CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Terrence Michael Malone**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2014/4133
DELIVERED ON:	8 May 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	24 January 2017; 10 April – 13 April 2017; 21–-24 August 2017, written submissions January - April 2018
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody; provision of disposable razors to prisoners; decision to suspend parole; mental health history; information sharing; suicide risk assessment.

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper, Mr Daniel Bartlett
Queensland Corrective Services:	Ms Kylie Hillard, instructed by Department of Justice and Attorney-General
Malone family:	Mr Chris Minnery, instructed by TASC National
Registered Nurses Maguire & Buckley:	Mr David Schneidewin, instructed by Maurice Blackburn
Muriel Simmons:	Dr Gavan Palk
West Moreton HHS and Darling Downs HHS:	Mr Aaron Suthers
Commissioner of Police:	Mr Craig Capper, QPS Legal Unit

Table of Contents

The Investigation 2
The Inquest 2
The evidence 3
Personal circumstances and correctional history 3
Mental Health History 5
Events leading up to the death 6
Autopsy results 22
Adequacy and appropriateness of the mental health care provided to Mr Malone 24
Decision to revoke the parole order 33
Provision of razors to prisoners 36
Conclusions 39
Identity of the deceased 40
How he died 40
Place of death 40
Date of death 40
Cause of death 40
Comments and recommendations 41

Introduction

1. Terrence Michael Malone was 54 years of age when he was found deceased in his cell at the Brisbane Correctional Centre (BCC) on 8 November 2014. He was lying on his bed covered in a large quantity of blood. A number of long cuts were observed on the inner surface of both forearms. He was unable to be resuscitated.

2. A small razor blade was found on the sink in the cell and another on the floor beside the bed. A dismantled blue plastic safety razor was found on the shelving unit beside the bed.

3. Mr Malone had a lengthy history of mental health treatment and a history of minor offending. While he had been held in the watch house on a number of occasions, he had commenced only his second period of incarceration in prison the day before his death. He had been returned to prison after an arrest warrant was executed relating to a breach of his parole. After he was arrested in relation to the warrant, he spent two days at the Toowoomba watch house on an at-risk observations regime. He was then transferred to BCC on 7 November 2014, where he was not placed on an observations regime.

4. These findings confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death; and consider:

   - The appropriateness of the response by the Toowoomba Hospital Acute Care Team to Mr Malone's presentation pursuant to an Emergency Examination Order on 1 November 2014;
   - The appropriateness of the decision made by Queensland Corrective Services on 3 November 2014 to suspend Mr Malone's parole;
   - The appropriateness of the observations regime placed on Mr Malone at the Toowoomba watch house from 5-7 November 2014, and the transfer/communication of information between the Toowoomba watch house and BCC regarding the observations regime;
   - The adequacy and appropriateness of the health care (particularly mental health care) provided to Mr Malone at BCC on 7 November 2014; and
   - The availability of razor blades to prisoners in Queensland correctional facilities.

5. The final issue relating to the availability of razor blades to prisoners was examined jointly with the inquest into the death of Garry Ronald Appleton, which also occurred at BCC in 2015.

The Investigation

6. The circumstances leading to the death of Mr Malone were investigated by the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). The investigation was led by Detective Senior Constable Marcelle Sannazzaro. She submitted a report to my Office and this was tendered at the inquest.

7. Detective Senior Constable Sannazzaro attended BCC with several other CSIU officers. She inspected the cell and oversaw the forensic examination of all points of interest.

8. CSIU officers commenced the process of taking statements from staff and inmates at BCC. They took steps to seize all relevant records and interrogated BCC's Integrated Offender Management System (IOMS). Detective Senior Constable Sannazzaro spoke to intelligence officers at BCC and made arrangements for statements to be obtained from senior officials at the prison. Relevant CCTV footage was also seized and scenes of crime officers took a series of photographs of the scene.

9. At the inquest, Detective Senior Constable Sannazzaro's evidence was that she did not consider the death of Mr Malone to be suspicious. She was satisfied that he was locked alone in his cell at the time and no other persons were involved.

10. In addition to the QPS CSIU investigation, the Chief Inspector, Queensland Corrective Services, appointed investigators to examine the incident under the powers conferred by s294 of the *Corrective Services Act 2006*. Those investigators prepared a detailed and thorough report which was submitted to the Office of the Chief Inspector (OCI). It examined matters within and beyond the scope of the coronial inquest. The report was tendered at the inquest and was of assistance in the preparation of these findings.

11. I am satisfied that the QPS investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The Inquest

12. A pre-inquest conference was held in Brisbane on 24 January 2017. Miss Cooper appeared as counsel assisting and leave to appear was granted to Queensland Corrective Services and representatives for Mr Malone's family. Leave was also granted to various health professionals who saw Mr Malone at the Toowoomba Hospital and at BCC, as well as their employing Hospital and Health Services and the Commissioner of Police.

13. An inquest was held over the weeks of 10 – 13 April 2017 and 21-24 August 2017. All of the statements, records of interview, medical records, photographs, CCTV footage and materials gathered during the investigations were tendered at the inquest. I heard from 18 witnesses.

14. Following the conclusion of the evidence, written submissions were provided between January and April 2018 from those granted leave to appear and from counsel assisting.

15. I am satisfied that all the material necessary to make the findings required under the *Coroners Act 2003* was placed before me at the inquest.

The evidence

Personal circumstances and correctional history

16. Mr Malone had not been in prison before he was incarcerated on 2 September 2014. He had a criminal history dating back to 2002 for minor property offences and breaches of court orders. Mr Malone identified as an Indigenous man and was proud of his Irish and Aboriginal heritage.

17. Statements from Mr Malone's daughters, Roisin Malone and Caitlin Malone, were tendered at the inquest.[1] A statement was also tendered from Mr Malone's former wife, Bernadette Stevens.[2] Those statements detail a number of concerns with respect to Mr Malone's care and supervision in the lead up to his death. It is clear from those statements that Mr Malone had a loving and caring relationship with his family and is deeply missed by them. I extend my condolences to Mr Malone's family.

18. Roisin Malone gave evidence at the inquest. Mr Malone was the sixth of seven children. Apart from his brother, who was diagnosed with obsessive compulsive disorder, there was no history of mental illness in the family. After finishing school, Mr Malone worked on his family's farm and then as a fireman, before changing careers to become a psychiatric nurse. He obtained a Bachelor of Nursing degree in 1993. He had worked for 16 years as a successful psychiatric nurse in Toowoomba. He also had several investment properties. Ms Malone said that her father had four children from his first marriage and two from a subsequent relationship.

19. Mr Malone was diagnosed with PTSD in 1997 and had turned to alcohol to manage the stress associated with his work. He had been assaulted on several occasions at work and his life was threatened. In 1999, he was diagnosed with bipolar affective disorder. In 2000, he was treated for alcohol dependence at the Palm Beach Hospital but did not complete this treatment.

20. Mr Malone was admitted to hospital for mental health treatment under the care of Dr Venugopalan, a Toowoomba psychiatrist, in 2000. Ms Malone said that he had twice attempted suicide at that time after drinking significant quantities of methylated spirits.

[1] Exhibits B8; B9 – B9.1.
[2] Exhibit B17.

21. Mr Malone was treated on an ongoing basis by Dr Venugopalan, but his continued alcohol dependency interfered with this treatment. He was unable to return to work after March 2004.

22. Mr Malone had moved to Brisbane following the dissolution of his marriage and his children remained in Toowoomba. Ms Malone said that her father was ashamed of his circumstances and hid a lot of things from his family. His life had spiralled out of control in the three years preceding his death, when he became homeless following a relationship breakdown, and increasingly involved with the criminal justice system.

23. Ms Malone said that her father was vulnerable to assaults and robbery. He was living out of his van but after that was impounded by police, he had no choice but to live in homeless shelters and on the streets.

24. A statement tendered from Dr Venugopalan confirmed he had not seen Mr Malone since November 2013.[3] On that occasion, Mr Malone was reported to be in a disorganised state, affected by alcohol and distressed about a property dispute with a former partner. He was assessed at the Toowoomba Hospital as having "*quite evident cognitive impairment, very simple responses, some psycho-motor retardation, blunted affect and limited problem solving capacity most likely due to his history of continued substance use/abuse*".[4]

25. Roisin Malone had moved to Melbourne but returned to live in Toowoomba in January 2014 to attempt to care for her father. As his next of kin, she would receive calls from the Toowoomba Hospital saying that her father was there seeking shelter from the cold, and he would threaten to harm himself if he was not given a bed. She said that she found accommodation for him at men's shelters but he was often evicted because he drank on the premises.

26. Ms Malone said that in June 2014, she found out that her father had been hospitalised at the Toowoomba Hospital for a week. He then sustained a fractured shoulder, after he fell from an elevated stretcher bed in the Emergency Department during a seizure from alcohol withdrawal. After spending over 10 days in the orthopaedic ward he was prepared for surgery, which was cancelled twice. Mr Malone was then discharged with painkillers and placed on a waiting list.

27. Ms Malone said that while he was waiting for surgery her father had secured a bed at the Sunrise Way rehabilitation facility. However, he was required to wait until his surgery had been carried out so that he was not on painkillers at Sunrise Way. Ms Malone was unable to persuade the Toowoomba Hospital that her father's surgery should be prioritised. He then travelled to Brisbane in an endeavour to have the surgery performed at the Princess Alexandra Hospital, but was advised to return to Toowoomba for treatment.

---

[3] Exhibit B27.
[4] Exhibit D2.2, p86

28. In late August or early September 2014, Mr Malone received a letter indicating that a warrant had issued for his arrest after he missed a court appearance. On 2 September 2014, Ms Malone took her father to the watch house to address the warrant. She expected the situation would be resolved. However, on that date he appeared in court and was sentenced to nine weeks in prison. His stronger painkillers (Endone, Targin and Norspan) were taken from him and substituted with Panadeine Forte.

29. While her father was in prison Ms Malone received three letters from him which indicated that he found the prison environment very challenging. During this time, he was also informed of the July 2014 death of his former partner, with whom he had two children. Ms Malone said that she was told it would be nine weeks before she was approved to visit her father in prison, and that she was not advised of his release from prison to Sunrise Way on 21 October 2014.

30. On 31 October 2014, Ms Malone received a call from the Toowoomba Hospital asking her to collect her father who was drunk. An hour later he arrived at her mother's home in a taxi. Ms Malone then drove him back to the men's hostel where he had been staying. He told her that he had thoughts of killing himself but he "*could not do that to his kids and everyone would just think he was weak if he did*".

31. On 5 November 2014, Ms Malone was advised by police officers that her father had been arrested for failing to attend a meeting with his parole officer, and was being returned to prison. She said she later received a call from Ms Meg Morse, a nurse who worked at the Toowoomba watch house. Ms Morse told Ms Malone that she had previously worked with Mr Malone, and informed her that she thought he was fine. Ms Malone disagreed. She said that she spoke to Ms Morse for over an hour and stressed that in her opinion her father was at elevated risk of suicide.

Mental Health History

32. In addition to the records from QCS and Toowoomba Hospital, a variety of other records were tendered at the inquest in relation to the mental health treatment Mr Malone received in the community before his custodial sentence. These included records from Platinum Health, a GP Clinic in Toowoomba which Mr Malone had attended on occasion to see Dr Gary Porter. A statement was tendered from Dr Porter which confirmed that Mr Malone attended the clinic infrequently, but he was known to have mental health issues.[5]

33. Records from psychiatrist, Dr Venu Venugopalan were also tendered at the inquest.[6] As noted above, those records confirmed Dr Venugopalan had been treating Mr Malone on an intermittent basis since 1999.

