analysis. A specialist fingerprint officer attended the scene and conducted an analysis of the body of Ms Inglis. Another SOC officer attended the post mortem examination and took a further set of photographs.

On arriving at TWCC mid afternoon, the CSIU investigators examined the scene and then began their enquiries with prison staff and inmates. They seized records pertaining to Ms Inglis, took statements from relevant TWCC staff and conducted interviews with four other inmates who were accommodated in the same unit as Ms Inglis. Also seized were two medical request forms found in the cell of Ms Inglis to which I will refer later.

Senior Constable Knaggs viewed CCTV footage of the residential block in which Ms Inglis was housed. A copy was taken and later tendered as an exhibit at the inquest. This footage formed a further record of all persons accessing the scene between 1:16am and the arrival of QPS officers. Investigators also obtained a recording of all telephone calls made or received by Ms Inglis from 19 August 2010 until her death and this too was tendered. At a later time, medical records for Ms Inglis from Cairns Base Hospital were obtained and provided to the Office of the State Coroner.

A specialist officer conducted a fingerprint examination of the deceased and this allowed formal identification through existing records that the body was that of Ms Inglis.

A separate investigation was conducted by investigators appointed by the Chief Inspector, Queensland Corrective Services (QCS). Those investigators conducted a number of interviews and compiled a detailed report in which several recommendations were made. Those investigators were not charged with examining the adequacy of the medical care provided to Ms Inglis, but where concerns arose they appropriately raised them with the Director of Offender Health Services (OHS), the arm of Queensland Health charged with providing health services to prisoners. The response to the findings of that report and to those recommendations was examined at the inquest.

At the pre-inquest conference, Counsel Assisting sought a number of further statements and reports from medical personnel involved in the treatment of Ms Inglis. He also sought statements addressing the response to Ms Inglis' death from QCS and OHS.

I am satisfied all relevant material has been produced to the court and find the investigation into this matter was adequate in circumstances where the more

complex medical aspects of the investigation were pursued by Counsel Assisting.

The Inquest

An inquest was held in Townsville on 7 and 8 December 2011. Leave to appear was granted to the mother of the deceased, the Department of Community Safety, and the Offender Health Service. Limited leave to appear pursuant to s.36(2) of the Act was granted to Prisoners' Legal Service and Sisters Inside who were jointly represented by counsel.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Eight witnesses gave oral evidence.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in this report the evidence I believe is necessary to understand the findings I have made.

Social history

Ms Tracey Lee Inglis was born on 16 February 1973 in New South Wales.

Her mother is Ms Janet Inglis, a woman of Aboriginal descent, who was born in Wagga Wagga. She is a member of the Wiradjuri people who still occupy an area which includes, Condobolin, Peak Hill, Narrandera and Griffith.

Tracey's father's side of the family is of Scottish descent.

Tracey was educated to Year 10 of High School, and she completed her final years of school at the Trinity Bay High School in Cairns.

Ms Inglis worked in a number of unskilled and semi-skilled jobs throughout her life.

She loved art and music.

Ms Inglis had a nineteen year old son, Charlie, who lives in Cairns. They have always been very close.

Tracey experienced a number of traumatic events and difficulties in her life.

She was involved in a serious motor vehicle accident in 2007 which resulted in Tracey having limited use of her left arm. Following this event she suffered from constant pain.

Approximately three months after the car accident, Ms Inglis became pregnant, and realising the difficulties which she would most likely experience raising a baby with her injuries, she agreed to the baby being adopted.

Other prisoners housed with Tracey described her as a strong and courageous woman, who didn't usually show her emotions to many people.

Tracey will be sadly missed by her family, her son Charlie, and her many friends. I offer her family my sincere condolences for their loss.

