CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Franky Houdini**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2015/2089
DELIVERED ON:	16 May 2018
DELIVERED AT:	Brisbane
HEARING DATE(s):	23 February 2018; 8-9 May 2018
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody; hanging; continuing detention under the *Dangerous Prisoners (Sexual Offenders) Act 2003*; information sharing between Queensland Corrective Services and Prison Mental Health Service employees.

REPRESENTATION:

Counsel Assisting:	Mr Daniel Bartlett/Miss Emily Cooper
Queensland Corrective Services:	Ms Kylie Hillard instructed by Queensland Corrective Services
West Moreton Hospital and Health Service:	Ms Anna-Maria Lofaro, Minter Ellison
Office of the Chief Psychiatrist:	Ms Stephanie Gallagher, Corrs Chambers Westgarth

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Introduction

1. Franky Houdini was 41 years of age when he was found hanged behind the door of his cell in the residential facility of the Wolston Correctional Centre (WCC) on 2 June 2015.

2. On the morning of 2 June 2015, muster duties were being carried out in 'residential cluster 1' by correctional services officers. Mr Houdini did not present as required at the door of his cell for the muster. As the officers approached Mr Houdini's cell, a towel was observed covering the cell door's window, which prevented the inside of the cell from being seen. The door to the cell was locked.

3. One of the officers used his key to open the cell door. There was some resistance to the door being opened. After officers entered the cell, they noticed Mr Houdini's body hanging by a cord behind the door. A Code Blue was called and Mr Houdini's body was cut down; there were no signs of life. CPR was commenced by the officers until medical staff attended. They used a defibrillator to check for signs of life, of which there were none. Mr Houdini was pronounced deceased soon after by the Nursing Unit Manager.

4. These findings:

    - confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death;

    - consider the adequacy of the sharing of information relating to prisoners' mental health treatment between Queensland Corrective Services and the West Moreton Hospital and Health Service, including information relevant to the Prisoner Mental Health Service and the High Risk Offender Management Unit; and

    - consider the adequacy of policies and procedures in place to deal with the mental health treatment of prisoners who are the subject of applications and orders under the *Dangerous Prisoners (Sexual Offenders) Act 2003* (Qld).

The Investigation

5. The circumstances leading to Mr Houdini's death were investigated by the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). The investigation was led by an experienced Detective, Sergeant Andy Seery. He submitted a report to my Office, dated 14 September 2015, which was tendered at the inquest.[1]

[1] Exhibit A8.

6. At the inquest Detective Sergeant Seery said that the scene at WCC was secured by Detective Sergeant Brendan Anderson, who was attending the prison in relation to another matter at the time. This occurred within minutes of Mr Houdini's body being discovered. He inspected the cell and oversaw the forensic examination of all points of interest.

7. CSIU officers commenced the process of taking statements from staff and conducting recorded interviews with inmates of the residential facility. They took steps to seize all relevant records and interrogated the WCC Information and Offender Management System (IOMS). Scenes of crime officers took a series of photographs of the scene.

8. 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 (the OCI Report). 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.[2]

9. The issues for this inquest were informed by the OCI Report which made investigation findings about the fact that assessments of Mr Houdini by QCS psychologists were hampered by a:

   - lack of information about Mr Houdini's mental health status and treatment needs from the PMHS;
   - lack of awareness of the DPSO application and risk assessment process, and the stress that this was placing on Mr Houdini; and
   - failure to carry out collateral checks in relation to the extent of Mr Houdini's self-reported family supports.

10. I am satisfied that the QPS investigation was thoroughly and professionally conducted and that all relevant material was accessed. Detective Sergeant Seery was satisfied that there was no evidence of the involvement of any third party in Mr Houdini's death.

The Inquest

11. As Mr Houdini died while in custody an inquest was required under s 27 of the *Coroners Act 2003*. A pre-inquest conference was held in Brisbane on 23 February 2018. Mr Bartlett appeared as counsel assisting and leave to appear was granted to Queensland Corrective Services and the West Moreton Hospital and Health Service. Leave to appear was also subsequently granted to Office of the Chief Psychiatrist within Queensland Health.

[2] Exhibit C6.

12. At the inquest on 8-9 May 2018 Miss Cooper appeared as counsel assisting. All of the statements, records of interview, medical records, photographs and materials gathered during the investigations were tendered at the inquest. Oral submissions were heard from the represented parties following the conclusion of the evidence.

13. I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The evidence

Personal circumstances and correctional history

14. The deceased was born Frances Phillip Kunde. He changed his name by deed poll to Franky Houdini. Mr Houdini worked as a magician/escape artist in the Ipswich area before his imprisonment. In 2000, he suffered a back injury in a motor vehicle accident which made it difficult for him to continue work as an escapologist.

15. On 26 November 2010, Mr Houdini was sentenced in the District Court at Ipswich to 6 years imprisonment for maintaining a sexual relationship with a child, and a number of other offences including multiple counts of indecent treatment of a child and possessing and creating child pornography.

