TRANSCRIPT OF PROCEEDINGS

CORONER'S COURT

TONKIN, Coroner

No COR 76 of 2002

IN THE MATTER OF AN INQUEST INTO THE
CAUSE AND CIRCUMSTANCES SURROUNDING
THE DEATH OF JODIE MAREE DAVIS

TOWNSVILLE

..DATE 16/05/2007

FINDINGS

CORONER: Jodie Maree Davis was found hanging in her cell in the women's secure unit at the Townsville Correctional Centre at 6.35 p.m. on the 30th of May 2002. Her life was pronounced extinct at 10.45 a.m. on the 1st of June 2002 at the intensive care unit at Townsville Hospital.

Today as Coroner, under the Coroners Act 1958 I deliver findings I am required to make by law. As a rider to those findings, I will make recommendations designed to prevent the recurrence of similar occurrences. I acknowledge that Jodie died almost five years ago. Her family has, no doubt, suffered significantly by virtue of the long time it has taken for findings to be delivered so they can have some closure. I acknowledge their grief.

There have been numerous investigations into Jodie's death. This coronial inquiry is the culmination of those investigations. I have had the benefit of evidence obtained in the course of those investigations and I will go through those investigations in turn.

On the 30th of May 2007 correctional officers on duty were each required to write a short report to the General Manager before going off-duty. Memoranda from, most relevantly, correctional officers Hopkins and Negus were Exhibits 33 and 34 respectively.

A post-mortem examination was conducted by Professor David Williams on 3 June 2002. The post-mortem examination

conclusion was the cause of death was hypoxic brain damage due to hanging. No suspicious circumstances were found and the toxicology revealed there were no drugs involved in Jodie's death.

On the 1st of June 2002 Detective Sergeant Phil Nataro of the Corrective Services Investigation Unit commenced the investigation by the Corrective Services investigation Unit which then formed the police report to the Coroner, as a result of which an inquest was held. That inquest was opened on 21 April 2004. Detective Sergeant Nataro took detailed statements from witnesses who included prisoners in the womens secure unit, correctional officers who were associated with Jodie, nursing staff from the prison, two psychologists and other associated mental health and welfare professionals, hospital medical staff, ambulance officers, and police officers who took control of the cell from prison staff and secured exhibits and photographed the scene. A statement was also taken by Detective Sergeant Nataro from the forensic pathologist, Professor Williams who conducted the post-mortem examination.

The detective sergeant also gathered relevant documentary exhibits including photographs of the unit, photographs of the body of Jodie and lists of property, call activity reports, a running log, a handwritten statement of a fellow prisoner, a report under section 219 of the Corrective Services Act, Jodie's criminal history, plans of the prison, details of inmates at the time, Queensland Ambulance service record, and

the life extinct certificate. No evidence of foul play was found by Detective Sergeant Nataro at the conclusion of that investigation.

On the 14th of June 2002 an operational debrief was held at the Townsville Correctional Centre at which all staff in the incident attended. All staff were invited to orally contribute. The purpose of the debrief was to reflect on what had been done well, what had not been done well, and what could be done better in the future. It was minuted that the response from staff was appropriate and some minor recommendations were made.

On 18 June 2002 John Garland and David James Haynes were appointed inspectors under section 219 of the Corrective Services Act by the Ethical Standards Unit to investigate and report on the death of Jodie Maree Davis. They had available to them files and documents held by Detective Sergeant Nataro from the Corrective Services Investigation Unit and they interviewed about 12 staff, including the General Manager, two psychologists, two counsellors and three correctional officers.

They produced a short report, which was Exhibit 16, addressing most of the matters set out in the Instrument of Appointment and Terms of Reference but, curiously, they did not address the matter which was F in the terms of reference; what action has been taken by the centre to identify and respond to issues identified in internal reviews/debriefs of this incident?

There were no documents attached to the report, despite the fact the report indicated there were, so it was not entirely clear how comprehensive the information was that they considered.

