QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Corey Allan McGEARY**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 508/05(5)
DELIVERED ON:	01 March 2007
DELIVERED AT:	Brisbane
HEARING DATE(s):	26-27 February 2007
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, suicide, hanging points

REPRESENTATION:

Counsel Assisting:	Ms Kim Bryson
GEO Group Australia Pty Ltd:	Mr Sandy Horneman-Wren
Department of Corrective Services:	Mr Gavin Handran
Prison Mental Health Service, Queensland Health:	Mr Andrew Ross

Findings of the inquest into the death of Corey Allan McGEARY

The *Coroners Act 2003* provides in s45 that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These are my finding in relation to the death of Corey Allan McGeary. They will be distributed in accordance with the requirements of the Act and placed on the website of the Office of the State Coroner.

Introduction

At the time of his death, Corey Allan McGeary was an inmate of the Arthur Gorrie Correctional Centre. He was discovered hanging in his cell on 7 March 2005. He was not able to be revived.

These findings seek to explain how the death occurred and consider whether any changes to the policies and/or procedures of the Department of Corrective Services would reduce the likelihood of similar deaths occurring in future.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

At the time of his death, Mr McGeary was in the custody of the Department of Corrective Services under the *Corrective Services Act 2000*. As such, his death was a "*death in custody*"[1] within the terms of the Act and accordingly was reported to the State Coroner for investigation and inquest.[2]

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly

[1] Refer s10
[2] Section 8(3) defines "*reportable death*" to include deaths in custody and s 7(2) requires that such deaths be reported to the State Corner or Deputy State Coroner. Section 27 requires an inquest be held in relation to all deaths in custody.

establish that the scope of an inquest goes beyond merely establishing the medical cause of death.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [3]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[4] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.[5]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because section 37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

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[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[4] s46
[5] s45(5) and 46(3)
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.[9]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

I will now say something about the investigation of Mr McGeary's death.

About twenty minutes after ambulance officers attended and indicated Mr McGeary was dead, police from the Corrective Services Investigation Unit (CSIU), a specialist squad within the Queensland Police Service (the QPS) that investigates incidents within correctional centres, were advised of the death.

An hour later, three detectives from that unit attended the Arthur Gorrie Correctional Centre and commenced the investigation. They co-ordinated the scenes of crime officers who also came to the prison, arranged for the cell and surrounds to be photographed and interviewed relevant witnesses.

A post mortem examination was performed by Dr Olumbe at the John Tonge Centre the next day.

The operators of the prison, GEO Group Australia Pty Ltd, commissioned its Investigations Manager to review the circumstances of the death and the Principal Adviser, Psychology and Counselling Services to undertake a peer review.

Staff of the Office of the State Coroner have also undertaken further inquiries focussed on the management of Mr McGeary's mental health risk factors.

As can be readily appreciated, any death in custody may raise suspicions in the minds of those close to the deceased, that he/she has met with some foul play and/or that the authorities have failed in their duty to properly care for the prisoner. It is therefore essential that even when a death appears at the outset not to be suspicious, the investigation is thorough and rigorous. I am satisfied that as a result of the contribution made by the various bodies which inquired into this case, including the evidence obtained at inquest, the circumstances of the death have been sufficiently scrutinised to enable me to make findings on all relevant issues.

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[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

[10] (1990) 65 ALJR 167 at 168

The inquest

A pre-hearing conference was held in Brisbane on 13 February 2007. Ms Bryson was appointed Counsel Assisting. Leave to appear was granted to the Department of Corrective Services, GEO Group Pty Ltd who operate the Arthur Gorrie Correctional Centre and Queensland Health. The family of Mr McGeary was not separately represented however they consulted with those assisting me before and throughout the inquest. The inquest then proceeded over two days commencing on 26 February 2007. Fourteen witnesses gave evidence and eighty-one exhibits were tendered.

The evidence

I turn now to the evidence. Of course I can not summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Family Background

Corey McGeary was born on 27 September 1984 in Southport, Queensland. From the age of two, he was cared for by his maternal grandmother, Velda McGeary in Ballarat, Victoria. He had no contact with his biological mother from the age of two until he was 18 years of age. He had very little contact with his father who took his own life by hanging in 1988 or 1989.