16. On 10 March 2011, an arrest warrant was issued for Mr Houdini by New South Wales Police in relation to other offences alleged to involve a young female. Before his full time release date in September 2014, an interim detention order was made for Mr Houdini's continuing detention under the *Dangerous Prisoners (Sexual Offenders) Act 2003* (DPSOA).[3] The interim order was made until such time as the application was finally determined. As part of that application, several opinions were sought from psychiatrists, who provided conflicting opinions about Mr Houdini's mental health and subsequent risk to the community. He remained on the interim detention order at the time of his death in June 2015.

17. Mr Houdini was accommodated in residential cluster 1 at WCC. This residential cluster contained four units comprised of six cells in each unit. Each cell contained a bed, a small table and an open cupboard with shelving. Each prisoner had a key to their own cell which they were able to access freely. A master key was also held by the supervising correctional services officer.

Mental Health History

18. Mr Houdini reported a past history of substance misuse including amphetamines, cannabis and alcohol since the age of 11 years. Medical records obtained from the Ipswich General Hospital indicate that, in July

[3] This order was made on 22 August 2014.

1991, Mr Houdini presented with a depressed mood and suicidal ideation in the context of cannabis use and difficult psychosocial circumstances. He was diagnosed with an adjustment disorder with depressed mood.[4] In July and December 2007, Mr Houdini had 2 brief admissions to the Ipswich Hospital and was diagnosed with a substance induced psychotic episode.[5]

19. Mr Houdini had spent some two years in pre-sentence custody before being sentenced on 26 November 2010. At that time, the sentencing Judge noted that Mr Houdini had been seen by a psychologist in prison, and that there was nothing 'psychologically wrong' with him. Mr Houdini had attempted to gain insight into his actions while he had been in custody and had communicated remorse to his victims during his sentencing.

20. By 2011, Mr Houdini had become heavily involved in religious themes – he had professed the Muslim faith and sought to celebrate Ramadan. Mr Houdini embraced a religious persona, studied various religions in great detail and became completely absorbed and preoccupied with religious themes. This inhibited his participation in sexual offender rehabilitation programs, as he claimed such programs were inconsistent with God's will.

21. In September 2014, Mr Houdini was interviewed by Consultant Psychiatrist at The Park Centre for Mental Health (The Park), Dr Angela Voita. During this interview, Mr Houdini was assessed as presenting as elevated with pressured speech, religious preoccupations and formal thought disorder. He refused to take medications and was assessed as lacking insight and the capacity to make informed decisions about his mental health. A recommendation for assessment was completed and a referral made for Mr Houdini to be transferred to The Park, where he remained until 5 March 2015.[6]

22. At The Park, Mr Houdini was admitted to the High Security Inpatient Service under the care of Dr Russ Scott.[7] Dr Scott assessed Mr Houdini as not presenting with symptoms consistent with a psychotic illness. A second opinion was obtained from Dr Jon Mann, who agreed with Dr Scott's assessment. However, as Dr Voita had identified symptoms of psychosis she agreed to take over the care of Mr Houdini, and remained his treating psychiatrist.

23. After Dr Voita interviewed Mr Houdini again, she assessed him as presenting with a psychotic illness and lacking in the capacity to make informed decisions about his mental health. On 5 December 2014, Mr Houdini was placed on an involuntary treatment order (ITO). He was diagnosed with paranoid schizophrenia.

[4] Exhibit D3, pages 145-153.
[5] Exhibit D2, pages 33-35.
[6] Exhibit D1.
[7] Exhibit D4.1, page 67.

24. In January 2015, Mr Houdini started to display an improvement in mental state. He became less pressured in his speech, less preoccupied with religious themes, less driven to write voluminous letters and his sleep returned to a normal pattern. He had become less rigid in maintaining his structured routine and was no longer engaged in fasting. He accepted legal advice relating to the DPSOA application for the first time, and also agreed to participate in sexual offender rehabilitation courses.

25. Mr Houdini subsequently developed hyperprolactinaemia (the presence of abnormally high levels of prolactin in the blood) and at higher doses of risperidone (an anti-psychotic medication) developed akathisia, a condition that causes a feeling of restlessness and an urgent need to move. His risperidone dose was consequently decreased to 1mg nocte, which resulted in no destabilisation of mental state. Mr Houdini was assessed as not requiring ongoing admission, and was discharged back to WCC on 5 March 2015, remaining on the ITO.[8]

Events leading up to the death

26. After Mr Houdini was received back at WCC in March 2015, he was assessed as being willing, cooperative and polite by correctional staff. He reported external support from his mother and sister through regular phone calls and irregular visits.[9] Within a week, he had been noted by correctional staff to conduct himself well within the residential environment. He had not been reported as being a problem in that environment, and he met the behavioural standards required of WCC.