[5] Exhibit B11.
[6] Exhibit D5.

Events leading up to the death

34. On 2 September 2014, Mr Malone, who was homeless and sleeping rough, was sentenced to nine weeks imprisonment for a number of minor property related offences, including stealing and trespass, breaches of bail and breach of a probation order. He was subsequently released to court ordered parole on 21 October 2014. During this initial period in custody, Mr Malone was referred to the Prison Mental Health Service ('PMHS').

35. Ms Hannah Williamson, a provisionally registered psychologist, performed an Immediate Risk Needs Assessment (IRNA) on Mr Malone on 4 September 2014 on his entry to BCC. A Self-Harm Episode History (SHEH) flag was not raised on IOMS, although Mr Malone had disclosed a suicide attempt three months earlier. The assessment stated that Mr Malone had "*attempted suicide approximately three (3) months ago via drinking a litre of methylated spirits and was subsequently admitted to Mental Health at the hospital*".

36. On 16 September 2014, Mr Malone was formally assessed by PMHS Consultant Psychiatrist, Dr Mark Schramm. Dr Schramm documented an extensive psychiatric history, including bipolar affective disorder, suicide attempts, alcohol abuse and two admissions under an Involuntary Treatment Order ('ITO'). Dr Schramm documented that Mr Malone had developed late onset alcohol dependence after his marriage breakdown in 2002. He reported that he was drinking litres of wine daily. Dr Schramm also noted that Mr Malone's primary concern was the delay in receiving treatment for his fractured neck of humerus and the chronic pain associated with this injury.

37. Dr Schramm reported that Mr Malone had a fairly convincing history of morbidly elevated mood, usually followed by a crash. Dr Schramm noted that Mr Malone had acknowledged intermittent suicidality, with his last thoughts in this regard in April 2014. Dr Schramm considered Mr Malone's mood was stable, and noted that he seemed to have a future focus. He planned to enter a rehabilitation program and reunite with a former partner. Dr Schramm suggested that Mr Malone continue on his current therapeutic regime of quetiapine and fluvoxamine, with a view to referral to a rehabilitation clinic or back to the Toowoomba Acute Care Team upon discharge from prison.

38. At the relevant time, Muriel Simmons was an Acting Senior Psychologist employed at BCC. On 22 September 2014, she conducted a psychological assessment on Mr Malone. The assessment arose out of events from the preceding weekend, during which Mr Malone indicated that he felt suicidal and was found to be hoarding pills. This led to a notification of concern ('NOC') being raised. Ms Simmons was interviewed as part of the OCI investigation, a copy of which was tendered at the inquest.[7]

[7] Exhibit C3.5.

39. In her interview with the OCI, Ms Simmons said that she assessed that Mr Malone was not at elevated risk of suicide or self-harm, and he was not placed on a formal observations regime. On her review of IOMS, she did not notice a SHEH flag. As a result of her assessment with Mr Malone, Ms Simmons also did not enter a SHEH flag on IOMS. Ms Simmons said her understanding was that SHEH flags "self-populated" on the IOMS system when an assessment raised a history of self-harm. In fact, they were required to be entered manually by the senior psychologist as required.

40. The fact that a SHEH flag was not entered against Mr Malone on IOMS on this occasion became relevant when considering Mr Malone's final period of incarceration.

41. On 7 October 2014, Dr Schramm assessed Mr Malone again. He reported improved mood with brighter affect, but no mood elevation. Mr Malone remained vague about his discharge plans, but still talked about alcohol rehabilitation. Dr Schramm determined that Mr Malone was at great risk of relapse into alcohol dependency without a plan for rehabilitation and support. As a consequence, an application was made for entry to Sunrise Way Rehabilitation Centre in Toowoomba.

42. Mr Malone saw Dr Schramm again on 14 October 2014. Dr Schramm reported that he did not feel Mr Malone was exhibiting signs of elevated mood. Mr Malone was reviewed again by the PMHS on 17 October 2014, just prior to his release. He was described as presenting with euthymic mood with reactive effect, with some anxiety regarding his release. His sleep was staggered. However, it was documented that he had no thoughts of self-harm or harm to others, and was motivated to address his problems with alcohol. He displayed no indicia of psychosis or pervasive mood disturbance. Mr Malone was marked as being 'closed to PMHS', and a referral letter was written to the Toowoomba Mental Health Service.[8]

43. After his release on parole on 21 October 2014, Mr Malone entered a six week rehabilitation program to address his alcohol dependence at Sunrise Way. However, Mr Malone was discharged from that program on 30 October 2014 when he was found in possession of alcohol.

44. A statement was tendered at the inquest from Mr Peter Sarquis, the Executive Director of Sunrise Way, in addition to the records from Mr Malone's time with that Centre. Mr Sarquis confirmed that Mr Malone was initially assessed in relation to his suitability for the Sunrise Way program on 29 July 2014. He was subsequently accepted into the program, to undergo six full weeks of rehabilitation, on the following conditions:

- that he be fully detoxed from alcohol;
- that he have his medication prescribed to the nearby pharmacy;
- that he no longer required Schedule 8 medications; and
- that he was not an imminent threat of suicide or self-harm.

[8] Exhibit D3, page 152.

45. Mr Malone agreed to these conditions. Mr Sarquis' statement indicated that most abstinence based residential programs for recovering alcoholics have similar rules.

46. Toowoomba Hospital records indicate that on 26 October 2014, Sarah Holland, a support worker from Sunrise Way called the Acute Care Team with concerns about Mr Malone, and asked that Ms Stumer speak with him. The hospital records note:

> *Terry stated that he was in a great deal of pain, he broke his shoulder in July and has been suffering chronic pain from this injury. This is affecting his sleep and appetite which is poor. States he also has "a lot going on", partner died in August and her children are being cared for by the family. Currently experiencing suicidal thoughts, declined to answer if he had a plan, intent, or means. Advised to present at ED for medical review if he was unable to wait to see a Doctor there at Sunrise tomorrow*

47. Ms Holland did not give evidence at the inquest but provided a statement after the conclusion of evidence. In her statement, she indicated that Mr Malone had come to her on 26 October 2014 because he was feeling suicidal but felt he would not be taken seriously by the mental health system. While she was unable to access her notes from that day her recollection was that she was told that Mr Malone was "drug seeking" and not suicidal. However, this assertion was not tested at the inquest. Ms Holland said that she subsequently called for an ambulance to take Mr Malone to the hospital.

48. Hospital records indicate that Mr Malone was assessed at the hospital in the Emergency Department and by ACT Nurse Buckley. Mr Malone requested S8 medications and was considered to be "not for additional analgesia". He was prescribed 5gm Diazepam and discharged back to Sunrise Way.

49. Mr Sarquis confirmed the duration of Mr Malone's admission to the program was only seven days. On the day of his discharge, 29 October 2014, he had admitted to drinking alcohol on the Sunrise Way premises, and also showed Mr Sarquis empty bottles of alcohol hidden in the backyard. Leading up to this, there had been complaints from other residents about Mr Malone drinking alcohol. According to Mr Sarquis, Mr Malone accepted his breach of the program rules, and knew he had to leave the program as a consequence. Mr Sarquis recalled Mr Malone saying he had safe and supervised accommodation to go to. Mr Sarquis also recalled Mr Malone was picked up by Paula Sturgeon, who was to provide crisis accommodation for Mr Malone at Kirk St, Toowoomba.

50. Records from the Toowoomba Hospital indicate that on 31 October 2014 Mr Malone presented in an ambulance seeking admission for alcohol detoxification. QAS notes indicate that the triage nurse advised ambulance officers that Mr Malone "had already presented to hospital earlier today and was removed by security for aggression".[9] On 31 October 2014, a referral was made for his admission to the Hospital Alcohol and Drug Service from 12 November 2014.

.

Emergency Examination Order – 1 November 2014

51. On 1 November 2014, Mr Malone presented at the Toowoomba Hospital Acute Care Team for the purpose of an Emergency Examination Order ('EEO') under the *Mental Health Act 200*3. He had been brought in by the Queensland Ambulance Service and was seen by Registered Nurses Tracey Maguire and Louise Stumer. Statements from both clinicians were tendered, and they gave evidence at the inquest.[10]

52. Also tendered at the inquest were three volumes of medical records from the Toowoomba Hospital, mainly from the Acute Care Team ('ACT').[11] Mr Malone's history with the ACT dated back to early 1997. Mr Malone had an extensive history of contact with Registered Nurse Buckley. I was assisted by a statement from Nurse Buckley, which provides detailed information regarding his dealings with Mr Malone over many years.[12] I note that while Mr Malone's history with the ACT dated back to 1997, Nurse Buckley had known Mr Malone since 1989, when he was Nurse Buckley's superior at the Baillie Henderson Hospital. The last dealing Nurse Buckley had with Mr Malone was on 26 October 2014.

53. Nurse Maguire is a registered nurse, specialising in mental health examinations, suicidality and risk management. She is an Authorised Mental Health Practitioner and had been working in Toowoomba since 2002. She had also known Mr Malone as a colleague. In her statement, she explained that the function of the ACT was a consultation service for mental health patients. The ACT is the first point of contact for someone in a mental health crisis. It operates on a 24 hour basis, and when someone presents to the ACT a mental health assessment is undertaken. Part of that assessment is to assess the risks of suicide and self-harm and consider what action should be taken in response.

---

[9] Exhibit D2.2, p207
[10] Exhibits B24-B24.5; B26.
[11] Exhibits D2-D2.2.
[12] Exhibits B25-B25.8.

54. Nurse Maguire confirmed that Mr Malone presented to the Toowoomba Hospital Emergency Department on 1 November 2014. Mr Malone had presented at 9:15am, and Nurse Maguire was made aware of him when she started her shift at noon. She was aware Mr Malone had presented pursuant to an EEO, and that he needed to be assessed. She understood that when he had presented to the ED he was intoxicated. The assessment had been delayed to allow him time to sober up. Nurse Maguire attended the ED in the company of Nurse Louise Stumer. Nurse Stumer is also a registered nurse specialising in mental health.

55. The EEO stated that Mr Malone had made suicidal threats of hanging himself or jumping in front of a truck.[13] He had numerous presentations to the Emergency Department over the previous days seeking detoxification and admission to the Alcohol and Other Drugs unit, which required a medical admission via the Emergency Department.

56. Nurse Maguire subsequently completed a consumer assessment, with Nurse Stumer assisting. During the assessment Mr Malone was spoken to, and the Consumer Integrated Mental Health Application ('CIMHA') was reviewed. The assessment of Mr Malone's mental health state is recorded in the Consumer Assessment document.[14]

57. Mr Malone was assessed as being at low risk of suicide.[15] Nurse Maguire explained in her evidence that this was due to the following factors:

- Mr Malone had sought help by calling the Queensland Ambulance Service;
- Mr Malone had said he did not want to die;
- Mr Malone had voiced vague suicidal threats earlier in the day but had no plan or intent;
- Mr Malone often voiced vague suicidal threats when in crisis; and
- Mr Malone remained at risk of misadventure due to his chronic alcohol dependency.

58. As was the usual practice, the on-call Consultant Psychiatrist, Dr Suren Putter-Lareman, was consulted with respect to Mr Malone. Nurse Maguire did not recall the specifics of her conversation with Dr Putter-Lareman, but stated it was her usual practice to discuss the Consumer Assessment in a clinical and risk formulation format. Based on the Consumer Assessment, Dr Putter-Lareman authorised for Mr Malone to be discharged from the EEO, with the following plan put in place:

- Mr Malone was provided a taxi to travel to his accommodation at Kirk St, Toowoomba; and

[13] Exhibit B24.4.
[14] Exhibit B24.5, page 5.
[15] Exhibit B24.5, page 10.