Approximately two years before his death, Mr McGeary came to Queensland and at times, lived with his mother. At some time, their relationship again broke down and at the time of his arrest, he was residing with friends in the Ipswich area.

Criminal History

In April 2003, when he was 18, Mr McGeary was charged with six counts of unlawful carnal knowledge. He was held in custody at the Arthur Gorrie Remand and Reception Centre for a period of time prior to the charges being dealt with in the District Court at Ipswich on 7 June 2004. He was sentenced to perform 240 hours community service and he was placed on a probation order for three years. Special conditions were attached to the probation order namely, that he undergo medical, psychiatric and psychological assessment and treatment and that he participate in certain rehabilitation courses.

On 8 September 2004, some twelve days prior to his arrest, Mr McGeary appeared in the Magistrates Court at Ipswich charged with breaching his probation order. The specific circumstances of the breach are not disclosed on the material. He was convicted of the breach and a fine was imposed. The probation order was ordered to continue.

Mr McGeary was again arrested on 20 September 2004 in relation to serious criminal offences. When the police apprehended him, Mr McGeary locked himself in a room at the house where he was staying and threatened to kill

himself. Police were forced to break open the door to get him out. When arrested, he was observed to have a number of self harm cuts on his left arm which required stitches.

Mr McGeary appeared in the Ipswich Magistrates Court on 21 September 2004. He was denied bail and was transported the following day, to the Arthur Gorrie Correctional Centre, a reception and remand facility. Mr McGeary remained there until his death.

Medical history

Little reliable evidence concerning Mr McGeary's medical history was available to the court. His grandmother's statement mentions that he threatened suicide when he was about seventeen. His prison medical records indicate that Mr McGeary had attempted suicide in the past and had been an inpatient at a psychiatric hospital and had been diagnosed with schizophrenia at some stage.

Mr McGeary was seen at the Ipswich Hospital on two occasions in relation to mental health issues prior to his admission on 20 September 2004. On 7 October 2003, Mr McGeary was brought to hospital by his mother with the assistance of the police. He was found under his mother's house with a knife and reported being unable to cope. He was initially seen in the accident and emergency department before being referred for mental health assessment. Mr McGeary reported feeling depressed and was assessed as having limited coping skills. Following assessment, he was referred to the Alcohol Tobacco and Other Drug Service.

On 4 September 2004, Mr McGeary was again seen at the Ipswich Hospital. He reportedly called the ambulance and was transported to the accident and emergency department where he was referred for mental health assessment. Mr McGeary advised staff that he felt sick in the head and could not explain why he called the ambulance. He was later discharged. Follow up phone contact was attempted unsuccessfully by hospital staff later on this day. On 5 September 2004, contact was made with Mr McGeary. He advised staff that he was unable to talk as he was with friends and agreed to contact them on a later occasion. It seems he did not do so.

When Mr McGeary was arrested on 20 September 2004 he reported to the arresting officers that he was hearing voices telling him to kill himself. He advised he had been medicated with Olanzapine in the past however he was not taking his medication. He had four slash wounds to his left forearm. He was therefore taken to the Ipswich Hospital at about 9.00 am. After of those wounds had been dressed, an involuntary mental health assessment order was made and Mr McGeary was transferred to the Mental Health Unit (MHU). At about 5.30 pm, he was seen by Dr MacKinnon, a consultant psychiatrist.

He reported to her a history of child abuse and previous diagnoses schizophrenia. He also reported auditory hallucinations but the psychiatrist expressed some doubt as to the validity of these. Although he had earlier

made threats of self harm and still reported suicidal ideation, he had no formulated plans. Given these reports, she came to the conclusion that Mr McGeary was not suffering from mental illness such that he should remain in the MHU and that he was not suicidal. Dr MacKinnon therefore authorised his release into police custody but recommend that he be kept under close observation initially. He was therefore taken to the watch house.

Mr McGeary's Management at the Arthur Gorrie Correctional Centre

Mr McGeary was transported to the Arthur Gorrie Correctional Centre on 22 September 2004. Soon after arrival he was assessed by medical staff and a counsellor as is routine. He complained of hearing voices, commanding in nature, telling him to harm himself. Having regard to information gained at that time and in view of the more recent assessment by the Ipswich Mental Health Service, namely that he posed a high risk of suicide, he was assessed as an "*at risk prisoner*" and placed on "*high risk – 10 minute observations*."