27. Mr Houdini was also placed on the Person of Concern (POC) Register as standard practice, because he was returning from a mental health facility. At the time, the POC Register procedure was a centre based process to ensure prisoners with greater vulnerabilities were identified and managed in accordance with their individual needs.[10]

28. On 30 March 2015, Mr Houdini received correspondence from the Crown Law Office, confirming that in preparation for a DPSOA application, he would be assessed by various external psychiatrists on 28 May 2015, 12 June 2015 and 16 July 2015.[11]

29. Mr Houdini was reviewed by his treating psychiatrist, Dr Voita, at WCC on 10 March 2015 and 7 April 2015. On the latter date, Dr Voita noted that Mr Houdini was compliant with his medication. However, he was only taking it because he was subject to an ITO. He had no issues with other prisoners, and was sleeping well. He confirmed his upcoming appointments with various psychiatrists in the DPSOA process, specifically with Dr Donald Grant

[8] Exhibit D4.1, page 167.
[9] Exhibit C2.
[10] Exhibit B15, paragraph 18.
[11] Exhibit C5, page 32.

on 28 May 2015. Dr Voita's overall impression was of a stable mental state. She recommended Mr Houdini be reviewed in 3 weeks.[12]

30. Mr Houdini was reviewed again by Dr Voita on 23 April 2015. He remained on an ITO at that time. He reported he was feeling well, and denied any perceptual abnormalities. Despite being on the ITO, he admitted to not taking his medication on one occasion the previous week. Dr Voita's overall impression was again of a stable mental state.[13]

31. Mr Houdini's final session with Dr Voita was on 26 May 2015. He reported that things were much the same, and denied any interpersonal conflict. He mentioned that he was waiting for Dr Grant to see him on 28 May 2015. He said that he was not stressed about this or otherwise given it much thought. He was being compliant with his medication, but stated this was only because he was compelled to do so. He reported being concerned about being charged with new offences in Queensland or in New South Wales.

32. On 28 May 2015, QCS psychologist Maria Kostyanaya interviewed Mr Houdini. She noted that he presented unremarkably, and he made direct and appropriate eye contact throughout the interview. He responded to all questions in a timely manner. There was no current suicidal ideation, intent or plan noted or detected during the interview.[14]

33. During the inquest I heard evidence from Susan Spencer, a psychologist employed by QCS, and acting Senior Adviser of Offender Assessments, Offender Rehabilitation Management Services. Ms Spencer explained that when a prisoner such as Mr Houdini is receiving treatment through the Prison Mental Health Service (PMHS), there is a weekly meeting between the QCS Psychological Services team and the PMHS. The purpose of the meeting is to facilitate communication about prisoners involved with the PMHS.[15] Ms Spencer also said that direct email and telephone contact could also be used to discuss cases with the PMHS clinical coordinator.

34. Ms Spencer's evidence was that on 29 May 2015 she attended the regular weekly meeting with the PMHS Clinical Coordinator, Chris Mangal. During this meeting, Mr Mangal asked that the QCS Psychological Services team conduct a welfare check on Mr Houdini, because he had presented as quite flat during the recent interview with his treating psychiatrist. There was also a suggestion that his sexual offending behaviour was resurfacing and that this may be distressing him.[16]

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[12] Exhibit D4.1, pages 169-170.
[13] Exhibit D4.2, page 103.
[14] Exhibit C2, page 24.
[15] Exhibit B15, paragraph 14.
[16] Exhibit B15, paragraph 20.

35. Ms Spencer explained in her evidence that, in terms of sharing of information about prisoners between the QCS psychologists and the PMHS, it was not the practice of the PMHS to provide QCS Psychological Services with written information relating to a prisoner's mental health.[17] Ms Spencer was not aware of the context of Mr Houdini's involvement with the PMHS, nor did she have any knowledge of a third court appointed psychiatrist interviewing Mr Houdini for the purpose of conducting a risk assessment under the DPSOA.[18] She was also unaware that relevant information had been provided by Crown Law to the HROMU about Mr Houdini's status under the *Mental Health Act*.

36. At the inquest, Ms Spencer said that she was aware of the Memorandum of Understanding (MOU) relating to confidential information disclosure in broad terms. She was not aware of the Operating Guidelines which supported the MOU. She was also unaware of the escalation pathway set out in those guidelines. Ms Spencer said that it would have been of assistance to have seen Mr Houdini's discharge summary and progress notes from The Park because these documents listed more specific and relevant information about his history of suicidal ideation than IOMS, which only had a flag for suicide risk from 2008. She said that contextual and historical information can assist in assessing ongoing risk.

37. However, Ms Spencer agreed that in five years at WCC Mr Houdini had not expressed suicidal ideation or made any suicide attempts, and was unable to say in retrospect whether access to this information would have changed the risk assessment for Mr Houdini on 1 June 2015. There was nothing in the request for a welfare check that would have prompted her to source the mental health progress notes prior to having the prisoner seen. If any risk indicators were identified during the welfare check a notice of concern would have been raised and observations increased, if necessary.

38. After her meeting with Mr Mangal on 29 May 2015, Ms Spencer sent an email to QCS psychologist, Ms Kostyanaya, asking her to perform the welfare check on Mr Houdini. Ms Kostyanaya conducted this check on 1 June 2015, the day before Mr Houdini's death.