Custody

Ms Inglis was sentenced in the District Court at Cairns on 17 August 2010 to imprisonment for a period of three years for the offence of arson. After one night in the Townsville watch house she arrived at TWCC on 18 August 2010. Ms Inglis had been imprisoned at the same institution while remanded in custody for the same offence from 15 October 2009 until 5 January 2010. Records reflect two other brief periods of imprisonment in 2004 and early 2009.

Medical and psychiatric history

Relevant physical injuries suffered by Ms Inglis date from February 2003 when she fractured both ankles requiring open reduction and internal fixation. On 18 September 2007 Ms Inglis was involved in a motor vehicle accident in which she sustained a penetrating injury to the upper left arm resulting in compound fracture of the left proximal humerus requiring internal fixation. In addition she suffered a fracture of the mid shaft of her right femur also requiring fixation. On 19 April 2009 Ms Inglis broke a bone in her foot as a result of falling in the shower.

It seems the injuries to her shoulder and upper arm in particular resulted in her suffering chronic pain up until her death.

On 30 May 2009 Ms Inglis presented to the emergency department at Cairns Hospital requesting mental health services due to thoughts of self harm. She told staff these thoughts emanated from her chronic pain, the recent further fracture and her having given her baby up for adoption in January 2009. Ms Inglis was admitted to the Cairns Mental Health Unit (CMHU) and treated as a voluntary in-patient between 30 May 2009 and 2 July 2009. Her discharge diagnosis was "*situational crisis, dependent/avoidant trait and substance abuse*". During her stay Ms Inglis had been prescribed the antidepressant medication dothiepin.

In the early hours of 28 September 2009 Ms Inglis again presented to the emergency department at Cairns Hospital stating she had run out of pain medication and was again having suicidal thoughts. She was again voluntarily admitted to the CMHU but discharged within 12 hours. Panadeine forte was administered and appears to have been effective. CMHU notes refer to Ms Inglis' adherence to her prescribed dothiepin as "*patchy*" and the discharge diagnosis was "*threatening suicide, dependent traits and ? pseudologia fantastica*". The psychiatrist attending to her on that occasion did not consider her to be suffering from clinical depression and noted by the time of discharge Ms Inglis denied any suicidal ideation.

In June 2009 Ms Inglis informed probation and parole service officers that she was, at that time, a voluntary in-patient at CMHU. This information properly found its way to her offender file at TWCC and was available to correctional staff at the time she was received at TWCC in both October 2009 and August 2010.

During her period of imprisonment on remand at TWCC in late 2009 Ms Inglis had regular contact with the Prison Mental Health Service (PMHS) and OHS staff including a VMO, Dr Glenda McDonald. PMHS noted that chronic pain was one of the significant factors underlying her mental health issues. The management of this chronic pain through October 2009 to January 2010 was through the use of Panadeine forte and tramadol. A later analysis by Qld Health of this period of imprisonment showed 22 instances of Ms Inglis seeking pain relief or adjustments to her existing prescription. The notes indicate nursing staff were able to readily access Dr McDonald (in particular) during this period and that changes were made.

During this period Ms Inglis moved away from the use of Panadeine forte and onto tramadol. The latter was adjusted several times due to Ms Inglis complaining that it made her drowsy. While on remand blood tests also showed Ms Inglis was positive for hepatitis C. Dr McDonald's notes indicate Ms Inglis was unaware of this status. The significance was explained to her and she was referred to the Hepatitis clinic at Townsville Hospital. There is some indication Dr McDonald may have been mindful of reducing the level of paracetamol prescribed given the likely stresses on the liver although this is not specifically noted. Certainly Dr McDonald says this was a consideration during Ms Inglis' last period of imprisonment.

When tramadol was taken during the day it resulted in Ms Inglis being unable to attend work which was a practice she wished to avoid. At the end of her imprisonment on remand in January 2010 Ms Inglis was receiving two 50mg doses of tramadol during the day and a 200mg, slow release dose at night.