- The ACT would visit Mr Malone at home the next day (Sunday) to provide support until he engaged with the Alcohol and Other Drugs Service on Monday.

59. Nurse Maguire said that Mr Malone did not consent for her to speak with his family to gather collateral information. He told her that he did not want to embarrass his daughter, who worked as a nurse at the Toowoomba Hospital. She said that gathering collateral information from family members was "not a practice at the time".

60. Nurse Maguire also said that she was cognisant of the principle under the *Mental Health Act* of patient autonomy, and that admission was not the only option to respond to an EEO. The preferred course was for patients to draw on their own resilience, and a mental health admission was not always the most beneficial and therapeutic environment. The criteria under the Act had to be met before an involuntary treatment order was authorised. Mr Malone made it clear that he did not want to be admitted under the *Mental Health Act* but did want to be admitted for detoxification.

61. Nurse Maguire recalled that when she spoke with Mr Malone, he was calm and oriented to place and time. She considered that the immediate crisis had settled, and the risk level had changed at the time of the Consumer Assessment. Nurse Maguire was aware that Mr Malone had presented to the Toowoomba Hospital three times on 31 October 2014. On the third occasion he had left the Emergency Department.

62. At the inquest, Nurse Stumer also said that she had also known Mr Malone as a colleague, but had limited contact with him in that capacity. When she saw him with Nurse Maguire on 1 November 2014, he was able to converse in a comprehensive way. She confirmed Nurse Maguire's evidence in relation to the assessment of Mr Malone's risk of suicide as low. He specifically stated that he did not want to die, he was not psychotic and displayed no thought disturbance. He spoke of his long struggle with alcohol. He said that he wanted to detox but was not able to do so. He was unable to recall seeing anyone from AODS the previous day or the plan to return on Monday. The discharge plan had been discussed with the on-call consultant psychiatrist and Mr Malone was discharged to his accommodation at Kirk Street. Mr Malone agreed to a home visit the following day and Nurse Stumer attended this with her colleague, Anthony Hill. He again declined to have the ACT contact his family.

Parole revocation

63. Statements were tendered at the inquest from each of the officers from Probation and Parole who were involved in the revocation of Mr Malone's parole order. After being released from prison on 21 October 2014 Mr Malone went to the Toowoomba Probation and Parole office and was directed to report in person on 31 October 2014. His parole officer was Ms Deanne Bailey. Ms Bailey then altered Mr Malone's reporting arrangement while he was in Sunrise Way so that he would report via a telephone call on 31 October 2014, rather than attending the Probation and Parole office.

64. Ms Bailey confirmed she had received a phone call from Sunrise Way on 29 October 2014 advising that Mr Malone would be discharged from the program that day after he was found with alcohol. Ms Bailey was provided with the number for Paula Sturgeon as a possible contact for Mr Malone. Ms Bailey phoned Ms Sturgeon, who agreed to pass a message on to Mr Malone should she see him. Ms Bailey did not identify herself as Mr Malone's parole officer.

65. Ms Bailey said that on 31 October 2014, Mr Malone failed to report or make contact with her, as required. She also noted that by 3 November 2014, Mr Malone had yet to report or make any contact with her. Ms Bailey proceeded to make a number of inquiries regarding possible contacts, and other residential possibilities for Mr Malone. She made contact with OzCare to no avail. Ms Bailey reviewed the Integrated Offender Management System (IOMS) for possible contacts, and located an address for Mr Malone's daughter but there was no contact phone number. That address was the OzCare hostel in Toowoomba, and Ms Bailey confirmed that neither Mr Malone nor his daughter were living there. A previous address for Mr Malone's next-of-kin was also located, but checks conducted satisfied Ms Bailey that the address did not exist.

66. Ms Bailey subsequently formed the view that she had exhausted all options to find Mr Malone. Her view was that Mr Malone's risk to the community had escalated and could not be reasonably managed in the circumstances. She noted that under previous parole supervision Mr Malone had committed criminal offences after failing to report for parole. She subsequently progressed a "case conference" for the consideration of her immediate supervisor, Ms Tammie Westman, on 3 November 2014. Ms Westman double checked the previous address for the next-of-kin, and was also satisfied that it did not exist.

67. On 5 November 2014, the day of Mr Malone's arrest, Ms Bailey and Ms Westman co-signed a Parole Board Report with respect to Mr Malone, recommending this his parole order be suspended indefinitely to allow him to receive assistance for alcohol treatment while in prison.[16]

---

[16] Exhibit C7, pages 100-101.

68. At the inquest I heard evidence from Mr Brett Wilson, who at the relevant time, was the District Manager of Toowoomba Probation and Parole. In his role as District Manager, it was his responsibility to ensure that all relevant factors had been considered and appropriate risk assessments and evaluation had been undertaken by the Supervising Officer, and the Supervisor, before any final recommendation regarding the parole order was made.

69. Mr Wilson's evidence was that Mr Malone came to his attention on 3 November 2014. He reviewed the Parole Board Report as signed by Ms Bailey and Ms Westman. Mr Wilson explained the assessment of risk for Mr Malone required consideration of his offence history, his response to prior supervision, consideration of collateral information provided by Sunrise Way regarding his alcohol consumption and any non-compliance with the requirements of his parole order. Mr Wilson determined that Mr Malone was an unacceptable risk to the community, and that his parole order should be suspended. Mr Wilson was unable to reasonably implement strategies to address the risk as Mr Malone's whereabouts were unknown.

70. Mr Wilson referred in his statement to the Risk of Re-offending score, described it as a screening risk assessment tool used to assess the risk of re-offending. Mr Malone scored 13 out of a possible 20, which Mr Wilson interpreted as placing him within a high risk category of further offending.

71. Mr Wilson also noted that some of Mr Malone's prior offending occurred while he was under the influence of alcohol, and that alcohol consumption was a factor in his discharge from Sunrise Way. Mr Wilson also considered Ms Bailey's unsuccessful efforts to contact Mr Malone's next-of-kin, and that Mr Malone was not residing at his previous accommodation at Oz Care. Mr Wilson regarded this information as significant, as Probation and Parole had no further options available to it to attempt to locate Mr Malone.

72. Mr Wilson supported the recommendation to suspend Mr Malone's parole order. He contacted the Regional Manager, Ms Lauren Thompson, on the afternoon of 3 November 2014. After consultation with Ms Thompson, a warrant was issued for Mr Malone's arrest that afternoon and signed by Mr Wilson.

73. Mr Wilson was cross examined at length at the inquest. He made some concessions concerning the process involving the suspension of Mr Malone's parole. An example was the continued repetition of the error that Mr Malone's offences involved his participation in a criminal organization. Mr Wilson also accepted that other avenues were available to parole office staff to locate Mr Malone between 29 October 2014 and 3 November 2014; including personal attendance at the OzCare facility. However, with the benefit of hindsight, Mr Wilson did not think that the parole officers should have acted differently.

Watch house admission – 5 to 7 November 2014

74. On 5 November 2014, Mr Malone was arrested and taken to the Toowoomba watch house. The Arresting Officer, Senior Constable Kevin Jones, provided a statement to the inquest.[17] He confirmed that police had spoken with Roisin Malone, who had confirmed she had not seen her father in a few days, and had last dropped him off in Bracker Street, Toowoomba.

75. Police located a number of boarding houses in this area, and conducted doorknocks in Bracker Street, as well as Kirk Street. When Mr Malone was located at a dwelling on Kirk Street, he appeared to be intoxicated. A wine bladder was sitting on the bedside table, and there was a strong smell of wine in the room. Mr Malone proceeded to gather his medications and personal possessions, and accompanied police to the Toowoomba watch house where he remained until he was transferred to BCC on 7 November 2014.

76. Statements were tendered at the inquest from each of the relevant watch house officers[18] and I heard evidence from Officers Smit, Gilloway and Hampson. In his statement, Sergeant Rodger Malcolm confirmed that at 11:48am on 5 November 2014, he booked Mr Malone into the watch house. Mr Malone had medication with him, namely Seroquel, Voxam and Esomeprazole. As part of the process of booking Mr Malone in to the watch house, Sergeant Malcolm asked a series of questions. Some of the questions and responses related to mental health, and are extracted from Mr Malcom's statement as follows:

> *"(13) Are you currently or have you ever been treated for a mental health problem.*
>
> *Yes.*
>
> *(14) Have you been treated for depression.*
>
> *Yes.*
>
> *(15) Have you ever attempted suicide or self harm.*
>
> *Yes.*
>
> *(16) Which suicide or self harm.*
>
> *Suicide.*
>
> *(17) How long ago.*
>
> *Years ago.*

[17] Exhibit B6.
[18] Exhibits B4; B7; B16; B31.

(18) What did you do.

Drank metho.

(19) Have you thoughts of suicide or self harm now or in the past 3 months.

Yes.

(20) Which suicide or self harm.

Suicide."[19]

77. Sergeant Malcolm recalled that as Mr Malone was on medication and possibly suicidal, a call was made at about 12:15pm to have Blue Nurses attend to speak with Mr Malone. Blue Nurses attended later that afternoon, and left notes for Mr Malone to be further reviewed by a nurse the next day.

78. Sergeant Lucas Hampson was rostered on during the day to perform general watch house duties. Sergeant Hampson recalled Mr Malone being placed at the watch house and that he looked dishevelled.[20] He knew Mr Malone from other times he had been held at the watch house. Sergeant Hampson did not observe Mr Malone to be upset or distressed during any of the physical checks that day.

79. Sergeant Tony Smit took over from Sergeant Malcolm as Shift Supervisor for the watch house at about 1:30pm on 5 November 2014.[21] Sergeant Smit's evidence was that he had over 20 years' experience working in watch houses. He was aware Mr Malone had an alcohol dependency and was medicated. He was also aware Mr Malone was suicidal. He placed Mr Malone on an observations regime whereby he was to be observed in his cell by watch house officers every 30 minutes. At the inquest he said that his view was there not an imminent risk of suicide.

80. Sergeant Smit observed Mr Malone a number of times throughout the shift, and initially observed he was a bit shaky. Sergeant Smit thought this was consistent with his alcohol dependency. He also spoke to Mr Malone a number of times throughout the shift and Mr Malone did not make any complaints about his condition. He handed over to the incoming Shift Supervisor, Sergeant Neil Gilloway at 9:30pm that night.

81. Mr Gilloway is now retired from the Queensland Police Service with over 39 years' experience. He provided a statement detailing his recollection of his dealings with Mr Malone.[22] He recalled taking over as Shift Supervisor from Sergeant Smit on the night of 5 November 2014. He observed that all prisoners were settled and there were no issues raised. He recalled being told that Mr Malone had an alcohol dependency and was medicated.

---

[19] Exhibit B7, pages 2-3.
[20] Exhibit B4, paragraph 5.
[21] Exhibit B16, paragraph 3.
[22] Exhibit B31.

82. Mr Gilloway was told that Mr Malone was suicidal, and had been placed on 30 minute observations for this, and also due to his alcohol dependency.[23] He allowed Mr Malone to change to a double cell over the course of the night after Mr Malone told him that he did not like being alone. Mr Gilloway also completed a Prisoner Movement Sheet over the course of this shift, on which he marked that Mr Malone was suicidal. This was faxed to the Brisbane City Watch house and BCC.

83. On the morning of 6 November 2014, Sergeant Hampson took over as the Shift Supervisor from Mr Gilloway. To start his shift, Sergeant Hampson performed a physical check on all of the prisoners, including Mr Malone, who was sleeping at the time.