39. In a note entered in the IOMS,[19] Ms Kostyanaya recorded that Mr Houdini again presented unremarkably, and he made direct and appropriate eye contact throughout the interview. He responded to all questions in a polite manner. He presented with his usual flat affect, but with "appropriate change of the mimic upon the flow of conversation". He did not report any concerns, only that he found the psychiatric assessments "challenging". He would not provide further details about that, stating to Ms Kostyanaya that he was "dealing" with those issues and that he "does not have any assistance from Psychological Services". He reported that he had enough support from his family members via regular phone calls and visits. Ms Kostyanaya advised Mr Houdini to contact Psychological Services if necessary. Ms Kostyanaya

[17] Exhibit B15, paragraph 26.
[18] Exhibit B15, paragraphs 26-27.
[19] Exhibit C2, page 24-25.

did not detect any current suicidal ideation, intent or plan throughout the interview.

40. Contrary to Mr Houdini's assertions in relation to family support, IOMS showed Mr Houdini had not received a family visit since August 2014. Similarly, he also had not been using his ARUNTA (Prisoner Telephone System) account.[20]

41. At about 10:40am on 2 June 2015, correctional services officers Kamlesh Singh, Jeff Bauer and trainee officer, Bradley Carroll, were conducting the morning muster in residential unit 1B. Prisoners were required to stand beside their cell door for the muster. Mr Singh was conducting the physical head count of the prisoners.[21] When he approached Mr Houdini's cell he noticed a towel was covering the glass window on the cell door, and he could not see through the glass panel. Mr Singh explained in his evidence that prisoners are not allowed to cover the windows to their cells. He tried to open the cell door, but it was locked. However, this was not considered unusual.

42. Mr Singh used a master key to unlock the cell door. As he pushed the door open he felt a heavy weight against it. When he pushed the door open further, the towel dropped down and he could see the back of Mr Houdini's head against the rear of the door. Mr Singh called out to Mr Bauer for assistance, and both Mr Bauer and Mr Carroll attended and moved into the cell. Mr Bauer called a 'Code Blue' for a medical emergency.

43. Mr Bauer cut Mr Houdini down and he was placed on the floor of the cell; there were no signs of life.[22] CPR was commenced by the officers until medical staff attended. They used a defibrillator to check for signs of life.[23] At 10:45am, the Nursing Unit Manager Lorraine Reid made the call to cease CPR.[24]

44. It became apparent that Mr Houdini had used a piece of thin nylon cord similar to that used on tennis court nets, and had woven one end through a grate above the door to his cell.[25] The residential accommodation unit provided a tennis court for use by the prisoners.[26] A note was found on Mr Houdini's bed which, among other things, expressed how it was time for him to "go back home to our maker for judgement" and asking those he had sinned against for forgiveness.[27] Other notes were found in his cell which expressed themes of repentance and accountability for his past sins. The key to Mr Houdini's cell was found located on a shelf within the unit away from access to the cell door.

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[20] Exhibit C6, page 10
[21] Exhibit B9.
[22] Exhibit B2, paragraph 12.
[23] Exhibit B6, paragraphs 35 – 38; Exhibit B8, paragraphs 31-32.
[24] Exhibit B8, paragraph 42.
[25] Exhibit B8, paragraphs 45-46.
[26] Exhibit A8, page 7.
[27] Exhibit C4.

Autopsy results

45. A full internal autopsy examination was conducted by experienced forensic pathologist, Dr Philip Storey, on 3 June 2015. The autopsy report was tendered at the inquest.[28] Dr Storey had attended at the scene of the death at WCC on 2 June 2015.

46. Autopsy examination confirmed a transverse linear abrasion mark in the neck, and this had typical features of a mark made by passive suspension, consistent with hanging. At the time of autopsy, the ligature was still present around the neck, and this conformed to the abrasion mark. There was no evidence of any defensive injuries to the body, and no evidence of sharp force or significant blunt force injury. Rib fractures were consistent with efforts at resuscitation.

47. Internal examination showed an acute fracture at the top of the left side of the major cartilage in the neck (the thyroid cartilage).

48. Toxicology testing confirmed trace levels of paliperidone, a metabolite of risperidone. No alcohol or other drugs were detected.

49. Dr Storey considered that it was possible for the focal acute haemorrhage to the thyroid cartilage to have been caused by the forces generated during passive suspension. He found no specific evidence to indicate direct third party involvement. Dr Storey confirmed the cause of death as being from hanging.

Adequacy of the sharing of information relating to a prisoner's mental health treatment between QCS and WMHHS (the PMHS)

50. The OCI report investigated the extent to which information about Mr Houdini was shared between the QCS psychologists and the PMHS. During interviews conducted for the purpose of the OCI report, Psychological Services staff conveyed an inability to obtain collateral information regarding a prisoner's diagnosis and treatment from the PMHS, despite the fact both agencies were effectively caring for and managing the same prisoner.[29] The OCI considered that this affected the quality of welfare checks conducted at various times with Mr Houdini, as they were not as informed as they could have been.