The sixth investigation was on the 13th of December 2002 when Chris Watters, the director of the Ethical Standards Unit reported to the General Manager, Martin Grandalous, his conclusions from inquiries he had made about allegations by correctional officer Melissa Hopkins that the oxygen bottle from the oxi-viva resuscitation unit used by the nursing staff in the resuscitation of Jodie was empty and that the nurses were therefore unable to deliver oxygen to her during the resuscitation. Now, this was not corroborated by other staff contacted and was denied by nursing staff and, accordingly dismissed.

It is appropriate to explain in detail why this inquest has taken so long. It was opened, as I have already noted, on 21st of April 2004. The statements and documents prepared by Detective Sergeant Nataro were tendered at that time and were admitted into evidence. An invitation was offered at that time for persons interested to request that witnesses be present to answer questions. That opportunity was not taken up by any person interested and so I heard a submission on behalf of the then Department of Corrective Services on the 27th of July 2004 and the matter was adjourned to the 18th of August 2004 to consider and then deliver my findings.

During that short period, Melissa Hopkins, a correctional officer on duty when Jodie died, advised the Coroner she had further evidence which was not contained in her statement to Nataro that she wished to tell the Coroner at the inquest. Due to the fact that the death was being investigated by police from Corrective Services Investigation Unit base in Brisbane, it was some time before statements from Hopkins and a number of other witnesses could be obtained. Mr Middleton, of counsel, was then engaged to assist the Coroner and he identified considerable additional evidence that should be before the inquest. These matters all take time and it was necessary during the inquest to adjourn from time to time to allow for additional evidence to be obtained and to wait for transcripts of evidence.

I note that the nurses Openshaw and O'Reilly were represented by Mr Gavin Rebetzke, solicitor; and the Department of Corrective Services, as it then was, was represented by Mr Fellows of counsel. I acknowledge the assistance given to this inquest, particularly by Detective Sergeant Nataro, who gave the Coroner considerable assistance at short notice.

I have heard oral evidence from many witnesses from the 24th to 28th of July 2006 and on 15 November 2006. Some witnesses gave several statements. An inquest is a fact finding exercise and is not a method of apportioning guilt. The procedure and rules of evidence suitable for a criminal trial are not suitable for an inquest. In an inquest there are no parties, there is no charge, there is no prosecution, there is

no defence and there is no trial. An inquest is simply an attempt to establish facts. It is an inquisitorial process. The process of investigation. No-one has a right to be heard. Nevertheless, the rules of natural justice and procedural fairness are applicable and an application of those rules will depend on the particular circumstances of the case in question.

In making my findings I am not permitted under the Act to express any opinion on any matter which is outside the scope of this inquest except in the form of a rider or recommendation. The findings I make are not to be framed in any way which may determine or influence any question or issue of liability in any other place or which might suggest that any person should be found guilty or otherwise in any other proceedings.

Objection was taken by Mr Rebetzke on behalf of the two nurses who attempted to resuscitate Jodie at the Townsville Correctional Centre to the admission of opinion evidence by correctional officers Negus and Hopkins. They were critical of procedures adopted by the nurses and of the competence of the nurses and, in particular, I refer to the statement of Melissa Jane Hopkins of 3 September 2004 and the statement of Linda Negus of 25 June 2005. They alleged, amongst other things, that the oxygen tank accompanying the oxi-viva resuscitation unit was empty, that the nurses failed to hyperextend Jodie's neck prior to the administration of oxygen, that they were not getting any air into the lungs,

that the oxi-viva mask was used upside down, and that the nurses were unsure of procedures and unfamiliar with the equipment and incompetent.

Hopkins further alleged she thought the defibrillator wasn't working and that the nurses were negligent and may have hampered any chance of recovery of Davis. Negus' view was that Jodie should never have been in prison due to her condition, that was expressed in that later statement she made.