Records from Ms Inglis' treating GP obtained by OHS on 25 August 2010 indicate she was being treated with "*Panadeine Forte Tablets 1-2 4-6 hourly prn"* as at her last consultation on 8 August 2010. The GP notes also reflect some concern and/or cynicism regarding Ms Inglis' attendance. The entry for 8 August 2010 notes she was advised to "*see her own G.P. from next time regarding her pain management*". The previous attendance on 23 May 2010 contains the following entry "*here hunting more p forte re old multi signif injuries mva*".

Reception at TWCC on 19 August 2010

On arrival at TWCC on 19 August 2010 Ms Inglis was seen by a QCS counsellor, Timothy O'Donnell. He had been employed with QCS for three months having graduated from university in 2009. He had predominantly worked in the men's prison during that period.

Mr O'Donnell conducted an Initial Risk and Needs Analysis (IRNA) with Ms Inglis. Its primary purpose was to identify if the prisoner is at risk of self harm.

It also seeks to channel newly received inmates into appropriate services in the prison such as the Risk Assessment Team or for further review by a psychiatrist employed by the PMHS. This is done by the raising of a Notice of Concern (NoC). The process also allows for the identification of acute cases of "at-risk" presentations so protective measures can be put in place even before the PMHS consultation if necessary.

When Ms Inglis underwent an IRNA in October 2009 the TWCC employee conducting that assessment noted the following:

> *Offender presented in a calm and appropriate manner for most of the interview. There were a couple of occasions when talking about the adoption of her child that caused her to become upset. Offender's mood was slightly depressed and the offender is in constant pain as a result of the injuries sustained in her MVA. Her eye contact and tone of voice was appropriate, posture was open and relaxed and there were mild perception disturbances surrounding her being able to heal herself and not needing any help to deal with her situation or pain. The offender reported having previously been diagnosed with depression and there were some signs of depression at the time of the interview. Referred to RN and for medication. NoC was raised.*

The "*NoC*" resulted in Ms Inglis being referred to PMHS who assessed her and arranged ongoing contact. It does not appear that Ms Inglis was prescribed any medication through PMHS with their approach focussing on ensuring she accessed pain management help including contact with the VMO and attendance at the pain clinic run through TWCC.

Mr O'Donnell provided a statement for the purposes of the inquest and also confirmed the accuracy of his record of interview with the QCS investigators. In both of these accounts and his oral evidence he stated it was his practice to check the most recent IRNA for a prisoner when he conducted a new assessment.

In the course of the IRNA on 19 August 2010 Mr O'Donnell recorded the following answers to the questions put to Ms Inglis that related to her psychiatric history:

> *The offender is currently seeing a psychologist or counsellor?*
>
> The offender denied seeing a psychologist or counsellor while out in the community.
>
> *The offender has been admitted to a psychiatric unit in the last six months?*
>
> The offender denied being admitted to a psychiatric unit in the last six months. Furthermore, offender denied being diagnosed with a mental health ailment, or being prescribed medication for same.

Including today, has thought about killing or mutilating themselves in the past week?

The offender denied any current thoughts of self-harm or suicide in the past week, including during the time spent in the Watch House.

There is nothing in the IRNA of 19 August 2010 that reflects the disclosure contained in her previous IRNA that Ms Inglis had been diagnosed with depression. Mr O'Donnell also specifically noted that while he recalled some discussion about a daughter, he did not recall any mention of another child in the course of his assessment. The significance of the adopted baby is clearly noted in the IRNA of 15 October 2009. When this was put to him at the inquest Mr O'Donnell acknowledged his reference to the most recent IRNA must have been incomplete.

In his interview with the investigators appointed by the QCS Chief Inspector Mr O'Donnell candidly admitted he had adopted a strategy of "cutting and pasting" pre-prepared pro-forma answers into the IRNA form. He told the investigators he had been trained to do this as a time saving tool. This was not disputed by his supervisor who was in the room with him when he said this to the investigators. Mr O'Donnell made it clear though, that he understood this tool was only to be used when no additional or variant information was forthcoming from the prisoner.