51. I heard evidence from Darryn Collins, a registered nurse in the role of Acting Team Leader for the PMHS.[30] Mr Collins confirmed that he was very cognisant of the MOU but in accordance with applicable statutory obligations, the PMHS does not provide QCS, specifically the prison psychologists, with

[28] Exhibit A7.
[29] Exhibit C6, page 30; Exhibit C6.10; Exhibit C6.12; Exhibit C6.16; Exhibit C6.21.
[30] Exhibit B17.

written documentation about a prisoner's mental illness.[31] He confirmed that no access is provided to the Consumer Integrated Mental Health Application - the state-wide clinical information system designed to support mental health services in Queensland.

52. Mr Collins advised that there are currently 720 prisoners open to the PMHS in the WMHHS catchment - covering 7 prisons and 2 prison farms. The high number of prisoners open to the PMHS meant that the more complex or concerning cases were prioritised in discussions with QCS staff.

53. Mr Collins gave evidence about several current methods that are used to share information with QCS which is relevant to the PMHS or the High-Risk Offender Management Unit (HROMU). These methods include:
    - A weekly interagency meeting;
    - Persons of Concern interagency meeting (held every 2 months);
    - The conduct of complex case discussions via telephone conference between QCS and the PMHS when required;
    - Inviting the QCS psychology team to meet with a returning prisoner and team before discharge to ensure a smooth process of return for the prisoner for the correctional facility; and
    - Other informal ways of information sharing between QCS and the PMHS, as required within the limits of the MOU and the *Hospital and Health Boards Act 2011*.[32]

54. The OCI Reported recommended that QCS undertake a review of whether current and proposed policies, procedures and agreements sufficiently facilitate the sharing of information between all Hospital and Health Services, the PMHS, QCS and/or private prison providers.[33]

55. Evidence was also heard at the inquest from Kate Petrie, QCS Principal Advisor, Policy and Planning about what has been done by QCS in response to this recommendation.[34] Ms Petrie provided a copy of the MOU relating to confidential information disclosure which was finalised by Queensland Health (Queensland Health) on 31 May 2016.[35] The MOU seeks to ensure the sharing of confidential information between Queensland Health and QCS in circumstances where other legislative avenues, such as obtaining consent, have been exhausted.

56. The MOU states that in the first instance, information provided by Queensland Health to QCS should be provided with the written consent of the prisoner.[36] However, in circumstances where consent is unable to be obtained, a non-exhaustive list of scenarios where confidential information may be disclosed to QCS is provided.[37]

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[31] Exhibit B17, paragraph 15.
[32] Exhibit B17, paragraphs 18-21.
[33] Exhibit C6, page 35 at 1.1.
[34] Exhibit B12 – B12.13.
[35] Exhibit B12.1.
[36] Exhibit B12.1, paragraph 6.2.1.
[37] Exhibit B12.1, paragraph 6.2.3 – 6.2.6.

57. The specific situation of a prisoner returning from treatment at The Park is not covered by the MOU, in which case the relevant contact person listed in the Operating Guidelines[38] and the dispute resolution process should be referred to. In all situations, Queensland Health retains the discretion to not disclose confidential information to QCS.

58. In his evidence, Mr Collins confirmed that his understanding of the MOU was that neither it, nor the *Hospital and Health Boards Act 2011*, specifically mandate or expressly permit the passing of written documentation about a prisoner's mental health by the PMHS to QCS.[39] It was also submitted on behalf of Queensland Health that the legislation refers only to the sharing of information, and does not specify that documents can be shared.

59. I was also assisted during the inquest by evidence from Associate Professor John Allan, Executive Director of the Mental Health Alcohol and Other Drugs Branch.[40] Dr Allan explained that the *Hospital and Health Boards Act 2011* prescribes a statutory duty of confidentiality that binds all Queensland Health staff.

60. Dr Allan's view was that the current legislative provisions are sufficient to enable the sharing of information with QCS about the assessment and treatment of persons under the *Mental Health Act 2016*. The *Hospital and Health Boards Act 2011* also provides a number of exceptions to the duty of confidentiality. One such exception is where the disclosure is allowed under an agreement between the chief executive and another entity which is prescribed under a regulation; and disclosure is considered to be in the public interest.[41] The MOU referred to above has been prescribed under the *Hospital and Health Boards Regulation 2012* in Schedule 3.

61. Ms Petrie also gave evidence surrounding a further recommendation from the OCI report, namely that QCS review the effectiveness of collaboration between QCS and Queensland Health with the aim of improving information sharing to enhance offender outcomes and optimise service delivery for both parties.[42] She confirmed that this issue had been identified in previous reports from the Office of the Chief Inspector.

62. In response to that recommendation, the Director-General of the Department of Justice and Attorney-General wrote to the Chief Executive of Queensland Health on 10 November 2016,[43] advising that in the absence of a central coordinating authority for offender health, QCS had experienced difficulty resolving complex policy and service delivery issues with individual Hospital and Health Services. The Director-General proposed that a joint interdepartmental committee comprising senior QCS and Queensland Health staff be established to provide ongoing oversight and governance for the delivery of health services at correctional centres across Queensland.

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[38] Exhibit B12.1, paragraphs 10.1 and 11.3.
[39] Exhibit B17, paragraph 17.
[40] Exhibit B16 – 16.6.
[41] *Hospital and Health Boards Act* 2011, s151 (1) (b); Exhibit B16 paragraph 5.
[42] Exhibit C6, page 35 at 1.2.
[43] Exhibit B12.3.