I have considered the submissions in relation to this evidence and I propose to admit the evidence on the basis that it explains the background to the extension of the inquest after August 2004. I have heard extensive evidence from other witnesses in relation to these specific issues. Both the nurses have had the opportunity to answer the allegations. An ambulance officer, Harris, corroborated the allegation that the mask was on upside down. Negus and Hopkins were cross-examined in relation to their allegations and recollections in great detail. It did emerge their recollections were, in some respects, incorrect and that in light of expert evidence, received particularly from Dr Peter Lavicombe, intensive care specialist, that their opinions were also incorrect. Indeed, neither was qualified to express expert opinion about the correctness or otherwise of the procedure used by the nurses.

I accept and consider, however, that the allegations were made

by Hopkins in good faith and out of concern for the welfare of the deceased. However, she was an ex-police officer and did not mention these serious allegations to Detective Sergeant Nataro on 2 June 2002 when he took her statement. Nor did she raise them in the memo she wrote for the General Manager on the 30th of May 2002.

In various forms and not comprehensively, the allegations became common knowledge and neither were the allegations that became common knowledge accurately represented. That was within the prison community they became common knowledge, including amongst management. I accept that subsequently Hopkins was dissuaded from raising them. Her failure, however, to document these issues, at least on 2 June 2002 to Detective Sergeant Nataro, is the primary reason this inquest was not able to proceed more efficiently or speedily earlier. It is disappointing she allowed her personal response to cause this result. Perhaps it is indicative, however, of the trauma experienced by people directly associated with a suicide, which was acknowledged by many of the people who gave evidence during the inquest.

The purpose of an inquest is to establish, firstly, the fact a person has died; secondly, the identity of the deceased person; thirdly, where, when and how the death occurred and; fourthly, whether any person should be charged with any of those offences referred to in section 24 of the Act which includes murder, manslaughter, dangerous driving causing death and assisting suicide.

I will now detail the events leading to Jodie's death which emerge from the evidence I have heard and received. Jodie was born on 5 April 1977 and was aged 24 when she died. We know very little about or relatively little about her life. Her family declined to be interview for the purpose of the inquest.

The Townsville Hospital file, which is Exhibit 41, contains some historical information and I have extracted some relevant entries. In December 1992 she attempted to hang herself. She reported having been kicked out of home in December 1992 in Sydney. At age 15 on 7 February 1993 she attended outpatients at the Townsville Hospital having cut her wrists. She was living in a womens shelter and attending Pimlico High School. Her long term suicide risk was assessed as high. She was uncooperative.

On 8 February 1993, the next day, she attended casualty again having ingested 40 Panadol. She was again uncooperative with the staff and she was expressing the wish to be dead. It was noted she made poor eye contact and minimal verbal response. On 9 February 1993 the psychiatrist diagnosed her as suffering from oppositional defiant disorder and evolving borderline personality disorder.

On 4 February 1994 she was involved in a fight and attended the hospital seeking a check up. In 1999 she was diagnosed as suffering from gall stones.

On 5 January 1995 she gave birth to a son named Freedom in the Townsville Hospital. She declined all assistance and information from staff and was noted as refusing to speak and avoiding eye contact. She was living in youth supported accommodation. She was described as unhappy but loving towards the baby. She was angry and bored and anxious to leave the hospital.

Her recorded interaction with the criminal justice system started in 1993 in the Cairns Childrens Court with street offences and clashes with police involving damage to property and alcohol. On 21 February 2002 she was convicted by a jury in the District Court at Townsville of the offence of grievous bodily harm. She was sentenced to three years' imprisonment and no recommendation was made for early parole. She had knifed the father of her child in the back. It appears that Jodie was affected by alcohol at the time. Her account of the circumstances of the attack was not believed.

On admission to the watch-house that day she attempted to hang herself and was admitted to Townsville Hospital. She denied any suicidal intent but then admitted she wanted to kill herself because she was sentenced to three years' imprisonment. Again, she made minimal eye contact and was avoidant of questions and demonstrated a hostile manner. She was very upset about her separation from her son who would be living with her sister. She felt unfairly accused and felt the complainant greatly exaggerated the impact of the attack.

By way of follow up at Stuart Prison, the hospital recommended four sessions of counselling.