At the time he conducted the IRNA Mr O'Donnell had received no training in relation to and did not know how to access parole and probation service contact reports which were recorded on IOMS. This and the focus of the IRNA on mental health issues in the past six months only, meant the issue of Ms Inglis' previous admissions for mental health problems at Cairns Hospital was not factored into this assessment.

Initial medical assessment

On arrival at TWCC Ms Inglis also underwent a medical assessment. The medical in confidence report prepared as a result recorded the significant history of fractures from the motor vehicle accident and Ms Inglis' comment that it limited her mobility. In the progress notes made on the same day a nurse recorded a referral to the VMO for analgesia. Ms Inglis told the nurse she had been prescribed Panadeine forte for her chronic pain at a dose of two tablets, twice daily. Despite this, she was prescribed only panadol PRN (as required) and Brufen tablets after the nurse telephoned the VMO, Dr McDonald, to arrange a drug order.

After her death, there was found in Ms Inglis' cell a Medical Request Form in which she had written, "*I need my medication an* (sic) *to be put on the list for dentist I'm having bad regular toothaches."* It was undated.

Ms Inglis saw Dr McDonald on 24 August for a routine reception review. She was prescribed three types of antibiotics for various infections, including a mouth abscess. No change was made to her analgesia but a nursing entry

indicated that "*forms sent to her own dr for verification of illness/ medication".* This referred to an authority sent to a Cairns general practice on 25 August. A response was forthcoming the same day. It disclosed as at 8 August Ms Inglis had been prescribed Panadeine forte as she had reported.

It appears no action was taken in relation to that advice.

On 26 August Ms Inglis submitted a General Request Form on which she wrote:

> *I have been patient. You've got the faxes from the doctors in Cairns. I am in constant pain. I don't ever have heavy pain killers, but due to the breaks I have got I need pain killers to have a decent sleep. I have been patient and now you have gone through the process, I still am suffering for no reason.*

This resulted in no change to her medication: rather a nursing note dated 28 August indicates Ms Inglis was seen in the clinic on that day and had requested Panadeine forte for left shoulder pain. Her request was denied; instead further medical records were requested from the Cairns Base Hospital "*for collateral*" which the nurse explained meant confirmation.

Last medical consultation

On 30 August the Cairns Base Hospital faxed to the TWCC the discharge summary of the 2007 treatment for the injuries Ms Inglis received in September that year. The next day she saw Dr McDonald who agreed at the inquest the purpose of the consultation was to discuss her analgesia. The progress notes record Ms Inglis' history of orthopaedic injuries and the proposal to "*Try Neurontin and nocte* (at night) *Tramal* (tramadol) *only."*

Dr McDonald explained at the inquest that Ms Inglis was not given Panadeine forte initially because it would have meant she would have received too much paracetamol. She also explained her approach was the result of her assessment that Ms Inglis' pain was not the result of residual physical injuries but rather neuropathic in origin. She said Ms Inglis had no joint injury, no muscle injury and full function of her arm.

In summary, Dr McDonald did not believe Ms Inglis had chronic or severe pain. She considers her views in that regard were confirmed when after taking the Neurontin for six nights, Ms Inglis declined further doses and apparently told the nurse she only needed Tramadol when required which was not regularly. She also said she didn't recall Ms Inglis ever complaining about inadequate pain relief.

Ms Inglis continued to take two 50mg tablets of Tramadol almost everyday. According to the other prisoners in her cell block, she was frequently in severe pain, leaning against the cold cell block wall when she couldn't sleep. There are however no records indicating the OHS nurses or custodial staff were made aware of this.

The circumstances of death

The other prisoners who shared the residential cell block with Ms Inglis indicated in the days preceding her death she was more quiet and withdrawn than usual.