63. Ms Petrie's evidence was that QCS is working with Queensland Health to complete a review of the MOU to address the recommendations in the OCI report.[44] A number of measures are being considered, and a working party has been established to work through the operational practice issues identified with disclosing confidential information.

64. Dr Allan confirmed that the Operating Guidelines are currently undergoing review, with a working group established with key stakeholders from Queensland Health and QCS. He confirmed that the working group is focusing on practical issues associated with information sharing and working on guidelines that better set out the process for sharing confidential information.[45]

65. Dr Allan agreed that the current Operating Guidelines did not contain examples that were applicable to the prison setting. He said that this was a matter that could be considered by the working group. In his view, several of the provisions of the current guidelines would have applied to enable the sharing of information, including written information, about Mr Houdini's assessment and treatment under the *Mental Health Act*.

66. Dr Allan considered that concerns about the extent to which information was shared should be addressed by enhancing working relationships between the respective agencies to operationalise the MOU, rather than prescribing the requirements in legislation.

Queensland Parole System Review

67. Consistent with recommendation 1.2 of the OCI report, the Queensland Parole System Review (QPSR) Report recommended that "*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.*"

68. As part of the response to the QPSR, $15M of funding was dedicated to expanding the PMHS as delivered by Queensland Health. Dr Allan provided evidence explaining the breakdown of this funding.[46] He said that the funding has been used to address immediate shortfalls in capacity at the PMHS. A review of the resourcing of the PMHS will be undertaken by Queensland Health during the 2019-2020 financial year.

69. I also heard at the inquest that an interdepartmental committee has been formed to oversee this recommendation, and others made by the QPSR. Both Queensland Health and QCS are members of this committee. Dr Allan provided the Terms of Reference for this committee[47], and confirmed that he

[44] Exhibit B1.4.
[45] Exhibit B16 from paragraph 16.
[46] Exhibit B16, from paragraph 25.
[47] Exhibit B16.6.

represents Queensland Health on the committee. Thus far, the funding provided to expand the PMHS has been confirmed as received by Queensland Health, and the review of resourcing confirmed to occur during the 2019-2020 financial year.

Adequacy of policies and procedures in place to deal with mental health treatment of prisoners the subject of orders pursuant to DPSOA

70. The OCI report investigated the extent to which QCS staff and PMHS staff were aware of the processes in place for prisoners the subject of DPSOA orders. It found that both the PMHS and QCS Psychological Services staff had an awareness that Mr Houdini was to be subject to a DPSOA risk assessment. However, neither service monitored or tracked the pending DPSOA risk assessment with any significance.[48]

71. The OCI report also found that departments responsible for arranging and conducting the DPSOA risk assessment did not communicate the pending process with QCS Psychological Services or the PMHS, as the individual significance was not visible to them or had not been communicated. The OCI report concluded that this influenced the effectiveness of welfare checks conducted by Ms Kostyanaya on 28 May 2015 and 1 June 2015.

72. I heard evidence from Ms Niclaire Byrne, Acting Deputy General Manager at WCC. Ms Byrne has previously held the position of Manager, Offender Development at WCC.[49] Ms Byrne confirmed that the previous practice regarding DPSOA prisoners was that they were required to be seen at least monthly for case management processes. These processes were factored around reintegration needs and motivation to engage in treatment in accordance with the DPSOA order. Prisoners who were incarcerated for the contravention of a DPSOA order, or were being considered for a DPSOA order, had no requirement for any higher level of service provision than the wider population. Therefore, there were no case management requirements for Mr Houdini prior to his death.[50]

73. The OCI report recommended that WCC review its local processes and include case management for prisoners subject to the DPSOA process by the centre's Psychological Services team.[51]

74. Ms Byrne confirmed that when prisoners are being considered for the DPSOA process, Sentence Management Services or the Manager, Offender Development are now provided with advice from the HROMU that a risk assessment process is to occur, together with the dates for key milestones in that process. This information is then passed on to the QCS Psychological

[48] Exhibit C6, page 31 & 35.
[49] Exhibits B11 – B11.1.
[50] Exhibit B11, paragraph 7.
[51] Exhibit C6, page 36 at 3.1.

Services team. The outcome is that a prisoner at WCC is seen before and after the DPSOA psychiatric risk assessment interview by a QCS psychologist.[52]

75. Ms Byrne's evidence was that a DPSOA prisoner was also placed on the Persons of Concern register, as was Mr Houdini. There is now a dedicated DPSOA register at WCC.[53] Prisoners on this register are assessed with a high level of frequency by a staff member from the QCS Psychological Services team. The level of frequency is determined through consultation with the Senior Psychologist. The minimum frequency is monthly.

76. The OCI report also recommended that QCS develop a communication strategy for communicating milestones in the DPSOA application process to inform all relevant parties.[54] I heard evidence about this issue from Mr Bruce Tannock, Principal Advisor in the HROMU.[55] Mr Tannock acknowledged that, in the past, psychiatric assessment appointments with DPSOA prisoners could be arranged without offender development staff being advised. This was because communication about the application process would occur directly between Crown Law and the prison general manager, without HROMU involvement.