He was kept in a cell in the medical centre so that these observations could be undertaken. As a result of this assessment, Mr McGeary's came under the auspices of the Hight Risk Assessment Team (HRAT) and was placed on the list of prisoners to be reviewed by the visiting psychiatrist.

Later that evening he was observed to be in a very emotional state, crying and referring to voices instructing him to self harm. He was noted to have unpicked some of the sutures in the wounds to his arm. He was administered Zyprexa and Largactil, drugs with antipsychotic and tranquilising effects and his wounds were cleaned.

A few days later, his observations were reduced to every fifteen minutes, and he was accepted into the special needs program.

Courtney Ward, a counsellor, interviewed Mr McGeary on 3 October 2004. She reported he presented with some paranoia and auditory hallucinations. She concluded that Mr McGeary should remain on 15 minute observations. She further noted that Mr McGeary was receiving good support from inmates in unit B5.

Hannah King, psychologist, also reviewed Mr McGeary while he was being managed by the HRAT. When she interviewed him on 15 October 2004, he had been on observations for the past twenty-three days. Ms King was of the opinion that he presented with no negative symptoms of psychiatric illness and that he reported receiving adequate support from both his mother and brother. Despite these reports, it appears that during this time, no phone calls were made or visits received from either his mother or brother. Ms King recommended that Mr McGeary's observations cease and that he be discharged from the HRAT.

In order for this recommendation to be implemented a second assessment was required. Ms Suzanna Alexis interviewed Mr McGeary later on the same

day and concluded that he should remain on observations but that they could be reduced to two hourly. The HRAT meeting accepted this recommendation.

On 7 October 2004, Mr McGeary was reviewed by a psychiatrist for the first time. Dr Purssey conducted an extensive review and concluded that Mr McGeary suffered from *"a severe cluster B personality disorder, mild intellectual disability and marijuana abuse; all in a context of an extraordinarily prejudicial childhood."*

On 25 October 2004, Mr McGeary was assessed by Mr Steven Hardie psychologist. He presented as coping well and a recommendation was made that he be removed from observations altogether. Mr Paul Denaro, a counsellor concurred with this recommendation and Mr McGeary's dealings with the HRAT concluded on this date. However, he continued to participate in programs offered by the Special Needs Unit – relaxation, stress release etc - until his involvement was terminated on 21 February 2005.

Mr McGeary was reviewed by Dr Purssey on 4 November 2004 when his prescription of Zyprexa was decreased from 15mg to 10mg and his Largactil increased was increased from 100mg to 200mg. On 18 November 2004, it was ordered that his Largactil cease and Zyprexa increased to 20mg.

Mr McGeary was again reviewed by Dr Purssey on 16 December 2004 were it was order that his dose of Zyprexa be weaned and Largactil re-commenced. No doses are recorded in the medical notes.

Dr Purssey said in evidence that there was nothing significant about the medication changes and that they were done more as a response to Mr McGeary's concerns – real or imagined.

Mr McGeary was next seen by Dr Katrina Chiu, psychiatry registrar on 7 February 2005. It was noted that Mr McGeary requested that he be taken off Largactil and re-commenced on Zyprexa. Dr Chui agreed that this course was suitable however again, doses were not noted, nor do the notes reflect why this was the preferred medication regime. Mr McGeary was due to be seen at the beginning of April 2005 for further review.

The only other incident of note is an assault that was suffered by Mr McGeary in November 2004. It seems he came into conflict with another prisoner in the stores area and suffered some facial injury as a result. Nothing else is known of the incident nor is it known whether it impacted on Mr McGeary's views about moving to another unit.

Events of 7 March 2005

At about 9.00 am on 7 March 2005, Corrective Services Officer Roberts was informed that four of the new inmates coming into the correctional centre were classified as protection prisoners. It was determined that some inmates currently housed in Unit B5 would need to be transferred to B3, another protection unit.

Discussions took place between Corrective Services Officers Roberts and Pirika who were working in B5, and Correctional Manager McKenzie as to which inmates would be suitable to transfer. The CSO's were aware that they would need to liaise with the prison's intelligence section and the sentence management section so that possible risks flowing from prisoner antipathies or antagonisms could be taken into account. Mr McKenzie confirmed in evidence that he told the corrective services officers that if any of the prisoners who were to be moved objected, he was to be informed.