The records show she was perceived as an ongoing potential risk in the short term which should settle once routine or familiarity with prison lessens her anxiety. She was admitted straight to the crisis support unit at the Townsville Correctional Centre where she stayed for her first 24 days in custody. This was followed by no less than four episodes of either self-mutilation or attempted suicide involving attempted strangling, cutting her wrists and this was accelerating in frequency in May 2002. She was also involved with some conflicts with other inmates.

She had had regular weekly contact visits with her mother and father and sister, or a combination of those family members, and with a friend, Jennifer Hanke, from 2 March 2002 to 25 May 2002. An arrangement was then made for her to have her first contact with her son, Freedom on the afternoon of the 30th of May 2002. She became engaged in a cognitive skills program which I understand was run by the psychologists at the prison, and she did some craft work. She made a pot which was in described, "Love ya RIP" with three crosses and that was completed on 24 May 2007, six days before she died.

She confided in other prisoners and some staff, including some psychology staff, of her feelings at being separated from her son for so long. She was fearful he would have forgotten her by the time of her release and that he didn't need her any more. The impending visit by her son was noted to have brought up feelings of fear, loss, anger and helplessness by the psychologist. It was recognised the visit might place her as risk so she was assessed before the visit on 30 May 2002.

A Notification of Concern in accordance with Corrective Services policy had been completed on that day by correctional officer Sandra Chapman and Jodie was assessed as a result of

that by Justine Doherty, a psychologist, at 3.30 p.m. and the entry records, "Nil risk." Ms Doherty assessed her as being slightly improved compared with earlier assessment. She was showing emotion and she was talking about the future.

She had written a letter to a person named Jennifer dated May 2002 and a copy of this letter is contained within Exhibit 31, evidencing her wish to end her life and telling Jennifer, who appears to have been in a close relationship with her that:

> "It is time you got on with your life and enjoyed yourself and found somebody else. Leave me in the past. Well, if I am still alive and don't hear back from you I will know that you have decided to walk away."

Other aspects of the letter evidence her lack of will to continue her life and her despair. It appears that other personal letters were found in her cell after she died but these were destroyed as they were not thought to be relevant.

After the visit with Freedom, Justine Doherty, the psychologist, had planned to have a further consultation with her, however Jodie avoided any further interview with Justine Doherty.

Around about the 30th of May, Jodie had been in some conflict with her cell mate involving a breach of confidence. Before correctional officer Sandra Chapman, who had put in the Notification of Concern, went off-duty she told other officers

she was concerned that Jodie might self-harm after the visit with her son, given her history, and the other officers she spoke to about this included Hopkins, and Alita Mast, the supervisor. She specifically asked Hopkins to keep an eye on Jodie that night. The then prisoner Janine Steel saw Jodie about 5.30 p.m. and was the last person to see her alive through the window of her cell door at 6.10 p.m. on 30 May. Jodie was discovered by another prisoner at 6.35 p.m. hanging by a sheet from bars covering the louvres in the shower cubicle in her cell. A plastic chair had been used by her and kicked aside.

Correctional officer Melissa Hopkins cut her down using her Swiss pocket knife as the cut down knife was not readily accessible. Jodie had no pulse at that time. Hopkins immediately commenced CPR and expired air resuscitation until the nurses Openshaw and O'Reilly arrived with the oxi-viva equipment and took over the airway. Ambulance officers arrived at 18.54 and took over from the nurses while Hopkins continued the CPR. A pulse was restored and she was taken to hospital at 19.16 by ambulance. She was unable to be revived and her life support was switched off in consultation with her family and life pronounced extinct at 10.45 A.M. on 1 June 2002.

In my view, on the basis of the evidence two major issues arise for my consideration. Firstly, whether the resuscitation administered by prison staff was adequate or, put another way, whether the nurses Openshaw and O'Reilly, or

indeed Hopkins as well for that matter, caused or contributed to the failure to revive the deceased; and secondly, whether the successful suicide by the prisoner could have been prevented or, put another way, were the psychological and psychiatric services provided to her and procedures adopted for her management adequate.