84. At about 6:40am, Sergeant Hampson recalled Mr Malone being brought to the charge counter so that his medication could be administered. He was shaking. He said he wished to see the Blue Nurse, and that he was not feeling well due to withdrawal from alcohol.[24]

85. Sometime between 8:00am and 8:30am, Sergeant Hampson recalled the Court Mental Health Liaison Nurse, Meg Morse, attended the watch house. Ms Morse assisted the inquest by providing a statement, as well as giving evidence.[25] Ms Morse explained that her role, at that time, was to ensure that persons remaining in custody who were experiencing mental illness received appropriate follow up assessment and care.

86. Ms Morse confirmed that she completed a mental health assessment on Mr Malone on 6 November 2014. This included a risk assessment addressing the domains of suicide and self-harm risk, risk of aggression or harm to others, vulnerability to harm and child safety.

87. Ms Morse concluded that Mr Malone was not demonstrating any symptoms that might indicate that he was experiencing a relapse of mania or psychosis. However, Ms Morse was concerned about Mr Malone being in the early stages of acute alcohol withdrawal, and that he was at risk of being seriously medically compromised in the watch house environment.[26]

88. Her assessment led Ms Morse to conclude that Mr Malone was at a slightly elevated, but not acute, risk of suicide. She noted his manner to be despondent, and he indicated some thoughts of hopelessness and helplessness. He denied having any thoughts of suicide, or having an intent to suicide. He indicated positive plans for the future, and that he loved his children. Ms Morse considered this as a positive connection, which was a protective factor. Ms Morse believed his mental state would improve with optimal treatment of his withdrawal symptoms, as it had on occasions in the past.[27]

---

[23] Exhibit B31, paragraph 5.
[24] Exhibit B4, paragraph 10.
[25] Exhibit B34.
[26] Exhibit B34, paragraph 10.
[27] Exhibit B34, paragraph 11.

89. After Ms Morse had seen Mr Malone, she spoke with Sergeant Hampson. Sergeant Hampson recalled Ms Morse telling him that Mr Malone should be placed on the Prisoner Movement Sheet as a medical priority. She said that Mr Malone was withdrawing from alcohol and he posed a suicide risk.[28] Ms Morse confirmed this conversation during her evidence. Ms Morse also recalled that she emailed the PMHS Clinical Coordinators a referral for ongoing care of Mr Malone. She did not think that transfer to a prison would increase his risk of suicide.

90. Ms Morse was not able to recall having a conversation with Roisin Malone about Ms Malone's specific concerns about her father needing frequent supervision or that he was at elevated risk of suicide. Her file note records Ms Malone's concern that her father may be mood elevated or psychotic and that Mr Malone's return to custody would be noted to PMHS.[29]

91. As a result of receiving the information from Ms Morse, Sergeant Hampson called the Brisbane City watch house and spoke with an officer who coordinated the prioritisation and allocation of prisoners to prisons. He explained Mr Malone's condition. Sergeant Hampson was told that Mr Malone would be prioritised to be accepted at BCC the following day. Sergeant Hampson did not have any concerns about Mr Malone for the remainder of his shift that day.

92. On the afternoon of 6 November 2014, Sergeant Malcolm was rostered on as the Shift Supervisor at the watch house. Sergeant Malcolm was aware that the Mental Health Nurse, Meg Morse, had attended that morning to see Mr Malone. Blue Nurses also attended that day, and left notes to the effect that Mr Malone was to be given 10mg Valium, 3 times a day.

93. Sergeant Malcolm recalled later that day Mr Malone started to experience chest pain and shortness of breath. The Queensland Ambulance Service was called and attended at the watch house. Mr Malone was transferred to the Toowoomba Hospital for a medical appraisal. He was returned to the watch house later that night at about 9:20pm.

94. Mr Gilloway took over as Shift Supervisor from Sergeant Malcolm that night.[30] Mr Gilloway recalled being informed that Mr Malone had been taken to hospital with chest pain but had returned. He was informed there were no new issues, and that Mr Malone had taken his medication. Mr Gilloway observed that Mr Malone was sleeping throughout the shift. Mr Galloway said that doing the nightshift he prepared Mr Malone's property for transfer, the warrant history and the property sheet, together with the medical record and the custody record. These documents were to be handed over to reception at BCC on Mr Malone's transfer. At that time, there was no discussion about individual prisoners following the transfer unless there had been issues during the transfer.

[28] Exhibit B4, paragraph 13.
[29] Exhibit B34.4
[30] Exhibit B31, paragraph 15.

95. Sergeant Smit took over from Mr Gilloway as the Shift Supervisor on the morning of 7 November 2014, when Mr Malone was transferred to BCC. Sergeant Hampson was performing prison escort duties for the relevant shift. He loaded the prisoners, including Mr Malone, into the prison van and arrived at BCC at about 8:25am. Sergeant Hampson said that Mr Malone did not appear to be agitated and, in fact, appeared calm.[31] Sergeant Hampson recalled that Ms Morse had told him that Mr Malone's withdrawal from alcohol dependency elevated his suicide risk and that the watch house was not an appropriate environment for him to undergo withdrawal. Sergeant Hampson agreed that the resources available to treat prisoners with medical issues were superior in prison.

96. At the inquest Sergeants Smit and Hampson were asked questions regarding the type of handover that occurred at this time, particularly regarding the observations regime that applied to Mr Malone at the watch house. Sergeant Smit said the prisoner movement sheet indicated a risk of suicide for Mr Malone. The sheet has Mr Malone at number 1 on the list and he is recorded as Medical Priority.[32] The prisoner property sheet also noted that Mr Malone had a classification of "Medical observation: Suicide". The sheet also noted that his medication included Seroquel, esomeprazole and voxam.

97. Sergeant Smit also referred to the QPS Operational Procedures Manual provision relating to the transfer and taking charge of persons in custody.[33] This requires watch house officers relinquishing custody of a prisoner to advise the person to whom custody is transferred every pertinent matter including any physical or mental condition and suicidal tendencies. The OPM requires that this advice is to be given verbally, and also included on the appropriate sections of a QPS person report and/or QPS prisoner property sheet.

98. Sergeant Smit also said that that the risk assessment completed at the watch house is given to QCS in a document folder when the prisoner is admitted to prison. Sgt Hampson confirmed that as part of escort duties he would check that all relevant paperwork was ready to accompany the prisoner. He was unable to recall whether he had personally handed the documents to Queensland Corrective Services staff as he was on escort duty with another officer. Neither did he recall verbally briefing Queensland Corrective Services staff in relation to Mr Malone's observations regime.

---

[31] Exhibit B4, paragraph 18.
[32] Exhibit B33
[33] Exhibit C13

The health care at the Brisbane Correctional Centre on 7 November 2014

99. Offender Health Services records confirm that when Mr Malone was received at BCC, he was assessed by Prison Medical Services. Registered Nurse Gurbir Singh conducted this assessment. I was assisted at the inquest by a statement from Nurse Singh, as well as by hearing oral evidence from him.[34]

100. Nurse Singh's evidence was that upon admission to BCC all prisoners are required to undergo a medical assessment. The prisoners are questioned by nursing staff about their health status and a number of documents are completed. One such form was a 'Screening tool for notification of concern'. This requires an assessment in relation to the offender's appearance, their behaviour, conversation and suicidal ideation. A further document is a 'medical in confidence' questionnaire. This is a detailed form that elicits information from the offender about their current medications, medical history, population health, drug and alcohol usage, mental health, self-harm and suicide risk and allergies or drug reactions.[35]

101. Nurse Singh confirmed that he did not have access to Mr Malone's full medical records during the course of the assessment. It was clear from his evidence that Nurse Singh was not provided with the information folder that accompanied Mr Malone from the Toowoomba watch house.

102. During the course of the assessment, Mr Malone was noted by Nurse Singh to have a history of self-harm from years ago, but he denied any current thoughts of ending his life or self-harm. Mr Malone referred to problems with his shoulder and also said he was withdrawing from alcohol. Nurse Singh noted Mr Malone's appearance, behaviour and conversation were all normal, and he denied any suicidal ideation.

103. Nurse Singh recommended that Mr Malone's medications continue and that he be seen by the Visiting Medical Officer regarding his alcohol withdrawal regime. In the meantime, Mr Malone was placed on Valium to assist with his alcohol withdrawal.

104. Nurse Singh did not make a recommendation that Mr Malone be referred to the PMHS. Nurse Singh's evidence was that during the assessment he asked Mr Malone whether he had ever received treatment for a mental health problem, to which he replied that he had. Mr Malone stated that he had bipolar disorder and anxiety, and that he had been treated for these conditions in BCC and had previously been seen by the PMHS. Because of this, Nurse Singh did not complete a PMHS referral form. It was his understanding that Mr Malone was already open to the PMHS.

---

[34] Exhibits B15-B15.12.
[35] Exhibit B15, paragraph 9.

105. Nurse Singh's evidence was that if Mr Malone had indicated that he had self-harm or suicidal ideation, he would have raised a NOC with the psychologist. Nurse Singh explained that where inmates present with a suicidal or self-harm ideation, they will be placed in a unit which is a dedicated observation unit with 24/7 CCTV and officer monitoring. However, Nurse Singh did not assess that Mr Malone required that level of monitoring, and Mr Malone was not placed on an observations regime similar to that in place at the watch house.

106. Nurse Singh's evidence was that his assessment of Mr Malone was a health assessment, of which mental health was only one component. He acknowledged that he did not having specialist mental health training. Mr Singh said he did not have access to the CIMHA and IOMS patient databases and that it would be unusual to receive any information from the watch house about their potential concerns about a prisoner, other than the documents received from the QPS in the transfer. He said that his assessment differed from Ms Morse's as to the severity of Mr Malone's alcohol withdrawal because Mr Malone's medication may have been having a positive effect. Mr Singh also said that if he had the information provided by Ms Morse he would have spoken to a psychiatrist straight away and referred Mr Malone to the Prison Mental Health Service.

107. Further to the medical assessment conducted by Nurse Singh, an IRNA was also conducted by a psychologist, Nicole Stagnitti. Ms Stagnitti was a provisional psychologist and had only commenced in the role a few days before she saw Mr Malone. She was interviewed for the purposes of the OCI report, and a copy of that interview was tendered at the inquest.[36]

108. During that interview, Ms Stagnitti said that Mr Malone appeared normal in presentation and displayed no present indication of suicidal ideation or intent. Ms Stagnitti observed a discrepancy in the previous suicide history recorded for Mr Malone, when compared to his self-reporting. She recalled him saying it had been some 12 years beforehand that he had made a suicide attempt, but the record indicated it was only 3 months.

109. Ms Stagnitti said that she thought that a SHEH flag was raised automatically if certain boxes were ticked in the IRNA. She had since become aware that a separate email to the senior psychologist is required before a flag is raised.

110. If required, at risk prisoners may be put under observations for two hours, one hour, 15 minutes or continuous observation. Prisoners on 15 minute or continuous observations are relocated to the medical unit. If a SHEH flag is raised it is recommended that a prisoner be placed in a suicide resistant cell. As a consequence of Ms Stagnitti's assessment, Mr Malone was not placed under any form of observation.

[36] Exhibit E15.

111. Ms Stagnitti told the inquest that she did not receive any information indicating that Mr Malone was on 30 minute observations at the Toowoomba watch house. She said that, while more information is of assistance, that even if she did receive that information she would have conducted an independent assessment, and that her assessment may not have changed. She did have access to his previous IRNA but had not read it. She did not have access to CIMHA or his hospital records. Ms Stagnitti said that her focus was on Mr Malone's immediate presentation and he had denied recent suicidal thoughts. She relied heavily on his self-reporting.