77. On 28 September 2016, a DPSOA Application Process Flowchart was published on the QCS Intranet in conjunction with the Custodial Operations Circular 01/2016 "*Communication of milestones in the DPSOA application process*." Copies of both documents were tendered at the inquest.[56] Mr Tannock said that that these documents were supplemented by training provided to each correctional centre's Psychological Services team.

78. HROMU is now advised by Crown Law when any DPSOA related psychiatric appointment is booked within a correctional centre. In line with the evidence given by Ms Byrne, HROMU communicates that information before the psychiatric appointment to the Manager of Offender Development at the relevant correctional centre for dissemination to staff as appropriate.[57] Mr Tannock's evidence was that this process ensures relevant parties are aware of upcoming psychiatric appointments for prisoners at the earliest opportunity.

79. These processes enable the QCS Psychological Services team to be mindful of the timing and significance of the upcoming assessments when scheduling and conducting prisoner welfare checks. Mr Tannock also said that if a psychiatrist assessing a prisoner for the purpose of a DPSOA application had concerns about the prisoner's welfare they would inform prison staff and Crown Law. He reported that the new process was working well, particularly at WCC, which houses a large number of DPSOA prisoners.

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[52] Exhibit B11 paragraph 11; Exhibit B11.1 paragraph 7.
[53] Exhibit B11.1, paragraph 8.
[54] Exhibit C6, page 35 at 2.1.
[55] Exhibits B14 – B14.2.
[56] Exhibit B14.1.
[57] Exhibit B14, paragraphs 9-10.

80. I also heard evidence at the inquest from the current acting Deputy Commissioner of QCS, Mr Peter Shaddock.[58] Mr Shaddock gave evidence surrounding the recommendation contained within the OCI report, that QCS review the procedure "Accommodation and Case Management - Prisoner Management."[59] The review was to occur with a view to ensuring it included the additional considerations toward DPSOA prisoners engaged in the application process, particularly the important milestones in the process.

81. Mr Shaddock referred to a document titled "*QCS Custodial Operations Practice Directive – Accommodation and Case Management (COPD)*" which relates to the accommodation and case management of prisoners in a corrective services facility. Mr Shaddock's evidence was that QCS Statewide Operations undertook a review of this Directive, and developed additional content to provide instructions to staff regarding the communication of relevant milestones to prisoners who are or may be subject to the DPSOA process.

82. A copy of the revised document was tendered at the inquest.[60] The additional considerations for DPSOA prisoners direct that staff ensure the prisoner is informed of, and understands, the milestones of the DPSOA process. Those milestones being the pre-application psychiatric risk assessment, the preliminary hearing, the court appointed psychiatric risk assessments (as in Mr Houdini's case) and the final hearing.

83. Mr Shaddock also provided evidence about the infrastructure of WCC.[61] He explained the existence of secure cells, and residential cells (in which Mr Houdini was accommodated). Mr Shaddock explained that while residential cells have design features like secure cells, residential cells allow a prisoner a greater degree of self-regulation and management, including the ability to lock/unlock their cell door. This capability effectively means that a cell door can be used as a ligature point. For this reason, residential cells are not deemed suitable for prisoners with a current status of at-risk behaviour.[62]

84. Emphasising the importance of information sharing, Mr Shaddock also noted that had QCS been aware that Mr Houdini was the subject of an ITO, it was unlikely that he would have been accommodated in a residential unit at WCC. However, an individual prisoner's circumstances would be relevant to this decision.

85. Mr Shaddock confirmed that Mr Houdini was not on any formal at-risk observations regime at the time of his death. He did have a self-harm flag on IOMS indicating he had previously been assessed as at-risk of self-harm or suicide, but this was a common feature for many prisoners, such that the allocation of a self-harm flag was in and of itself unremarkable. This was confirmed in numerous instances in the IOMS reports, where Mr Houdini was

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[58] Exhibit B13 –B13.2.
[59] Exhibit C6, page 36 at 3.2.
[60] Exhibit B13.1 from page 37.
[61] Exhibit B13.2.
[62] Exhibit B13.2 page 1-2.

seen to present unremarkably, and with no current suicidal ideation, intent or plan.

86. In terms of the information sharing recommendations which came out of the OCI report, Mr Shaddock confirmed the evidence given by Dr Allan and Ms Petrie regarding the body of work which is continuing in that regard at the interdepartmental level.

Conclusions

87. Mr Houdini died as a consequence of suicidal hanging. The Queensland Police Service investigation concluded, "*there is no evidence to suggest any other person was involved in the actions of the deceased and there appeared to be no indicators the deceased was planning this course of action at the time.*"

88. I am satisfied from all the evidence that no other prisoner or member of staff at WCC was directly involved in Mr Houdini's death.

89. I do not consider that Mr Houdini's death could have been prevented if access to the nylon cord from the tennis net was restricted. I accept that he had a range of other possible methods at his disposal, in circumstances where he was not assessed as being at risk of suicide, and was housed in a residential unit where he enjoyed relative freedom of movement.