On 17 September custodial officers undertaking a routine head count saw her in bed and apparently asleep at 11.00pm. When they next did their rounds at about 1.15am they saw Ms Inglis on the floor between the bed and the wall. There was blood smeared on the wall and a lot of blood on the floor. A code blue was called and the officers entered the cell. The first officer who attended to her found Ms Inglis was cold, not breathing and with fixed pupils.

Nurses were quickly on the scene and CPR commenced. The QAS was called at 1.22pm but the paramedics did not get to the patient until 1.45am and then declared Ms Inglis deceased at 1.49am.

The scene was secured, during which the prisoners who shared Ms Inglis' cell block were locked in an adjoining unit. The investigation detailed earlier was commenced when the CSIU officers arrived at the centre mid afternoon.

They found in Mrs Inglis' cell two notes: one to her family and one to her son Charlie. The notes express her disappointment at being in jail and her desire to be going or gone. Much of the writing is in the past tense and expresses regret she will not be involved in spending the compensation she anticipates receiving in future. She apologises to her son, tells him how proud she is of him, and gives him advice for the future. In my view the letters clearly evidence Ms Inglis' expectation that she will not see her family again.

Autopsy results

On 20 September 2010 an autopsy examination was carried out on the body of Ms Inglis by Professor David Williams, an experienced forensic pathologist. Blood and urine samples were taken and sent for toxicology testing.

Professor Williams noted the following recent injuries:

> "*…on the right upper limb there are two incised wounds at the antecubital fossa, one 18mm long, the other 9mm long. This longer wound is 25.4cm from the distal wrist line. The 9mm injury is medial to the 18mm long injury and is 24.6cm from the same line. At the right wrist on the ventral surface there are a number of hesitation wounds on the skin and three incised wounds, 12, 16 and 23mm long respectively. These wounds are 1.7, 4.2 and 5.5cm from the distal wrist line.*"

Professor Williams stated that his examination "*…demonstrated that she had died as a consequence of blood loss from incised wounds to the wrist and right elbow, primarily due to injury to the brachial artery at the right elbow*"

Professor Williams listed the cause of death as exsanguination.

Conclusions

Adequacy of IRNA

The junior counsellor who undertook the Initial Risk and Needs Assessment did not access all relevant information held by QCS because the procedures then in place did not require him to do so. As a result, the assessment was inadequate: Ms Inglis' history of numerous serious physical injuries; resulting chronic pain and the fluctuating doses of analgesia she used to respond to it coupled with her mental health history meant she had an elevated baseline risk of suicide or self harm. Because this was not identified during the IRNA she was not seen by members of the Risk Assessment Team or any mental health clinicians.

However, there is no evidence this in itself prevented Ms Inglis from receiving appropriate mental health care. Indeed a nurse who reviewed her the same day made explicit inquiries about suicidal ideation and her mental health history and also concluded no further psychiatric review was necessary.

Adequacy of pain management

Ms Inglis told the nurse who undertook the initial medical assessment that prior to her incarceration she was taking Panadeine Forte pursuant to a prescription from a Cairns medical centre. It was reasonable for the OHS staff to confirm this before the administering of the drug. It was not reasonable for them to take six days to make the inquiry and a further six days to act on it.

I also have other concerns about the way Ms Inglis' pain was managed. During her period of incarceration in 2009 Dr McDonald actively engaged with Ms Inglis in seeking a pharmacological solution for her on-going pain problems. It does not seem this engagement continued when she was incarcerated in August 2010. From her reception on 19 August until a consultation on 31 August she was given medication for her dental pain only. Thereafter she was given analgesia for what was presumed to be neuropathic pain which she stopped taking after a few days. No inquiry was made as to why the drug was declined but as the Neurontin would have had no effect on muscle or joint pain her actions are consistent with Dr McDonald having been mistaken about the cause of the pain. Contrary to submissions made on behalf of OHS, I note Ms Inglis continued to take tramadol daily except on three days between 31 August and 17 September. Tramadol is known to be effective for chronic joint and muscle pain and was the drug she had used when last in prison.