I turn firstly to the resuscitation. As I have already said, correctional officer Hopkins alleged that nurses Openshaw and O'Reilly were incompetent in their management of the airway of Davis. They were responsible for ensuring that the oxygen tank for the oxi-viva was full. Correctional officer Hopkins said it was empty. The nurses sent for another tank during the resuscitation. I am satisfied that Hopkins was mistaken on this issue and that the allegation was unfounded. There was no evidence that the oxygen tank was empty.

Hopkins also initially alleged the defibrillator did not work. She subsequently acknowledged that if it detected a heart beat it did not shock. This was called an unshockable rhythm and that she was initially mistaken about this. She alleged that the nurses failed to hyperextend Davis' neck to ensure the airway was open before delivering oxygen and that because of this, and a further allegation that the oxygen mask used was upside down, they were not getting any air into the deceased's lungs.

Her insistence on the need for hyperextension of the neck as a precondition for delivery of oxygen was shown to be mistaken.

The expert evidence of Dr Lavicombe, supported by Queensland Ambulance staff, being that a jaw thrust and chin lift is sufficient. Indeed, Dr Lavicombe said that care should particularly be taken in hanging cases. I am satisfied that Hopkins' information in relation to this issue was out of date and not a basis to criticise the nurses.

Her allegation that the oxi-viva mask was being used upside down by nurse Openshaw, thus preventing a proper seal, was corroborated by Queensland Ambulance officer Harris who had a clear independent recollection of this. She described being able to hear evidence of the escape of air under the sides of the mask. This was denied by the nurses, each of who had previous experience of use of the oxi-viva equipment but neither of whom had used a defibrillator previously. Nor had they any experience of CPR in an emergency situation. Each had up to date certificates as to the currency of their training. Each flatly refused to accept the possibility that the mask was used upside down.

Given the independent evidence of Harris, taken with that of Hopkins, I accept that nurse Openshaw at least was using the oxygen face mask upside down. She had taken over the airway from O'Reilly when O'Reilly went to collect another oxygen tank in case it was needed. I accept Dr Lavicombe's evidence, however, that as the mask swivels on a flexible hose it may have swiveled around during that change over. The nurses deny they heard Hopkins say repeatedly, "You are not getting any air in.", but accept it is possible with all the noise going

on, including very upset prisoners in the background, they may not have heard.

Nurse Openshaw said that she thought that Hopkins was accusing her of putting the Guedels Airway in upside down. It did appear that from the evidence given by nurse Openshaw that she had a poor understanding of how the defibrillator worked.

I thank Mr Rebetzke for commissioning the evidence of Dr Lavicombe which was Exhibit 43. He gave evidence that it is feasible to obtain an adequate seal with the mask upside down. Even if this was not attained, and Harris' evidence was she could hear the escape of air, supports that it may not have been, then his evidence was that the in drawing of air due to the recoil of the chest between CPR compressions, where the air was 100 per cent oxygen, would ensure adequate gas entering the lungs. In response to the criticism that the absence of visible rise and fall of the chest during oxygenation was evidence that no air was getting into the lungs, he said:

> "During CPR due to the extent of the compression almost to residual capacity of the lungs, after release of the pressure the chest expands to normal resting position and a normal tidal volume will be inhaled during that process. This will not cause anywhere near the same movement as a tidal volume put into the chest from the functional residual capacity."

Having regard to the evidence of Professor Williams as to the hypoxic brain damage sustained and the read out from the automatic external defibrillator, supporting a severely hypoxic heart, Dr Lavicombe expressed the expert view that Jodie had been hypoxaemic for quite a significant number of minutes before the resuscitation started. He concluded there was evidence that the cardiopulmonary resuscitation was quite effective from the ease with which the drugs administered by the Queensland Ambulance officers managed to restart Jodie's heart.

A review by Dr Lavicombe of all the relevant evidence permits the conclusion without reservation that the damage done prior to commencement of resuscitation was irreversible and would lead, as it did, to Jodie's inevitable death.