90. I consider that the first aid Mr Houdini received after he was located was of a suitably high standard. Once he was found it is highly doubtful anything could have been done that would have prevented his death.

91. The OCI report made the following findings under the headings Investigation Findings Table and Chain of Causation[63]:

- Assessments of the prisoner's mental health and welfare (including the reception assessment conducted on 5 March 2015) were not effective toward guiding the management of Mr Houdini.
- The welfare check conducted on 1 June 2015 shortly after the meeting with the court appointed psychiatrist was ineffective.
- Staff were not aware about the extent to which the prisoner had difficulty in coping with acknowledging his offending behaviours associated with the DPSOA process.

92. The OCI Report[64] notes that the "*chain of causation highlights causes from the failure point to the assessed root cause".* While I acknowledge the assessment of the relevant contributory factors underpinning the findings in the OCI Report, including the lack of awareness of Mr Houdini's current mental health diagnosis and treatment needs, there was insufficient evidence at the inquest

[63] Exhibit C6, pp 30, 32. The Chain of Causation refers to a welfare check on 28 May 2015.
[64] Ibid, page 34.

to enable me to adopt the first two findings from the OCI report as being directly contributory to Mr Houdini's death.

93. In particular, there was insufficient evidence to support the retrospective conclusion that additional collateral information from the PMHS about Mr Houdini's diagnosis and treatment at The Park when the relevant welfare checks were conducted on 5 March 2015 and 1 June 2015 would have changed the WCC's approach to his management or altered his outcome. As Ms Spencer noted in her evidence, while this information would have provided valuable contextual and historical background, it may not have changed the approach of the relevant QCS psychologists when assessing Mr Houdini's immediate risk of self-harm on those dates.

94. In the week of his death Mr Houdini was seen twice by a QCS psychologist (Ms Kostyanaya), by his treating psychiatrist (Dr Voita) and by an independent psychiatrist for the purpose of the DPSOA risk assessment (Dr Grant). None of these individuals identified an elevated risk of self-harm. If they had, I am confident steps would have been taken to have the Risk Assessment Team at the WCC review his management, including placement within the centre.

95. I accept the OCI Report's finding that while QCS Psychological Services staff were aware in broad terms of the DPSOA application process, they should have been better informed about the key stages in that process to better understand Mr Houdini's response to it.

96. I also accept that collateral checks should have been undertaken to verify Mr Houdini's claims that he was being supported by family and friends.

Findings required by s45

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

Identity of the deceased – The deceased person was Franky Houdini.

How he died - Mr Houdini died after he hanged himself inside his cell with the intention of taking his own life while he was an inmate in a residential unit of the Wolston Correctional Centre. Mr Houdini had been the subject of an Involuntary Treatment Order under the *Mental Health Act 2001* since 5 December 2014. He was seen by his treating psychiatrist and prison psychologists in the week before his death but was not assessed as being at risk of suicide.

In August 2014, he had been made the subject of an interim order for continuing detention under the *Dangerous Prisoners (Sexual Offenders) Act 2003*. He also faced extradition to New South Wales at the conclusion of his term of imprisonment in Queensland. It is likely that he chose to end his own life in the context of the stress associated with a probable lengthy period of incarceration beyond his original release date and an ongoing mental illness.

Place of death – He died at the Wolston Correctional Centre, Brisbane in the State of Queensland.

Date of death – He died on 2 June 2015.

Cause of death – Mr Houdini died due to hanging.

Comments and recommendations

98. Section 46 of the *Coroners Act 2003*, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

99. The OCI report made five recommendations,[65] which have been discussed above, associated with its findings in relation to root causes. I am satisfied that the recommendations have been responded to appropriately, and acknowledge the body of work that is continuing particularly with respect to enhanced funding for the PMHS, and the resolution of ongoing practical difficulties associated with the sharing of confidential information between QCS and the PMHS. I am satisfied that these steps will address the root causes identified in the OCI Report.

100. I was not persuaded that the current legislative framework prohibits the appropriate sharing of relevant confidential information between the PMHS and QCS psychologists. I agree with Dr Allan that enhancing working relationships between the respective agencies to operationalise the MOU, rather than prescribing the requirements in legislation, is likely to lead to improved information sharing.

101. I also consider that the policy underpinning the current information sharing arrangements is sound. This requires that the wishes of a prisoner regarding the release of information about their mental health treatment to be respected, unless there is a legal or clinical requirement for the information to be shared.

[65] Exhibit C6, page 35 'Attachment 5'.

102. Submissions from those represented at the inquest identified concerns that written information was not expressly captured by the current legislative provisions enabling information sharing, together with concerns about personal liability attaching to staff who share information in good faith.

103. Noting that an existing working group is examining the MOU and Operating Guidelines, I recommend 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; and
- amendments to the Operating Guidelines under the MOU on Confidential Information Disclosure to provide more relevant contextual information in relation to the sharing of information in correctional settings.

104. I close the inquest.

Terry Ryan
State Coroner
Brisbane
16 May 2018