When Corrective Services Officer Pirika notified Mr McGeary that he was to be transferred, he expressed opposition to this proposal. Ms Pirika recalls hearing Mr McGeary, over the intercom in his cell, telling other inmates that he didn't want to be moved. He further told Ms Pirika over the intercom that he didn't want to be transferred.

Corrective Services Officer Roberts recalls returning from lunch and observing Mr McGeary to be packing up his cell. Mr McGeary approached Mr Roberts and asked to speak to the Correctional Manager. He was advised by Mr Roberts that the decision to transfer him had already been approved and that he was not the only person who was being transferred. He says after being advised of this, Mr McGeary was compliant with the transfer process.

Mr Roberts account in evidence of this period and CSO Pirika's statement is in stark contrast to the account given by a counsellor, Mr Denaro, who was in the unit for another meeting. He says that Mr McGeary aggressively stated that he was not supposed to be moved, that another named correctional manager had "*promised"* that he would not be moved and that he would sue the jail operators for this breach of agreement. Mr Denaro said in evidence that when this was occurring Mr McGeary was "*quite upset and angry."*

Both Mr McGeary and a second inmate were transferred from Unit B5 to B3 at approximately 1.30pm. They were initially spoken to by Corrective Services Officer Oppermann in the airlock and then let into the common area whilst Mr Oppermann contacted the allocations officer to find out which cells were to be utilised for the new inmates.

Corrective Services Officer Davis returned from lunch at approximately 2.05pm. He greeted Mr McGeary before taking him to his allocated cell, cell number 28. Mr Davis then locked Mr McGeary in his cell upon his request.

At this stage there was nothing to indicate that Mr McGeary was distressed of depressed.

At 4.50pm, Davis unlocked Mr McGeary's cell so that muster could be completed. Dinner was then served to all inmates and Mr McGeary was locked back in his cell at approximately 5.35pm by Mr Davis. At 5.45pm, Mr Davis double checked the cells and observed Mr McGeary to be sitting on his bed, looking out the window. There was no one else in the cell.

The death is discovered

At approximately 8.55pm, Corrective Services Officers Forsyth, Willcox and Weight entered Unit B3 to conduct a head count. Mr Forsyth went to the fishbowl area while Mr Willcox went to the left of unit and Mr Weight went upstairs. Cell number 28 was the first cell located upstairs on the left hand side of the unit. Initially, when Mr Weight looked inside cell 28, he could not see Mr McGeary.

After calling out and receiving no response, Mr Weight decided he should open the cell door. He broadcast over his radio that he needed assistance. It was at this time, Mr Weight noticed that material was tied to the ventilation bars set in the cell walls above and to the right of the door. Mr Willcox arrived at the cell. Shortly after, Corrective Services Officers Tumahai, Armstrong and Ellwood came to the door of the unit from Unit B2 and were granted access by Mr Forsyth. Mr Willcox left the cell to retrieve the door key from the fishbowl.

After gaining permission to open the cell door, CSOs Weight, Willcox and Forsyth entered the cell. Messrs Willcox and Tumahai lifted Mr McGeary up while Mr Weight cut him down. Correctional Managers Forrest and Spiers also attended at the cell and assisted the other officers.

Mr McGeary was placed outside the cell to enable more room for CPR to be performed. CPR was then commenced by Spiers, Weight and Tumahai. Registered nurses O'Brien and Miller arrived with a stretcher and took over CPR at approximately 8.58pm. Mr Willcox kept a log of events.

The Queensland Ambulance Service was called very soon after Mr McGeary was found hanging. Ambulances officers arrived at the unit at 9.18pm. CPR was continued by them until 9.25pm when it was clear that he was dead.

The investigation detailed earlier then commenced.

Autopsy evidence

A post mortem was performed by Dr Olumbe, an experienced forensic pathologist, on 8 March 2005 at the John Tonge Centre. He concluded that the cause of death was neck compression. He found no injuries or other evidence that any third party was involved in the incident.