112. Ms Stagnitti assessed Mr Malone as not being an immediate risk of self-harm, and referred him to the Prison Mental Health Service with the expectation he would be seen early the next week. At the inquest she said that Mr Malone was future oriented, he maintained eye contact and was relaxed and engaged. Mr Malone was adamant that he had no intent to suicide and spoke of a strong relationship with his children.

113. Ms Stagnitti then discussed her assessment with her supervising psychologist, Ms Simmons. She also drew Ms Simmons' attention to the discrepancy surrounding the dates of suicide attempts. Ms Stagnitti could not recall Ms Simmons' response. Ms Stagnitti could not recall if a SHEH flag had been raised. Ms Stagnitti and Ms Simmons agreed that Mr Malone was not at immediate risk of self-harm at the time and he was not placed on an observations regime. Ms Stagnitti also noted that 50% of the prison population had a SHEH flag.

114. Ms Stagnitti said that her current process was to review each prisoner's IOMS records the day before she undertakes the IRNA. She did not have access to PMHS records or to Mr Malone's medical records from the Toowoomba Hospital ACT. She stated that if a watch house had flagged a prisoner she would call the watch house to discuss the reasons why.

115. Ms Simmons recalled in her interview with OCI inspectors that she was Ms Stagnitti's supervisor on the relevant day and she recalled reviewing each of the IRNAs submitted by Ms Stagnitti. Ms Simmons recalled checking the assessment for Mr Malone and that she was "happy enough" with it.[37] She did not check to see if a SHEH flag had been raised.

116. Ms Simmons' did not consider that recent historical material concerning Mr Malone, such as the watch house and Sunrise Way assessments, would have made a difference to the IRNA of 7 November 2014. Like Ms Stagnitti, Ms Simmons said that she did not cause a SHEH flag to be entered on IOMS as she thought this was happened automatically once the IRNA was completed.

[37] Exhibit C3.5, page 21.

117. Just before 11:30pm the following night, Saturday 8 November 2014, Custodial Correctional Officer (CCO) Brendan Ritson was conducting the routine headcount in unit S12 with CCO Rocco Varvaro. Both officers provided statements which were tendered at the inquest.[38] CCO Ritson explained that it was his usual practice to shine his torch inside each cell, via the viewing panel, to observe each prisoner in their cells.

118. When CCO Ritson arrived at cell 24, he noticed Mr Malone lying on his back on his bed; his waist and legs were covered with a doona, but his upper body and arms were exposed. There was nobody else in the cell. The cell lights were off but the television was on. CCO Ritson saw what seemed to be congealed blood near the right side of Mr Malone's head. There also appeared to be blood on the cell floor. Mr Malone's eyes were open, but CCO Ritson could not see any movement, or rise and fall of his chest. He immediately suspected that Mr Malone was deceased.

119. CCO Ritson called out to CCO Varvaro, who had been conducting the headcount for other cells in S12. CCO Ritson called a Code Blue. Nurse Singh arrived at the cell within minutes, and checked Mr Malone's pulse near his neck. He also pushed down on his chest but there was no reaction. The Queensland Ambulance Service attended just after midnight. Mr Malone was subsequently declared deceased.

120. In addition to the razor blades, a letter was located inside the cell which was written by Mr Malone and addressed to his family. A copy of the letter was tendered at the inquest.[39] In the letter, Mr Malone wrote of his love for his children and his regret that he could not defeat his alcohol dependency. He said that that he was at the end of his tether in the prison system. He had no glasses and was unable to read. He spoke of his struggle with bipolar disorder, that he felt the system had let him down, and his feelings of rejection due to his illness. He also spoke of the pain he had been suffering from his injured shoulder and of his struggle with his withdrawal from alcohol. He said that he was not given medication to manage his pain or his symptoms.

Autopsy results

121. A full internal autopsy was conducted by forensic pathologist Dr Philip Storey, on 11 November 2014. Dr Storey's report was tendered at the inquest.[40]

122. External examination noted an incised wound to the right lateral upper neck, which extended into the underlying fatty tissues and into the muscular tissues of the neck. There was also a superficial scratch-like wound to the left side of the neck which did not penetrate the skin and was at an analogous position as was the deeper wound to the right side of the neck.

[38] Exhibits B13 and B21.
[39] Exhibit C1.
[40] Exhibit A2.

123. Internal examination of the wound to the right lateral upper neck showed that it had penetrated the underlying sternomastoid muscle, and then the carotid sheath where focal cuts were found in the right internal carotid artery, and in the right jugular vein.

124. Dr Storey explained that the carotid arteries are blood vessels under high pressure, and a cut in one of the vessels would result in the rapid loss of a large amount of blood. He also explained that the internal jugular veins are large blood vessels, but they are under a fairly low amount of pressure. However, despite this, their size means a large volume of blood can be lost of a relatively short period of time.

125. Dr Storey confirmed the combined injuries to the right internal carotid artery and to the right internal jugular vein were life-threatening with the possibility of death over a period of time, potentially as short as a few minutes.

126. Dr Storey confirmed the cause of death was from an incised wound to the neck.

127. The autopsy report also noted "*an apparent posterior fracture of the right proximal humerus, with extensive comminution of the humeral head associated with areas of apparent evolving avascular necrosis.*[41] *The main humeral head fragment is displaced posteriorly and appears to be impacted along the posterior glenoid rim. There is apparent fracture of the post inferior glenoid, with a small medialised bone fragment. There is evidence of fracture healing, with some callus forming around the fracture, which remains un-united. Several loose bodies are present in the joint.*"[42]

[41] Death of bone tissue due to interruption of blood supply

[42] Exhibit A2, p7

Adequacy and appropriateness of the mental health care provided to Mr Malone

128. I was assisted at the inquest by a report from Dr Anand Choudhary, Consultant Psychiatrist and Deputy Director of Medical Services at the Metro North Hospital and Health Service.[43] Dr Choudhary also gave evidence at the inquest. He was asked to provide an opinion as to the adequacy and appropriateness of the mental health care provided to Mr Malone in the six months before his death and, in particular, the response by the clinicians at the Toowoomba Hospital ACT to the EEO on 1 November 2014.

129. Dr Choudhary pointed out that Mr Malone had a very long history of contact with multiple mental health services dating back to 1997. Mr Malone had gone from being a successful Clinical Nurse in a psychiatric hospital to homelessness, experiencing multiple psychosocial issues. In Dr Choudhary's opinion, his psychiatric issues could be clustered into two main diagnostic categories:

    1. Mood disorders – Bipolar, depression and anxiety; and
    2. Substance related disorders – Alcohol Dependence Syndrome with multiple relapses.

130. Dr Choudhary reviewed Mr Malone's presentations to the Toowoomba Hospital Mental Health Service from April 2014. Dr Choudhary noted presentations from April; June and July 2014. The presentations related to seeking assistance for alcohol dependency, depressive symptoms and social issues. Dr Choudhary noted satisfactory in-patient stays with appropriate plans to keep Mr Malone engaged in the community. There were patterns of disengagement with services, possibly due to recommencement of alcohol and subsequent psychosocial issues. Dr Choudhary observed that Mr Malone received multiple home visits and assertive engagement in the community through the ACT.

131. Dr Choudhary also reviewed the mental health care provided to Mr Malone during his first period of incarceration. His evidence was that Mr Malone's mental state remained stable during this period, and he was regularly reviewed by Consultant Psychiatrist, Dr Schramm. Dr Choudhary agreed with Dr Schramm's decision not to alter Mr Malone's medications during this period. In Dr Choudhary's opinion, this level of care was adequate and appropriate.

132. Dr Choudhary also confirmed that Mr Malone had several presentations to the Toowoomba Hospital between 26 October 2014 and 2 November 2014. In particular, he presented to the Toowoomba Hospital Emergency Department on five occasions over a 24 hour period, from noon on 31 October 2014 to noon on 1 November 2014.

---

[43] Exhibit B32.

133. As noted above, at 8:50am on 1 November 2014, Mr Malone was brought to the emergency department by the QAS pursuant to an EEO. He was actively drinking and was carrying a cask of wine. He was expressing suicidal ideas to ambulance officers. Mr Malone was referred to the ACT and I heard evidence from the clinicians who assessed Mr Malone for the purposes of the EEO at lunch time that day.

134. Dr Choudhary confirmed that appropriate processes were followed with respect to the EEO in terms of steps needed to assess someone on an EEO and consultation with a Consultant Psychiatrist. A home visit was made by the ACT to Mr Malone the following day, when Mr Malone was noted to be sober. The importance of alcohol rehabilitation was discussed with him at this time, and he was again referred to OzCare for ongoing support.

135. Dr Choudhary's opinion was that, with the benefit of hindsight, he would have assessed Mr Malone as being at moderately high risk of self-harm. Although he was not expressing any convincing suicidal plans when assessed for the purposes of the EEO, he was expressing feelings of hopelessness and worthlessness. A holistic assessment of his suicide risk by the ACT clinicians, supported by a Psychiatry Specialist could have assisted in the short-term management of Mr Malone, particularly having regard to the fact that Mr Malone presented at the hospital five times within 24 hours.

136. Dr Choudhary said that a face to face assessment would have opened up more options for responding to Mr Malone, apart from his discharge without any additional support. Those options included discharge with medications, admission for detoxification or involuntary admission in the mental health unit.

137. Dr Choudhary said that it was unfortunate that the view of clinicians at the Toowoomba Hospital was that detoxification should happen in the medical wards. He said that his review indicated that the Emergency Department doctors did not see that it was their role to arrange detoxification and that an intoxicated person should not be admitted for detoxification.

138. Dr Choudhary said that Mr Malone's significant psychiatric history indicated that he was not presenting only for detoxification. He was also talking about suicidal ideation. Dr Choudhary said that it unfortunate that it was seen, "that detoxification was something that emergency doctors or medical doctors will do, when in fact it's everybody's job to offer the right care to the patient". Dr Choudhary also noted that the lack of integration between CIMHA and the AODS information system contributed to clinicians not having a global perspective when assessing a patient.[44]

[44] Mechanisms to ensure that CIMHA interfaces with other electronic medical records are planned under the Connecting Care to Recovery Plan 2016-2021.

139. Dr Choudhary was critical of the assessment of Mr Malone by Ms Stagnitti and Nurse Singh in his initial report, describing it as less than adequate, possibly because of his "level of training and inability to take into account the holistic clinical picture". However, at the inquest he accepted that the IRNA process was limited and that the assessments carried out at the prison were going to be less than adequate because of a lack of access to collateral information, including prior mental health history.

140. I was also assisted by a statement from Ms Laura Dyer, Nursing Director for the PMHS,[45] and heard evidence from Nurse Dyer with respect to the process of Mr Malone's admission to BCC, particularly the questionnaire administered by Nurse Singh and the consideration of a referral to the PMHS.

141. Nurse Dyer confirmed that a referral to the PMHS was not considered for Mr Malone upon his admission to BCC on 7 November 2014. Ms Dyer pointed out that the mental health screening document, states "*if yes to any of the above questions, refer to Prison Mental Health Service (PMHS) referral criteria to determine whether a referral is required*."[46] Despite Mr Malone having answered 'yes' to a number of the standard mental health screening questions, the PMHS referral criteria did not appear to have been considered.

142. Nurse Dyer's evidence was that the Medical in Confidence questionnaire has since been revised. This revision was conducted with a view to better drawing the intake nurse's attention to the need to make a referral to the PMHS where any of the mental health screening questions have been answered in the affirmative. A copy of the new version of the questionnaire was tendered at the inquest.[47]

143. Nurse Dyer explained that 7 November 2014 was a Friday. This meant that any referral to PMHS for Mr Malone would not have been processed by PMHS until Monday, 10 November 2014. Nurse Dyer explained there were other avenues in place for prisoners deemed 'at-risk', or otherwise with more urgent psychological needs. She explained the option for a prisoner to be assessed by a prison psychologist, such as Ms Simmons or Ms Stagnitti. The psychologist could, if necessary, arrange for the prisoner to be housed in Unit S3, which is a dedicated observations unit with 24hour monitoring.