Professor Williams' evidence was that restriction of the flow of blood to the brain for eight minutes was sufficient to cause hypoxic brain damage. The evidence was she had probably suffered a reflex cardiac arrest early on in the hanging.

I find that no person was at fault.

I turn now to the sufficiency of the services provided and the procedures in place to manage the case of a prisoner with known suicidal intention. I have already detailed Jodie's history prior to and following the 24th of February 2002 when she was sentenced. Clearly she was a suicide risk with a poor prognosis. Exhibit 18 contains the resumes of the two very

junior psychologists who had graduated in 2001 with the degrees of Bachelor of Psychology at JCU, Tegan Milton and Justine Doherty, as well as offender management procedures for the Department of Corrective Services in relation to the subjects of suicide prevention, initial receptions to custody and crisis support units with the implementation date of 1 July 2001.

Additionally, contained in Exhibit 18 is an action plan headed Review of At Risk Management for Townsville Correctional Centre forwarded from the Acting General Manager, Martin Grandalous to the managers and senior psychologist on 12 June 2002, a date I accept was coincidentally very soon after Jodie died. I accept that the procedures were under regular review. It is clear from these documents, particularly the action plan review of at risk management, that formal suicide prevention training was recognised as necessary for all psychologists.

Mr David Starkey was a senior psychologist at the time and he and James Haynes, at the time a psychologist at the Brisbane Womens Prison and co-author of the Workplace Investigations Australia section 219 report, gave evidence about the psychological services at the Townsville Correctional Centre in 2002.

There was no formal suicide prevention training. It was assumed by Dr Stones, the psychiatrist contracted by Queensland Health to the prison that the suicide risk assessment is a significant aspect of psychological training.

As at 30 May 2002, the date of Jodie's death, Justine Doherty had four months' experience as a psychologist and Tegan Milton had three months. Neither had any suicide prevention or assessment training. Starkey described Jodie to Haynes and Garland, when they were preparing their section 219 report, as "a very disturbed person" and said she should have been in a psychiatric ward given her long history of attempts to kill and harm herself.

His evidence was that the primary role of a psychologist in prisons is suicide prevention. James Haynes expressed the same view. Whilst Starkey had concurred with Doherty's assessment before the visit with Freedom on 30 May, that Jodie was not at risk of self-harm, he did make the distinction between being highly suicidal which Jodie had been for many years, and critically suicidal. It should be noted that Jodie was known to be noncompliant with medication.

The evidence was she was difficult to establish rapport with, both for correctional officers and for the staff providing psychological and psychiatric services. With staff she took a dislike to she either treated them with disdain and refused to engage or she reported feelings and symptoms completely at odds with those reported to staff she preferred. She persisted in wearing a cap and sunglasses and would turn her back. She clearly had contempt for Dr Stones. She would daily speak of ending her life and made it clear that no-one could stop her when she decided do so.

The only available option for suicide prevention was confinement in the Crisis Support Unit. This was not for treatment but to enable constant observation and monitoring. Admission was on the recommendation of a psychologist and release to the general prison population was on the recommendation of a psychiatrist. Upon release to the general prison population the patient would remain on observations, however standard operating procedures was two hourly and the psychologist had no power to increase the rate of observations.

Starkey expressed the view that for Jodie it would have been preferable to have observations more often, this is borne out by the fact of her death. The policy was to keep the prisoner in the least restrictive environment where they can be supported which is a laudable policy. Jodie hated the CSU so much that she negotiated with the psychologists to go to the detention unit instead on occasions. Starkey conceded to keep Jodie alive we would have completely trampled on her human rights. That is, she would have had to be kept permanently confined under 24 hour surveillance in the Crisis Support Unit.

He did, however, express frustration at the lack of access by psychologists at the prison to medical records and frustration at the fact despite his concerns for Jodie's safety in the general population, and at the same time the preferability of keeping her in the general population, he could do nothing about the fact she was in a cell with sheets, a hanging point

and a chair.