Mr McGeary's grandmother was advised of the death and she travelled to Brisbane and identified his body

I consider that the evidence establishes that Mr McGeary was alone in his cell when it was locked shortly after 5.30pm and that no one entered it until he was found hanging soon before 9.00pm by which time he was deceased. I find that no one other than the deceased was directly involved in his death and that the staff of the AGCC took all reasonable action when he was discovered hanging. I find that when he was discovered, Mr McGeary was already dead and nothing could have been done to revive him.

Findings required by s45

I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have described above my findings in relation to this last aspect of the matter, the manner of death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other particulars of the death.

Identity of the deceased	The deceased person was Corey Allan McGeary
Place of death	He died in Cell 28, Unit B3 of the Arthur Gorrie Correctional Centre
Date of death	He died on 7 March 2005
Cause of death	He died from self inflicted hanging.

Concerns, comments and recommendations

Section 46 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 circumstances of Mr McGeary's death, in my view, raise the following issues for consideration from this perspective:-

- Was the transfer of Mr McGeary on the day of his death appropriately managed having regard to DCS policies and/or GEO's duty to protect him from avoidable harm?

- Would any changes to QCS policies reduce the risk of deaths occurring in similar circumstances in future?

- Would the screening or removal of the bars from the cells in unit B3 reduce the likelihood of deaths occurring in similar circumstances and if so is there any reason that should not occur?

The transfer of Mr McGeary

I don't accept that connecting the death of Mr McGeary to his transfer on the day of the death is speculative. While that connection can not be proved with scientific certainty such a connection can be readily deduced and any response to the death should proceed on the basis of such a connection.

I consider the evidence establishes that Mr McGeary vociferously protested about being moved and that he was angry and distressed. His futile threat to sue the jail operators, rather than physically resisting or even threatening those involved in the decision and its implementation, could be seen as a demonstration of his vulnerability and powerlessness. His acquiescence to the move when his complaint had been ignored and he was denied an opportunity to speak to a superior officer was not acceptance but resignation; his self destruction the exertion of the only power he retained.

The failure of any of those who became aware of Mr McGeary's distress to take any action to address it or even to attempt to understand its cause was conduct falling below the standard one would reasonably expect, particularly as the two CSO's primarily involved had been told by their superior to report to him any such protests. It is also concerning that one of those who failed to taken any action was himself a counsellor. I would have expected a person with that background to more sensitively respond to the emotional needs of a vulnerable prisoner.

However, I have no basis to conclude that this incident is indicative of any widespread problem within the facility. The correctional manager who gave evidence and the senior departmental psychologist who reviewed the incident readily recognised what should have happened. I trust the other participants have now recognised the deficiencies in their response. I do not consider there is a need for any formal recommendation from me in relation to the individuals involved; the policy issue will be dealt with in next section.

I should also acknowledge that there is no basis to conclude that had the officers acted more appropriately, that the outcome would have been any different. The decision to move Mr McGeary was not in itself unreasonable, albeit could have been handled better.

Flagging prisoners chronically at elevated risk of self harm

In a thorough and insightful peer review the Acting Principal Adviser, Psychology and Counselling Services of the Department of Corrective Services expressed the view that because of a combination of his personal circumstances including his personality disorder, his mild retardation, his history of previous suicide attempts, his dysfunctional family relationships and a number of other matters, Mr McGeary was at chronic risk of self harm which could be anticipated to escalate in a range of destabilising circumstances. The author of the report, Ms Bennett expressed the view that having regard to this particular vulnerability, a counsellor or psychologist should have been consulted when it was contemplated moving Mr McGeary and he objected to the proposal.

Ms Bennett's views found their way into a revised departmental policy concerning management of prisoners at risk of suicide promulgated on 28 August 2006. With all due respect to those responsible for drafting the policy, I am not persuaded that it is a particularly useful addition to the tools available to correctional professionals working in this very difficult area of prisoner

management. The policy requires prison staff members who become aware of "*elevated baseline risk issues*" to discuss the case with a senior psychologist "*as soon as practicable."* Appended to the policy is a schedule which lists 30 such risk factors but warns that *"(T)his list is not exhaustive."* As they are obliged to do, GEO sought to operationalise this DCS policy by amendments to its policies but with respect to those responsible for this work I am of the view that it too fails to meet the concerns raised by Ms Bennett in that it too requires prison officers to nominate prisoners they detect to have risk characteristics for referral.