144. Nurse Dyer's evidence was that, even without a referral to PMHS on 7 November 2014, it is likely Mr Malone would have been seen by the PMHS due to his ongoing mental health condition and associated medication requirements.

---

[45] Exhibits B3-B3.12.
[46] Exhibit B3.2, page 6.
[47] Exhibit B3.5.

145. With respect to the alcohol withdrawal regime implemented for Mr Malone from 7 November 2014, Nurse Dyer's evidence was that she had considered the comments made by Mr Malone in his suicide note. Nurse Dyer explained that the Prison Health Service is guided by the Queensland Alcohol and Drug Withdrawal Clinical Practice Guidelines ('the Guidelines').[48]

146. Nurse Dyer referred to the Alcohol Withdrawal Scale document completed for Mr Malone, and confirmed he was assessed as '3' on that scale.[49] Mr Malone was commenced on step 2 with respect to his Valium dosage, and this was approved by the VMO, Dr Lethbridge. Nurse Dyer confirmed that on her reading of the records, on 8 November 2014, the AWS medication chart stated Mr Malone received 10mg Valium at 07:30, and 15mg Valium at 18:00. He also received 200mg Thiamine, and a multi-vitamin at 18:00.

147. Nurse Dyer explained that after Mr Malone's death it was determined that the AWS medication chart could be improved. The improvements were aimed at clarifying exactly what dosages of Valium are required, at what times they should be administered, and for how many days. A copy of the improved form was also tendered at the inquest.[50]

148. Mr Malone also commented in his suicide note that he had told the intake nurse he should have been on 'alcohol withdrawal observations'.[51] Nurse Dyer acknowledged in her evidence that the Guidelines recommend that four hourly observations be considered for people with an AWS score of less than 4.[52] However, Nurse Dyer also explained that the Guidelines are drafted for a clinical setting, such as a hospital or specialist residential setting. The QCS structured day effectively means that PHS staff have access to prisoners for 10 hours per day. The exception is where a prisoner was housed in Unit S3, where constant observations and monitoring apply.

149. Mr Malone's medical records were also independently reviewed by Dr Gary Hall of the Clinical Forensic Medicine Unit. Dr Hall was asked to provide an opinion about the appropriateness of the alcohol withdrawal regime on which Mr Malone was placed. That report was tendered at the inquest.[53] I also heard oral evidence from Dr Hall.

150. Dr Hall noted that Mr Malone reported on reception to BCC that he took the following medications:

- Quetiapine 900mg daily (anti-psychotic);
- Pantoprazole 20mg daily (anti-ulcerant);
- Alcohol withdrawal regime (not specified); and
- Fluvoxamine 300mg daily (anti-depressant).

---

48 Exhibit B3.6.
49 Exhibit B3.8.
50 Exhibit B3.12.
51 Exhibit C1, page 2.
52 Exhibit B3.6, page 34.
53 Exhibit B30.

151. The screening tool completed by Nurse Singh identified Mr Malone as being an Indigenous person with a history of self-harm. The Tool recorded normal behaviour, appearance and conversation with Mr Malone, and he denied any suicidal ideation or thoughts of deliberate self-harm. Mr Malone's response regarding alcohol use was that he consumed a carton of beer daily, and that he last consumed alcohol on 4 November 2014. Nurse Singh documented that Mr Malone was withdrawing from alcohol and he would speak with the Visiting Medical Officer regarding a withdrawal regime.

152. Dr Hall said that the watch house medication sheet noted Mr Malone was "shaky from alcohol withdrawal" on the evening of 5 November 2014 and "shaking and feeling generally unwell (from) alcohol withdrawal" on the morning of 6 November 2014.

153. Dr Hall did not purport to provide an opinion about Mr Malone's mental health, as this was outside the scope of his expertise. However, he addressed Mr Malone's suicide note, and his comments that he was disgruntled with the management of his alcohol withdrawal. Dr Hall stated that Mr Malone's death was not directly caused by alcohol withdrawal. In that light, Dr Hall assessed whether Mr Malone's mental health was acutely affected by the alcohol withdrawal, and whether this might have lowered his threshold to self-harm and commit suicide.

154. Mr Malone's symptoms had progressed to having been observed in the watch house to be shaky, as a result of his alcohol withdrawal, to being noted on reception at BCC to engage in normal behaviour. Dr Hall confirmed that this would suggest Mr Malone was not affected by alcohol or its withdrawal at the time of his reception to BCC. However, Dr Hall did note that Mr Malone had received a dose of diazepam shortly before being received at BCC, which could have resulted in a relaxed presentation.

155. Dr Hall confirmed most persons with a large daily intake of alcohol will withdraw without incident over 2-4 days. Dr Hall confirmed the evidence of Nurse Dyer, in that management of alcohol withdrawal, either as an inpatient or an outpatient in Queensland Government facilities is guided by recommendations found in the Queensland Alcohol and Drug Withdrawal Clinical Practice Guidelines.

156. Dr Hall confirmed that withdrawing patients require monitoring. In severe cases, a hospital setting would be required with frequent observations. In ambulant settings like watch houses, observations by a nurse can be done as much as three times a day, but for most cases at least daily. Medication for withdrawal is usually in the form of a long acting benzodiazepine sedative, with anticonvulsive and muscle relaxing properties (e.g. Diazepam).

157. Dr Hall assessed Mr Malone's withdrawal symptoms as being moderate. He saw nothing of concern in the admission notes of Nurse Singh, or on the Alcohol Withdrawal Scale, that would lead him to suspect that Mr Malone was at high risk of acute alcohol withdrawal. He noted no history of seizures. Dr Hall would have started Mr Malone on diazepam when he was noted to have been shaky in the watch house. Dr Hall was surprised that prison staff began Mr Malone's dosing on "Step 2" of the Guidelines, given that he had only received 24 hours of treatment in the watch house. It would have been reasonable to monitor Mr Malone for signs of withdrawal at least two or three times a day, and for these observations to be conducted by someone experienced in recognising alcohol withdrawal.

158. Dr Hall concluded that Mr Malone's alcohol withdrawal regime was probably below where it ought to have been in terms of the dose of diazepam at both the watch house and BCC. However, Dr Hall considered that it would be "drawing a long bow" to suggest that the withdrawal of diazepam and inadequacy of the alcohol withdrawal regime, as stated in Mr Malone's suicide note, were the reasons for his suicide.

159. Dr Hall did not believe the regime was inadequate, in terms of placing Mr Malone at risk of severe withdrawal symptoms or suicidality, due to an adverse effect on his mental health. I agree with Dr Hall's assessment of the adequacy of the alcohol withdrawal regime at BCC.

Submissions on the adequacy of mental health care at the Toowoomba Hospital

160. It was submitted by Counsel Assisting that concerns raised about the treatment of Mr Malone at Toowoomba Hospital revolved around the ACT clinicians' assessment that Mr Malone posed a low risk of suicide when the EEO of 1 November 2014 contained references to Mr Malone's specific and detailed suicidal ideation.

161. Counsel Assisting submitted that the assessment by ACT clinicians derived from their training, experience and information on hand. It was submitted that it was not difficult to accept the information elicited directly from conversations with Mr Malone would carry substantial weight, notwithstanding inconsistencies with information such as EEO notes or historical information.

162. Counsel Assisting submitted that the treatment of Mr Malone by the ACT team on 1 November 2014 was appropriate and that, on the evidence before the court, no adverse comments concerning Mr Malone's treatment by the ACT on 1 November 2014 were warranted.

163. Submissions on behalf of Nurse Maguire reiterated that the information obtained during the assessment of Mr Malone on 1 November 2014 after his intoxication had waned carried substantial weight in assessing his then suicidal risk as low.

164. Counsel Assisting submitted that this does not discount, nor is inconsistent with, Dr Choudhary's opinion that a holistic assessment taking into account Mr Malone's history and repeated presentations was required, and may have provided more opportunity for a beneficial outcome.

165. It was submitted on behalf of Mr Malone's family that he fell through the cracks at the Toowoomba Hospital on 1 November 2014 in that Nurses Maguire and Stumer assessed his risk of suicide as low, and did not see it as part of their role to advocate for him in relation to his admission for detoxification. The family also submitted that Nurse Stumer was dismissive of Mr Malone's pain management concerns on 26 October 2014.

166. Essentially, the family submitted that the ACT nurses were focussed solely on the suicide risk assessment to the exclusion of all other concerns. Despite their knowledge of Mr Malone's lengthy history, they failed to advocate for him in relation to the management of his alcohol dependency. Consistent with Dr Choudhary's view, the ACT team failed in its approach to Mr Malone by not taking a holistic view of his needs and failing to have a face to face consultation with either the psychiatric registrar or consultant psychiatrist, which may have resulted in an admission for detoxification.

167. Submissions on behalf of Nurse Maguire noted that the absence of a holistic assessment taking into account Mr Malone's repeated presentations needed to be considered in the context of systemic circumstances at the hospital in late 2014, and were outside the scope of responsibility of individual clinicians. The inability of ACT nurses to arrange admission for detoxification and to access to AODS records were also systemic issues for the hospital.

168. While I conclude that the assessment, treatment and management of Mr Malone by clinicians in the ACT team in November 2014 was appropriate, I agree with Dr Choudhary's opinion and the submission from Mr Malone's family that there were systemic failings in the Toowoomba Hospital's response to Mr Malone in the lead up to his death.

169. As a former nurse Mr Malone had a good understanding of the system. He would likely have been a very challenging person to deal with due to his chronic alcohol abuse and frequent presentations to the hospital. Notwithstanding, I consider that the Toowoomba Hospital failed to take a person-centred approach to Mr Malone's needs. Despite the recognition by the ACT that he had impaired functioning as a consequence of his alcohol dependency and significant ongoing mental health issues, he was treated in a siloed fashion.

170. There was a lack of integration between the Alcohol and Other Drugs Service and the mental health services provided at the hospital. Mr Malone's mental health and alcohol dependency were treated as separate issues. It is clear that a referral was made by AODS on 31 October 2014 for his admission to the Hospital Alcohol and Drug Service from 12 November 2014.[54] However, due to his level of intoxication Mr Malone appeared to have no awareness of this. His blood alcohol reading recorded at AODS on 31 October 2014 was 0.263. He was required to navigate entry into detoxification on his own when he had very limited capacity to do so. It was identified in the consumer assessment that Mr Malone remained at risk of misadventure due to his chronic alcohol dependency, yet he was discharged from the hospital on his own.

171. The Toowoomba Hospital had also failed to respond to Mr Malone's fractured shoulder in a timely way. The injury had occurred in the context of a seizure at the hospital in July 2014 but it remained untreated at the time of his death. The post-mortem report indicated that the shoulder injury was significant and had progressed to necrosis. I have no doubt it would have been very painful. Notwithstanding Mr Malone's repeated requests for assistance to manage his pain he was dismissed as a person who was addicted to pain medication and drug seeking.

Submissions on the adequacy of mental health care at the BCC

172. Submissions from counsel assisting noted that it was difficult to reconcile the psychological assessment of Mr Malone on 7 November 2014 with his subsequent actions on the night of 8 November 2014, raising the question whether the method by which he was assessed was adequate or the persons who conducted the assessment performed adequately.

173. Counsel assisting also submitted that notwithstanding their denial that the information would have affected their assessment, it is concerning that information from the watch house about Mr Malone was not available to Ms Stagnitti and Ms Simmons. This is especially the case in light of Dr Choudhary's evidence that the watch house information may have affected their assessment.