Mr James Haynes, the co-author of the workplace solutions report, is now a consulting forensic and clinical neuropsychologist in private practice and an adjunct assistant professor at Bond University. His evidence about the state of psychological services in the prison system was damning. Nursing staff appeared to have restricted access, like psychologists, to medical files of inmates. He considered it imperative that access be given. Suicide prevention training of psychologists was a very ad hoc matter and they were required to learn on the run. A number of staff were very junior. Staff were overworked and under resourced.

He spoke of the difficulty of recruiting and retaining staff, that is psychological staff, not only in regional areas such as Townsville but also in Metropolitan areas. He delivered training at Townsville in July 2002 but was unaware of any training done since then. His own policy when in the Department of Corrective Services located in Brisbane was to require suicide prevention training to be undertaken within the first 16 hours of a new psychologist coming on line in his team.

He did, however, concede the only way to guarantee prevention of a prisoner taking their own life would be by complete physical restraint, including with handcuffs. A prisoner could, he said, end their life lying in their own beds. On the issue of personal sedation and forced medication he did,

however, also give evidence from his own experience as the manager of the Crisis Support Unit at the Moreton Correctional Centre where he held that position, I understand, for some four years. The use of sedation to manage angry and aggressive prisoners was not a satisfactory solution but that it had its place, however with good professional intervention such difficult prisoners could be encouraged to be compliant with medication regimes.

He confirmed that policies and procedures are constantly upgraded when the Department of Corrective Services. His view was that those policies and procedures need to be in a state of almost constant review and of seeking input from the field on an ongoing basis to keep pace with change.

He confirmed what I have already noted which is that assessment of suicide and self-harm risk is the absolute most important task that any psychologist or counsellor will undertake during their role with the Department of Corrective Services or, as it is known now, Queensland Corrective Services.

In relation to the issue of retention of psychologists he identified the importance of the recognition of the professional role of psychologists. This would involve, he said, salary structure and improving salaries, providing ongoing professional development, including funding of attendance at work shops and conferences, and providing paid professional supervision inside working hours.

He commented that recognition of the profession and conditions for psychologists have worsened compared with the situation some 10 years ago. It is noteworthy that Dr Charles Stones, who was the Queensland Health contracted psychiatrist visiting the Townsville Correctional Centre twice a week at the time Jodie was there, assumed that suicide risk assessment training and prevention training was a part of the training of psychologists as a matter of course. He was unaware of the level of inexperience of some of the psychologists and their lack of any suicide risk assessment training.

He had not accessed previous medical records of Davis, even though it is apparent they were obtained by the Department of Corrective Services from the Townsville Hospital on 26 February 2002 and that they would have disclosed her long history of risk. It does seem, however, he was able to extract from her some history of her previous attempts.

His diagnosis, in light of the attempt on her life in the watch-house, was of adjustment disorder with depressed mood, consequent upon her imprisonment which he expected to settle and considered, given a calmer presentation on 15 May, that she had settled in. However, she remained aloof and largely uncooperative, he noted at that stage.

In hindsight, his evidence was that his view was she had already decided on the 15th or by the 15th of May to end her life and in light of this he said that he would have liked to

ensure more strongly that she took the appropriate medication when he was asked what he would have done differently, in hindsight. He accepted that all of the evidence pointed to her being very much at risk of taking her own life. His evidence was that he was unaware that in her cell she had a chair and that an obvious hanging point presented itself in the form of bars across the louvres.

Dr Stone's evidence was, not surprisingly, that continual confinement in the CSU was not the answer and his evidence was that establishing of rapport, possibly via more frequent and more sympathetic counselling, might have enabled that to develop to allow professional staff an insight into what Jodie was thinking.

Whilst the services offered to Jodie left considerable room for improvement in the form of proper training and resourcing of the psychological staff, including the engagement of more experienced staff to try to establish a better rapport, there is no guarantee such improvements would have prevented Jodie from taking her own life. She had a long history of self harm and a poor prognosis dating from 1993. She was a particularly challenging patient and it's quite possible only 24 hour surveillance in the Crisis Support Unit would have prevented her death. That was not a realistic option as it would have, as David Starkey put it, completely trampled her human rights.