Dr McDonald did not believe Ms Inglis suffered from chronic pain. It seems this was based solely on her assessment that the various severe orthopaedic injuries she had suffered over the years would have healed completely. She made no inquires to confirm this view. She also believed Ms Inglis never complained about inadequate pain relief during her last incarceration. She was seriously misinformed. In fact Ms Inglis made numerous written and oral requests for more medication and complained on numerous occasions to her cellmates that she was in severe pain.

Ms Inglis was receiving more effective medication when she was in the community. The failure of OHS to give an equivalent standard of care means the service failed to comply with the standard the government has set for it.

As a result of these mistakes Ms Inglis' pain management was inadequate for the duration of her last period of incarceration.

I completely agree with Dr Hoskins' observation: *"we do people a great disservice if they have a genuine need for pain relief and we fail to prescribe it when they are deprived of their liberty."*

Manner of death

There is no evidence of any third party involvement in the death. It is clear Ms Inglis inflicted the wounds that caused her death – the question is whether she did so intending they end her life.

It is possible to look at the various circumstances that prevailed in isolation and interpret them in different ways. That is the wrong approach in my view. Rather, all of the relevant events, artefacts and characteristics need to be considered together. The letters may well have been interpreted merely as expressions of regret and remorse had their writer not died of self inflicted injuries before they were read. It may also be true that generally Ms Inglis was a stoic fighter who usually had plans for the future. However suicide is a notoriously impulsive act. It is noteworthy on previous occasions when she had expressed suicidal thoughts she had mentioned her chronic pain was one of the causes of her despair.

Having regard to the nature of her injuries; the length of time they would have taken to render her unconscious; and the contents of the notes found in her cell, I am of the view that Ms Inglis intentionally took her own life. I regret that finding will add to her family's distress.

It is impossible to know the extent to which insufficient analgesia and the resulting sleep deprivation contributed to her decision to end her life, but they were probably factors. I say that not to apportion any blame for Tracey Inglis' death to those responsible for her health care but to remind them, if that's necessary, of how far reaching the effects of their decisions can be.

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 she came by her 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 Tracey Lee Inglis.

How she died - While serving a period of imprisonment, Ms Inglis intentionally took her own life by making

	incisions on her forearm resulting in massive blood loss
Place of death –	She died at the Townsville Women's Correctional Centre, Townsville in Queensland.
Date of death –	She died on 17 or 18 September 2010.
Cause of death –	Ms Inglis died from exsanguination.

Section 46 comments

Section 46 provides that a Coroner may comment on anything connected with a death that relates to public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. That requires the coroner to consider whether the death under investigation was preventable and/or whether other deaths could be avoided in future if changes are made to relevant policies or procedures.

In this case the circumstances of the death have already been considered from a prevention focus by Inspectors appointed by the QCS Chief Inspector and a Root Cause Analysis (RCA) commissioned by the Executive Director of OHS. The reports of both processes were accepted into evidence and were very helpful to me.

The Inspectors' report made a number of recommendations. It called on QCS to review the practice of cutting and pasting IRNA answers; to review (with a view to extending) the timeframe over which the IRNA process seeks information on suicidal or self-harm ideation; and, to implement refresher training on the IRNA process for relevant QCS staff.

The inquest heard from the General Manager of Townsville Correctional Complex (which incorporates TWCC) as to the practical steps taken to implement these recommendations. He was able to produce tangible evidence of a training regime put in place at the complex since Ms Inglis' death which addresses those recommendations.

The inquest heard changes have been made to QCS guidelines relating to the IRNA process so that staff members are now expected to inquire further than was previously the case with respect to historical mental health issues. These updated guidelines were in fact formally implemented while the inquest was sitting.