174. It was submitted that ultimately, it is a matter for the Brisbane Correctional Centre to ensure that all relevant information is available to psychologists so that they can ensure that their assessment is as effective as possible and that it was open to find that the system by which information is communicated to the Brisbane Correctional Centre is inadequate.

175. Counsel assisting submitted it is also the responsibility of the Brisbane Correctional Centre to ensure that the psychologists undertake the duties adequately, and that the flawed misapprehension by the psychologists of the SHEH process did not reflect well on them.

[54] Exhibit D2, p111

176. It was submitted on behalf of Mr Malone's family that the health care provided to him at BCC on 7-8 November 2014 was woefully inadequate. The family submitted that irrespective of the merits of the reduction in the Valium prescription given to him for alcohol detoxification, he was not placed on any observations regime for his alcohol withdrawal. Neither was he placed on an observations regime in response to his risk of suicide because none was identified, even though Ms Simmons had seen him two months earlier after he was found hoarding pills and had expressed suicidal thoughts. In addition, the pain resulting from his untreated shoulder injury was not recognised. He was also unable to contact his family and his glasses were missing.

177. It was submitted on behalf of Ms Simmons that having regard to the assessment of Mr Malone's suicide risk as low by Nurses Maguire, Stumer and Morse in the days leading up to his transfer to BCC, it was highly unlikely that Ms Stagnitti and Nurse Singh would have reached a different conclusion even if they had access to historical information. I do not accept that submission as it suggests suicide risk is not dynamic. Suicide risk is dynamic and can fluctuate considerably in the prison context.

178. After considering the evidence of Dr Choudhary, I conclude that the assessment of Mr Malone's immediate risk of suicide by Ms Stagnitti on 7 November 2014 was adequate, notwithstanding that she was inadequately trained to perform this function. I also acknowledge that there is very little evidence that suicide can be accurately predicted.

179. I accept the OCI Report's finding that Ms Simmons, as senior psychologist, had an incomplete knowledge of the prisons processes and procedures, which impaired her capacity to carry out her supervisory role in relation to Ms Stagnitti. I note that Ms Simmons has subsequently ceased practise as a psychologist.

180. I also agree with the conclusion of the OCI Report that even if a SHEH flag had been raised, it would not necessarily have led to Mr Malone being accommodated in other than a main stream cell or placed on observations. However, as the OCI report noted the absence of a SHEH flag impaired a comprehensive assessment of whether Mr Malone should have been subject to an observations regime or other actions to reduce the risk of harm he posed to himself.

181. Consistent with my conclusion about the response of the Toowoomba Hospital, I do not consider that there was an adequate and person-centred response to Mr Malone's needs at BCC. In my view, it was necessary to consider more than Mr Malone's self-reporting in relation to current suicidal ideation and his recent history of suicide attempts. As his letter to his family prior to his suicide indicated, he was clearly in distress. He had a range of other concerns that were not identified or responded to, and contributed to his decision to end his own life. These ranged from not having reading glasses, the chronic pain from his shoulder injury and concerns about coping with alcohol withdrawal in prison.

182. I note that the need to shift away from an approach that focuses solely on whether a person is at risk of suicide to one that embeds a systems approach for suicide risk screening, assessment and management has been recognised in *Connecting care to recovery 2016–2021- A plan for Queensland's State-funded mental health, alcohol and other drug services.*

Decision to revoke the parole order

183. Mr Malone's family submitted that the decision to suspend Mr Malone's parole after he had missed one appointment, had failed to notify his change of address after three days, and started consuming alcohol, was harsh and excessive in the circumstances, especially as other options were available through collateral sources to obtain more information and locate Mr Malone. The family submitted that none of the conditions for mandatory parole suspension applied, and the revocation was also hasty and premature.

184. Based on all of the evidence, I consider that the decision to revoke Mr Malone's parole order was made on the basis that his whereabouts were unknown despite the efforts to locate him. He was aware that he was required to maintain contact with his parole officer. It was also established that he had been drinking alcohol, which was a known precursor to his offending. As such, he was deemed an unacceptable risk to the community, and the warrant was issued for his arrest with a view to his alcohol withdrawal occurring in prison.

185. While I am satisfied that this was a course of action which was technically open to Queensland Corrective Services officers, based on the information before them I consider that more could have been done by the relevant QCS officers to engage with Mr Malone before breach action was taken. For example, a home visit could have been made to him while he was at Sunrise Way.

186. It appears that Mr Malone's parole officer had never met him in person when she initiated the case conference that resulted in his return to prison. The failure to report was alleged to have occurred on Friday 31 October 2014. The case conference was initiated on the following Monday. I consider that more could have been done to locate Mr Malone after he failed to attend in person at the Toowoomba Probation and Parole Office. The QPS had very little difficulty locating Mr Malone after QCS issued the return to prison warrant.

187. As the Queensland Government's Response to the Report of the Review of the Parole System in Queensland identified,[55] reimprisoning offenders for relatively minor breaches of parole conditions is rarely effective, and it is "counter-productive to churn parolees in and out of the prison system for minor violations of their parole orders, such as failing to report". Those comments are apposite in the circumstances of Mr Malone's parole suspension.

188. I have had regard to the 2016 Report of the Review of the Parole System in Queensland to ascertain whether any of its 91 recommendations might have assisted Mr Malone. Relevantly, the Report identified that three of the most important factors in a prisoner's success on parole were a home, a job and freedom from substance misuse.

> *"Parolees the subject of court ordered parole commonly start parole homeless. For others, there can be no parole without proof that there will be suitable accommodation; but accommodation is difficult enough to secure for anyone convicted of a serious crime and it is even harder to secure from behind the walls of a prison.*[56]

189. Having regard to the comprehensive nature of the recommendations in that Report I make no recommendations specifically in relation to the parole system. Relevant recommendations, which have been accepted by the Queensland Government, include:

> ***Recommendation No. 12***
> *Queensland Corrective Services should implement a dedicated case management system that begins assessing and preparing a prisoner for parole at the time of entry into custody and should consider utilising a model whereby a dedicated Assessment and Parole Unit is embedded in each correctional centre.*
>
> ***Recommendation No. 16***
> *Queensland Corrective Services should provide for continuity of case management for offenders returned to custody on parole suspension.*
>
> ***Recommendation No. 17***
> *Queensland Corrective Services should increase the number and diversity of rehabilitation programs, and training and education opportunities, available to prisoners in custody, including short term programs.*
>
> ***Recommendation No. 19***
> *To provide equitable access to rehabilitation for prisoners and offenders, including short term prisoners, Queensland Corrective Services should develop and increase rehabilitation program delivery in partnership with non-governmental service providers.*

---

[55] At page 2.
[56] Queensland Parole System Review Final Report, November 2016, page 16.

Recommendation No. 20
As a significant component of end-to-end case management, Queensland Corrective Services should increase the delivery of accredited programs to offenders supervised by the Probation and Parole Service, particularly in light of the issues associated with delivering programs in custody.

Recommendation No. 21
Queensland Corrective Services should have all rehabilitation programs that it offers evaluated to ensure that they are effective in reducing reoffending as intended.

Recommendation No. 24
In response to the increased demand for mental health services, in line with the significant increases in prisoner and offender numbers across the State, the Queensland Government should review the resourcing of prison and community forensic mental health services.

Recommendation No. 26
Queensland Corrective Services and Queensland Health should jointly develop a plan for the administration of a screening assessment for all prisoners on admission to prioritise substance misuse rehabilitation, especially for those prisoners with short sentences.

Recommendation No. 27
Queensland Corrective Services should increase delivery and should develop new rehabilitation programs specifically designed for Aboriginal and Torres Strait Islander people, by Aboriginal and Torres Strait Islander people.

Recommendation No. 28
Queensland Corrective Services should provide substance misuse rehabilitation to all prisoners and offenders as required in accordance with their assessed risk and need.

Recommendation No. 29
Queensland Corrective Services should increase the number of high intensity substance misuse programs available to prisoners.

Recommendation No. 32
The Government should undertake a short-term evaluation of Queensland Corrective Services redesigned re-entry service after 12 months of implementation, with a further review prior to the contract renewal period.

Recommendation No. 33
Queensland Corrective Services should expand its re-entry services to ensure that all prisoners have access to the services, including specialty services to assist remandees and short sentenced prisoners.

Recommendation No. 34
An intergovernmental taskforce, with representation from the Department of Housing and Public Works, Queensland Corrective Services and the Department of Premier and Cabinet, should be established to examine the issue of the availability of suitable long-term accommodation for prisoners and parolees.

The observations regime at the Toowoomba watch house and the communication of information to the Brisbane Correctional Centre

190. The evidence from the police officers who worked at the Toowoomba watch house from 5-7 November 2014 and from Ms Morse indicated that the primary concern with respect to Mr Malone during his detention at the watch house related to alcohol withdrawal symptoms, rather than an assessment that he was at immediate risk of suicide. However, he was appropriately placed under a 30 minute observations regime after he self-identified that he had previously attempted to take his own life.

191. I accept Ms Morse's evidence that she was concerned that the watch house was unable to provide adequate medical supervision in relation to Mr Malone's withdrawal from alcohol, and that his transfer to prison should not have escalated his risk of suicide.

192. The QPS Operational Procedures Manual requires QPS officers transferring a prisoner to ensure that they advise the receiving custodian of any pertinent matter. The OPM specifically refers to suicidal tendencies as a pertinent matter. I am satisfied that the QPS officers met this obligation by recording the relevant information in the documentation forwarded to the BCC with Mr Malone.

193. It is concerning that QCS officers did not refer to all of the information that accompanied Mr Malone from the Toowoomba watch house, including the fact that he had been on 30 minute observations. However, I accept that there have been steps taken since Mr Malone's death to improve lines of communication between watch houses and QCS staff, as outlined in the evidence of Inspector Cryer.

Provision of razors to prisoners

194. Given the circumstances of Mr Malone's death, the availability of razor blades to prisoners in custody was examined at the inquest. This issue was investigated jointly with the inquest into the death of Mr Garry Ronald Appleton.

195. Mr Malone was provided with two disposable razors as part of his amenities pack on admission to BCC.[57] A document was tendered at the inquest entitled 'Amenities Pack Contents' which lists all of the amenities a prisoner is to receive upon admission to a QCS correctional centre. Those items are listed in that document as follows:

- *1 comb;*
- *1 cake of soap;*
- *2 disposable razors;*

- *1 tube of toothpaste;*
- *1 toothbrush;*
- *1 bottle of shampoo.*[58]

196. The document goes on to state that male prisoners are to receive an additional 2 disposable razors and shaving soap.

197. In the 2013 inquest into the death in custody of Lawrence McCarty before State Coroner Barnes, Counsel for QCS explained that providing disposable razors and toothbrushes to all prisoners in the mainstream population commenced in 2010 to assist in the prevention of the spread of communicable diseases (presumably from sharing razors).

198. Counsel for QCS also submitted that the dismantling of razors had been identified as a risk and steps were in place to manage this risk. Mr McCarty's death occurred at the Arthur Gorrie Correctional Centre, a privately run correctional facility. In the circumstances, the State Coroner did not consider that he had sufficient evidence to take the matter further in terms of recommendations.

199. In this inquest I was provided with a statement from Mr Peter Shaddock, General Manager, Operational Service Delivery, State Wide Operations, QCS.[59] Mr Shaddock confirmed that there are no policy documents on the specific topic of razor blades being made available to prisoners. He confirmed that approximately 46.2% of the managed prisoner population (as at 7 November 2014) had an Elevated Base-Line Risk, meaning there was some awareness of self-disclosed self-harming or suicide ideation/behaviour in the prisoner's history, either immediate, recent or long term.