I am provided with evidence that in May 2006 the only deaths in Queensland prisons were two by natural causes, that is no

suicides or other unnatural deaths. However, as at 27 July 2006 there was still no formal psychologists retention strategy in the Department of Corrective Services.

I turn now to my formal findings which are as follows: firstly, that the deceased person was Jodie Maree Davis. Secondly, that she died on the 1st day of June 2002 at 10.45 a.m. at the Townsville general hospital. Thirdly, that the cause of death established by post-mortem examination was 1A, hypoxic brain damage due to; 1B cardiac arrest due to; 1C hanging. I am satisfied that she caused her own death intentionally by hanging in the Townsville Correctional Centre and that no other person was involved in causing her death.

This Court has jurisdiction in appropriate cases to commit for trial any persons which the evidence shows may be charged with the offences mention in the section 24 of the Act. On the evidence that has been placed before this Court, I am satisfied, and so further find and determine, that the evidence is not sufficient to put any person or persons upon any trial. Therefore no person will be committed for trial.

Pursuant to section 43 of the Act I make the following recommendations by way of rider to the formal findings:

That all medical files, including previous hospital files, be made accessible to the prison psychology staff and copies be able to be kept with the files maintained by the prison psychologists for ease of ongoing reference.

That sentencing remarks and copies of any reports tendered on sentence be made available to prison psychological staff to be kept on their files.

That the senior psychologist be consulted in relation to review of operational procedures at the prison especially in relation to reception/admission, CSU, suicide prevention and like matters.

With standard operating procedures, incorporate provision for observation of a prisoner in a general population to be increased to more often than two hours on the recommendation of a psychologist and that staff levels be adapted to enable this.

That within 24 hours of employment, psychologists without recent suicide prevention training receive suicide prevention training that be repeated at regular intervals.

That incentives at least on a par with those offered to such professionals in the public sector, be devised to attract and retain experienced psychological professionals at the prison and steps be taken to increase job satisfaction for such professionals, including adoption of salary structure recommended by the Australian Psychological Society or equivalent professional body; salaries and conditions of psychologists employed by Queensland Corrective Services be at least the same level as those paid to other psychologists in

the public sector in Queensland.

Professional supervision be routinely funded and undertaken during paid working hours. Attendance at work shops and conferences be funded on a regular basis.

Further, that the essential professional role of psychologists in suicide prevention be formally recognised by prison management and communicated to correctional officers and medical and health staff.

That a protocol be developed with Queensland Ambulance so that where Queensland Ambulance has attended or Queensland Ambulance officers have attended an emergency at the prison, the officers attending be invited to give feedback about issues that might have come to their attention to assist in improving the emergency response of prison staff. If relevant issues are identified by Queensland Ambulance staff, in an internal Queensland Ambulance debriefing, they be fed back to the relevant administration, for example, the General Manager of Townsville Correctional Centre.

That in the case of prisoners assessed as being at risk of self-harm contact by counselling professionals be made with next of kin and regular visitors to gain insight into issues of concern and assist with management and development of rapport with the prisoner.

That nursing staff at correctional centres be provided with

the opportunity to shadow emergency workers, for example at hospital emergency departments or ambulance officers, to gain experience in actual emergency situations.

That correctional officers with first aid training be given the opportunity to regularly update their skills and be funded for this purpose.

That obvious hanging points, including bars, be immediately retro fitted with alternative security, for example, mesh, to reduce obvious opportunities for hanging.

I note in conclusion that section 21 of the Corrective Services Act 2006 now compels a prisoner to submit to medical examination or treatment by a doctor if the doctor considers the prisoner requires medical attention. This appears now to provide the power to mandate the taking of medication which was a significant issue in the management of Jodie Davis.

In closing I thank Mr Laurie Middleton for his assistance as counsel assisting the Coroner. I thank Mr Michael Fellows for his assistance during the inquest and I thank Mr Rebetzke for his assistance.