There appears to have been limited changes made to the process of cutting and pasting as adopted by Mr O'Donnell when he conducted the IRNA for Ms Inglis. This practice continues to be recognised as a legitimate time saving tool albeit with the further training stressing the need for template answers to only be used when no further, or different, information is given by the prisoner.

The findings of that RCA were delivered on 1 September 2011. A number of recommendations were made, some of which re-iterated the deficiencies already noted in the QCS IRNA process. A separate recommendation was made that all prisoners entering a correctional centre as a result of a prescribed list of offences be automatically referred to the PMHS. This list would include arson, murder, attempted murder and stalking. Queensland Health and QCS have agreed to adopt such a process.

The RCA also focussed on aspects of the information sharing arrangements between QCS and Queensland Health staff. The inquest was told that implementation of the long awaited memorandum of understanding between those agencies is imminent (only awaiting signature by the relevant Directors-General).

I am satisfied the recommendations contained in these two documents are well constructed and adequately address many of the systemic problems brought into focus by the events leading to Ms Inglis' death. I am satisfied adequate steps have been taken to implement those recommendations.

Counsel for Sisters Inside and the Prisoners Legal Service made some further submissions which warrant attention. In some cases the proposed recommendations related to issues which I consider are already being adequately addressed by the relevant authorities, in other cases I consider I have an insufficient evidence base on which to proceed. I have therefore confined myself to the following matters.

Culturally and gender sensitive IRNA

The effectiveness of the IRNA largely depends upon a newly arrived prisoner volunteering information. It is therefore essential that all reasonable procedures which will increase the likelihood of a prisoner being frank and truthful should be implemented.

Recommendation 1 – Culturally and gender appropriate IRNA

To maximise the likelihood of the IRNA gathering reliable information, prisoners should be explicitly asked whether they identify with any ethnic group and if so whether they would like a person from that ethnic group to be present during the assessment. Similarly, prisoners should always be offered the option of having the assessment undertaken by a counsellor of either gender. I recommend QCS consider mandating such policies be implemented in all correctional centres.

Pain management guidelines

I have found the assessment of Ms Inglis' need for analgesia was mismanaged. I accept Dr Richards' evidence that it is a complex issue not readily amenable to standardised assessment tools, drugs or doses. However, I consider there is a need for policies that stipulate how a prisoner should be treated when they are on medication when they arrive in prison. I also consider clinical guidelines which reference mechanisms or tools for

assessing the level and source of pain and appropriate medications that might be used to alleviate different types of pain are urgently needed. I acknowledge these should not be overly prescriptive but should in my view, provide a framework for clinical decisions. Dr Richards' suggestion that he would get to it in due course gave me little confidence the issue would receive the attention I consider it deserves.

Recommendation 2 – Continuity of care

In view of the lengthy and unnecessary interruption of the deceased's prescribed medication after her incarceration, I recommend Queensland Health urgently develop guidelines to assist visiting medical officers engaged by Offender Health Services to make appropriate judgements concerning continuity of care for newly received prisoners and implement procedures that ensure verification of existing prescriptions occurs in a timely fashion.

Recommendation 3 – Pain management guidelines

In view of the inadequate pain management provided to the deceased in this case and the paucity of guidelines available to OHS staff on how to respond to chronic pain, a disproportionately common complaint among their patient population, I recommend that Queensland Health urgently develop guidelines to assist visiting medical officers engaged by Offender Health Services make appropriate judgements concerning the assessment and treatment of the condition.

Contact with HQCC

The HQCC is the specialist health care complaints body. Prisoners are among the most vulnerable of patients. They deserve unfettered access to the HQCC.

Recommendation 4 - Prisoner access to the HQCC

In view of the generally poor health and vulnerability of prisoners, I recommend QCS require all prison operators to make information about the role and function of the Health Quality and Complaints Commission readily available to prisoners and allow free telephone calls to the agency.

I close this inquest.

Michael Barnes
State Coroner
Townsville
9 December 2011