200. Mr Shaddock confirmed there was a review being conducted of the broad 'At Risk Management' topic. A Suicide Prevention Working Group had been formed to analyse and consider a range of current practices to align with contemporary research. However, Mr Shaddock confirmed the broad use of razors is not part of the consideration of the working group. He said that this was due to fact that razor blades are very rarely used by prisoners as a means to commit suicide. In his statement, Mr Shaddock provided some statistics which support this statement.[60]

[58] Exhibit C2.
[59] Exhibits B29 – B29.5.
[60] Exhibit B29, paragraph 10.

201. Mr Shaddock also provided a copy of the ‘At Risk Management’ practice directive.[61] He confirmed that if a prisoner is being managed under an observations regime for ‘at risk’ concerns, depending on the level of concern, the prisoner may have no or very limited access to property at his or her disposal. He confirmed that under these types of observation regimes, a prisoner’s access to property is carefully supervised and monitored. Mr Shaddock provided pictures of items contained within a modified amenities pack, which is provided to prisoners who are accommodated in the High Dependency Unit due to being identified as an ‘at-risk’ prisoner. That pack does not contain a razor.

202. Mr Shaddock explained that the default QCS position is that prisoners are treated under normal regimes unless otherwise noted (e.g. if there are no indicators of self-harm that may warrant the raising of a notice of concern). He explained that this default position is a deliberate and accepted practice of normalising the correctional environment to the extent possible as part of the rehabilitation of each prisoner.[62]

203. Mr Shaddock accepted in his evidence that some prisoners are prolific self-harmers, and access by those prisoners to razor blades or sharps in general population to enable self-harm does present as a complex challenge for Corrective Services Officers. These Officers are limited in the ways in which they are able to conduct personal searches. Mr Shaddock explained the variety of ways in which prisoners have, in the past, been able to hide these items, including internal secretion and within existing open wounds or pockets of scalp skin.[63]

204. Mr Shaddock confirmed that there has been no viable alternative put forward to QCS regarding the need for disposable razors to fulfil the personal grooming needs of prisoners.[64] Mr Shaddock was not confident that withholding razors from prisoners during, for example, the first week of incarceration would be a viable option and considered that the procedure in place for the management of at risk prisoners was robust.

205. It was submitted on behalf of Mr Malone’s family that razor blades should only be provided to prisoners if there was no viable alternative, and that razors are provided to prisoners because it is easier than doing anything else. It was also disputed that the risk to prisoners in possessing razors could be adequately managed under the “At risk management” practice directive. Mr Malone’s family submitted that disposable razors should not be issued to prisoners within the first month of incarceration, during which time their shaving needs could be managed by other means such as electric razor use. Alternatively, this policy could apply to prisoners identified with a history of self-harm, or of assaulting other prisoners or corrective services officers.

[61] Exhibit B29.1.
[62] Exhibit B29, paragraph 16.
[63] Exhibit B29, paragraph 18.
[64] T7, p60

206. Research published by the Australian Institute of Criminology has demonstrated that prison suicide risk is highest early in the period of incarceration. For example, in South Australia, 26 percent of suicides were found to occur in the first week of custody and 39 percent in the first month.[65] AIC data show the first one to three months of imprisonment are a time of heightened risk of, and vulnerability to, self-inflicted death. Of the 233 self-inflicted deaths occurring between 1999 and 2013 where time in custody was recorded, 117 (50.2%) occurred during the first three months of imprisonment. This included 68 deaths (29.2% of all self-inflicted deaths) that occurred during the first month of imprisonment.

207. In addition to the introduction of universal screening for suicide risk on entry to prison, successive governments have spent many millions of dollars in removing access to means used for suicide in prisons, such as hanging points in cells. It seems contradictory in that context that almost all prisoners are provided with a means to take their own life on entry to prison. While I acknowledge that the default position should be that prisoners have access to as normal an environment as possible, I do not accept that the current policy should be regarded as sound because, as the family submitted, it is easier than doing anything else.

Conclusions

208. Mr Malone died by his own actions in cutting himself with a prison-issued razor blade with intent to end his life. I am satisfied that he was locked alone in his cell at the time and no other persons were involved in his death.

209. Mr Malone's death might have been prevented if he had been kept on an observations regime similar to that in place at the watch house in the days prior to his transfer to BCC. I accept that a referral to the PMHS would not have realistically made a difference to the outcome, given Mr Malone's death occurred only a day after his admission to BCC. This meant that there was unlikely to have been enough time for the referral process to have been completed.

210. Mr Malone's death might have also been prevented if his known mental health history and history of self-harm had prompted the withholding of a prison issued razor blade. As noted above, prisoners are most at risk of taking their own lives during the initial stages of incarceration. Mr Malone's level of distress on being returned to prison was not accurately identified or responded to after his initial risk assessment.

[65] Self-inflicted deaths in Australian prisons, Australian Institute of Criminology 2016.

211. I do not consider the fact that Mr Malone had recently been assessed at the Toowoomba Hospital as being at low risk of suicide was a factor that minimised his risk in prison. It has been identified that 25% of people who were suspected to have died from suicide in Queensland in the first half of 2015 had contact with a Queensland Health Service in the seven days before their death,[66] indicating that there is an ongoing risk of suicide after a period of crisis. There is a need for the enhanced approaches to responding to suicide risk that have been identified and are being applied in community settings to be translated to the correctional environment.

Findings required by s45

212. 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. After considering all of the evidence, including material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – The deceased person was Terrence Michael Malone.

How he died - Mr Malone had a lengthy history of mental illness and alcohol dependency. He died as a result of cutting himself with a prison-issued razor blade in his cell while he was an inmate at the Brisbane Correctional Centre. Mr Malone left a note indicating his intention to end his own life. Mr Malone had been assessed as being at low risk of suicide on entry to the prison on 7 November 2014 and was not placed on any observations regime.

Place of death – Brisbane Correctional Centre, Wacol in the State of Queensland.

Date of death – 8 November 2014.

Cause of death – Mr Malone died from an incised wound to the neck.

[66] Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023, p11

Comments and recommendations

213. Section 46 of the *Coroners Act*, as far 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. The submissions of those granted leave to appear have canvassed a wide range of possible comments and recommendations under s 46.

214. I acknowledge that since Mr Malone's death in 2014 there have been significant reforms in a number of areas that fall within the ambit of section 46 and are relevant to Mr Malone's circumstances. Any recommendations that I make need to be cognisant of those developments. These include the reforms to the parole system, and amendments to the Emergency Examination Authority process under the *Public Health Act 2005* to specifically include risk of serious harm to a person caused by intoxication, enabling a person to be detained for treatment or care.

215. The Drug and Alcohol Court started in Brisbane in January 2018. This court treats offenders with a severe substance use disorder that contributed to their offending. Offenders are required to undertake treatment to address their drug or alcohol dependency issues and criminal offending. An expansion of this court to regional areas is unlikely before 2023, when the court will have been evaluated. Such a court would clearly have benefited Mr Malone.

216. An Offender Health Services Review was completed in late 2018. The OHSR Report found that the efforts of health staff have been "hampered by a lack of leadership which has meant that many system-wide challenges such as overcrowding, insufficient clinic space and differences in operational requirements between Queensland Corrective Services and the Department of Health are not being adequately addressed." The Report identified that the prison population's health care needs have not been well met and that there has been a loss of focus on quality and patient-centred care. Queensland Health has accepted or supported all the Report's recommendations, and is establishing an Office for Prisoner Health and Wellbeing.

217. There are also significant efforts being undertaken to improve services in relation to suicide, alcohol dependency and mental illness in the context of *Connecting care to recovery 2016–2021: a plan for Queensland's State-funded mental health, alcohol and other drug services* and *Shifting Minds-the Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*. Priorities under the Strategic Plan include:

    - the development of service responses and capacity to ensure people and families receive appropriate and timely assessment, care and support following an episode of self-harm, attempted suicide, or heightened risk; and

- expanding responses to people involved in the criminal justice system through better coordination across mental health, AOD, justice, housing, disability, employment and psychosocial supports.

218. The Queensland Mental Health Commission is also overseeing the development of a whole-of-government Suicide Prevention Action Plan. The Plan is expected to identify key priority groups, with the framework expected to feature action focus areas of: Individual and Service System; Population; and System. The Suicide Prevention Action Plan is expected to be released in 2019.

219. A common issue arising in Mr Malone and Mr Appleton's circumstances was the inadequate communication of their recent mental health history to the assessing mental health practitioners at the Brisbane Correctional Centre. Counsel assisting submitted that all practicable attempts to ensure that all relevant information is passed on to those assessing incoming prisoners at correctional centres would assist in the completion of those assessments.

220. Counsel assisting also submitted that QCS procedures be reviewed to ensure that all relevant information is provided to the persons who undertake initial medical, and mental health, assessments of incoming prisoners.

221. A number of the recommendations submitted on behalf of Mr Malone's family were also related to information sharing between police, health and correctional officers. The family submitted that access to CIMHA be given to all medical staff in Queensland Hospitals and staff undertaking risk assessments within prisons. The family also submitted that there should be changes to probation and parole processes, and processes within hospitals where person with co-existing mental health and alcohol dependency issues are being assessed for admission.

222. Information sharing between QCS and Queensland Health regularly arises as an issue in inquests relating to deaths in custody. In the May 2018 findings into the death of Franky Houdini I recommended that Queensland Health and Queensland Corrective Services *"consider whether amendments are required to legislation to supplement the release of information (including documents) under the MOU on confidential information disclosure to optimise the health care provided to persons in custody; and protect health practitioners from liability when sharing prisoner health information appropriately"*. I note that recommendation is still under consideration.

223. It was submitted on behalf of QCS that I make recommendations specifically in relation to IOMS enhancements, the recruitment and retention of psychologists in prisons, and the trial of a collaborative and multidisciplinary approach to intake, health assessment and mental health assessment at the Brisbane watch house. Recommendation 6 below seeks to address issues relating to the transfer of documents, handover and access to information through a collaborative assessment process at the point of entry to custody.

224. I make the following recommendations.

Recommendations

1. *I recommend that Queensland Corrective Services develops a policy in relation to the management of the risks associated with the provision of razor blades to prisoners within the first month of entry to prison, particularly where a prisoner has recently expressed suicidal ideation or has recently been discharged from a hospital emergency department following an Emergency Examination Authority.*

2. *I recommend that Queensland Corrective Services, in partnership with Queensland Health, reviews its approach to suicide risk assessment and assertive responses to suicide risk in the context of best practice approaches.*

3. *I recommend that these findings be provided to the Queensland Mental Health Commission and the Strategic Leadership Group overseeing the implementation of the Mental Health, Alcohol and Other Drugs Strategic Plan with a view to informing the enhancement of responses to persons with co-occurring mental illness and substance use disorders who are at risk of entering or have entered the criminal justice system.*

4. *I recommend that the Queensland Government considers an increase in funding to enable QCS to enhance the IOMS system to support the recommendations of the Office of the Chief Inspector to enable risk assessment information to be displayed and accessible for QCS staff within a drop down menu.*

5. *I recommend that the Queensland Government consider an increase in funding to enable QCS to be a competitive employer to attract and retain experienced psychologists and senior psychologists within custodial settings.*

6. *I recommend that the Queensland Government consider a trial program for "Front End Services" of intake, health assessment and mental health assessment at the Brisbane City watch house that involves collaboration between relevant stakeholders, including Queensland Corrective Services, Queensland Health, the Queensland Police Service and the Prison Mental Health Service.*

225. I close the inquest.

Terry Ryan
State Coroner
Brisbane
8 May 2019