As I understand Ms Bennett's opinion, it is that a clinical judgment can be made that certain prisoners will remain at risk even though they might not warrant on-going observations or other direct interventions, except when their circumstances change such as to activate the hyper sensitivities those prisoners have. The characterisation of prisoners in this way is not readily made by people who do not have a mental health services background.

I am conscious of the need not to make recommendations that if implemented would mean that all or nearly all prisoners would be classified in this way so that the management of the prison would be compromised because, for example, too many prisoners would not be able to be transferred within a prison without a psychologist first being consulted.

However, as I understand the evidence, it is not every prisoner who has a history of self harming or suicide attempts or a personality disorder that would need to be dealt with in this way. As I understood Ms Bennett's evidence it is a reasonably rare combination of characteristics that prevent a prisoner being able to be assisted to become sufficiently robust to deal with the vicissitudes of prison life. It is these prisoners she considers need some involvement of counsellors or psychologists when identifiable stressors may negatively impact. The IOM System offers an easy and effectively facility for "flagging" such prisoners and the initial assessment process provides an opportunity for identifying them.

Recommendation 1 - Flagging prisoners with chronic elevated risk of self harm

I recommend that the Department of Corrective Services investigate whether it is feasible for counsellors or psychologists who undertake the initial assessment of all prisoners soon after incarceration to identify those who pose a chronic risk of self harm which, while not acute so as to warrant observation or other immediate intervention, should be flagged so as to require the involvement of a counsellor or psychologist whenever defined events are likely to impact such a prisoner.

Elimination of hanging points

In commenting on these issues I should not be taken to have concluded that Mr McGeary's death was necessarily preventable. The evidence does not prove that had Mr McGeary been dealt with more sensitively when he protested about being moved he would not have none the less committed

suicide. However, I am satisfied that his movement was the precipitating event and the exposed bars in his new cell provided an unnecessary opportunity for him to take his life.

Suicide is by far the single biggest cause of death among prisoners accounting for 46% of all prison deaths. In raw numbers, in the period 1980 to 2005, 520 prisoners took their own lives while the second most common cause of death was natural causes which accounted for 403 deaths. Prisons are viewed by many as dangerous places, yet in the same period homicide cuased only one tenth as many deaths as suicide.[11]

Hanging is by far the most common mechanism by which prisoners take their own lives accounting for 90% of all cases.[12]

Research has consistently shown that suicide in many cases is an impulsive action. A number of expert witnesses gave evidence to this inquest that Mr McGeary's mental state made him susceptible to poorly controlled impulsivity. It is not the case that if obvious opportunities to commit suicide are removed, all potential victims will find another way. Studies have shown that the placing of even minimal barriers will discourage numerous attempters. In prison this is even easier to effect as prisoners have such limited access to other means – this is why hanging is so often the method used: it is almost the only mechanism available.

The submissions made on behalf of the department assert that the screening of the bars in question with mesh that would prevent a ligature being affixed would reduce airflow to an unacceptable level. They provided no evidence that this has been proven by any trial. The submission also asserts that it to address the problem on a centre wide basis "*would cost millions."*

On 16 April 2003, a new correctional centre was opened in Maryborough at a cost of $97 million. On 29 November 2006, the government advised of its intention to build a new correctional precinct in the Gatton Shire at a cost of $500 million. I therefore do not accept that funding these remedial rectifications, which would undoubtedly save lives, is more than the public purse can afford. Spending priorities are matters Government must determine but they are also something upon which a coroner must comment if he/she is to discharge the statutory duty to suggest ways in which further unnatural deaths could be prevented. I therefore note that prioritising the building of hundreds of new cells ahead of making safe the cells already in existence is inconsistent with the government's obligation to protect prisoners from known risks.

It is also inconsistent with the undertaking the government made to implement a recommendation of the Royal Commission into Aboriginal Deaths in Custody to the same effect.

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[11] *Joudo J., "Deaths in custody in Australia : National Deaths in Custody Program annual report 2005"*, Australian Institute of Criminology*, 2006, 65*

[12] ib id, 64

Recommendation 2 – Removal of hanging points

I recommend that the State Government immediately make available sufficient funding to enable the removal of the exposed bars in all cells at the Arthur Gorrie Remand and Reception Centre.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
1 March, 2007