QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Garry Reginald Dubois**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO:	2021/2503
DELIVERED ON:	30 January 2026
DELIVERED AT:	BRISBANE
HEARING DATES:	13 May 2025
FINDINGS OF:	Deputy State Coroner Gallagher
CATCHWORDS:	Coroners: Inquest, death in custody, risk assessment, access to razors in custody

REPRESENTATION:

Counsel Assisting:	C McKeon
Queensland Corrective Services:	J Franco, Crown Law
Wide Bay Hospital and Health Service:	M Jacobs

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Introduction

[1] Garry Reginald Dubois (**Mr Dubois**) was 74 years old when he was located deceased in his cell at the Maryborough Correctional Centre (**MCC**) on 7 June 2021.[1] Queensland Corrective Services (**QCS**) staff conducting the first headcount of the day found him lying on the floor of his cell, unresponsive, and observed there to be a large volume of blood on his bedding and the floor. They then noticed that the inside of Mr Dubois' right arm had been lacerated. He was unable to be resuscitated. A small metal razor blade was later located on his bed by attending police (**QPS**).

[2] Mr Dubois had been serving a term serving a term of imprisonment for various offences including murder, rape, manslaughter, and deprivation of liberty at the MCC.[2]

Inquest

[3] As Mr Dubois died whist detained at the MCC, his death was a death in custody within the terms of the *Coroners Act 2003* (**the Act**) and was subject to mandatory inquest.[3]

[4] Despite the mandatory nature of this inquest, and indeed any death in custody, it is a well-accepted principle that:

> *Deaths in custody warrant particular attention because of the responsibility of the State to protect and care for the people it incarcerates, the vulnerability of people deprived of the ability to care for themselves, the need to ensure the natural suspicion of the deceased's family is allayed, and to ensure public confidence in state institutions is maintained. Further, a thorough and impartial investigation is in the best interests of the custodial officers.*[4]

[5] It follows that I consider the interests of both the community and Mr Dubois' family are served by a thorough, competent and impartial investigation into his death. In addition to the findings I am required to make in accordance with s.45(2) of the Act, it was determined that the following issues would be investigated at inquest:

Issue 2: Whether the supervision of Mr Dubois was adequate and appropriate in the three months leading up to his death;

Issue 3: Whether the medical care afforded to Mr Dubois by the Maryborough Correctional Centre was adequate and appropriate in the three months leading up to his death;

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[1] Ex. A1- Form 1 at page 1.
[2] Ex. B- QPS Investigation- QPS Coronial Report Appendices at Attachment G-- Queensland Court Outcomes for Garry Reginald Dubois at page 3.
[3] ss.8(3)(g), 10 and 27(1)(a)(i) *Coroners Act 2003.*
[4] *Inquest into the death of Mulrunji*, delivered on 14 May 2010, per Deputy Chief Magistrate Hine at [14].

Issue 4: Whether the mental health care afforded to Mr Dubois by the Maryborough Correctional Centre was adequate and appropriate in the three months leading up to his death; and

Issue 5: Whether the provision of razors to Mr Dubois in the three months leading up to his death was appropriate.

Evidence

[6] The brief of evidence compiled during the coronial investigation was tendered at inquest, and four witnesses gave oral evidence:

a) Correctional Supervisor Beth Shostakowski;

b) Inspector Janelle McHaffie;

c) Dr Margaret Purcell; and

d) Acting Deputy Commissioner Eloise Hamlett.

[7] I consider that the evidence tendered in addition to the oral evidence from these witnesses was sufficient for me to make the requisite findings in this case.

Autopsy results and cause of death

[8] On 11 June 2021, forensic pathologist Dr Jessica Vidler and senior forensic pathologist Dr Beng Ong conducted an autopsy consisting of a full internal and external examination of the body, along with toxicology testing.

[9] Toxicology results showed diltiazem, metoprolol, prazosin and clopidogrel were present in the admission bloods, all of which were medications prescribed to him. These drugs were detected to be present at non-toxic levels.[5]

[10] Drs Vidler and Ong noted that there was:

a) Evidence of injury including incised wounds to the limbs with incised superficial veins in the right cubital fossa and left leg, a recent T12 spinal fracture, and injuries attributable to CPR attempts; and

b) Evidence of natural cardiac disease.[6]

[11] Drs Vidler and Ong concluded that the cause of Mr Dubois' death was:

1(a) Incised wounds to limbs
2 Ischaemic heart disease, antiplatelet therapy.[7]

[12] In drawing this conclusion, it was noted that the mechanism of death in this case was ongoing haemorrhage from the incised wounds to the limbs, with

[5] Ex. A4- Toxicology Certificate at page 1; Ex. A3- Autopsy Report at page 17.
[6] Ex. A3- Autopsy Report at pages 15-16.
[7] Ex. A2- Autopsy Certificate; Ex. A3- Autopsy Report at page 18.

continuous bleeding occurring due to Mr Dubois's antiplatelet therapy. It was opined that his significant ischaemic heart disease would have hastened death, as his heart would have had limited reserve to continue to function in the setting of haemorrhage. Death would have occurred due to lethal arrhythmia in the setting of intravascular volume loss and diminished oxygenation of the heart muscle. It was further opined that the scene investigation and autopsy findings indicated that the incised wounds were likely self-inflicted. The minor injuries were determined to be non-suspicious.[8]

[13] I accept the opinion of Drs Vidler and Ong in respect of Mr Dubois' cause of death.

Consideration of the circumstances leading up to the death

Personal, correctional and medical history

[14] Mr Dubois was born in Mackay on 11 March 1947. His wife was Jan Dubois, who at the time of Mr Dubois' death lived in Burrum Heads, Queensland. They had a daughter, Nicole Dubois, and the family had a close relationship.[9] Mr Dubois and his family predominantly resided around the Wide Bay Burnett and Northern Sunshine Coast areas, and at the time of his final arrest, Mr Dubois lived in Torbanlea.[10]

[15] Mr Dubois's adult criminal history commenced when he was 17 in 1964 with dishonesty- based and traffic offences. His offending escalated to violence the same year, the nature of which escalated from unlawful assault to rape and aggravated assault on a female. Conviction for latter two of these offences saw him being imprisoned for 8 years and 3 months respectively. His time in prison was extended by 3 days after he was convicted for a breach of the *Prisons Act* (now repealed) on 10 April 1970. With one exception, between 1973 and 2017, Mr Dubois' offending related to major and minor drug offences, one firearms offence, and traffic offences. He served a term of imprisonment in 1981 in relation to drug offences.[11]

[16] In October 2014, Mr Dubois was arrested and subsequently charged with the kidnapping and murder of Barbara McCulkin and her two daughters, Vicki and Barbara, along with the rape of the two girls. The charges related to the disappearance of the three from their family home at South Brisbane on 16 January 1974. Vicki and Barbara were 13 and 12 at the time. Mr Dubois was tried along with his co-accused, Vincent O'Dempsey, and found guilty by a jury of two counts of murder, one count of manslaughter, one count of rape and one count of depravation of liberty.[12] He was sentenced on 1 June 2017 to concurrent terms of life imprisonment, 15 years' imprisonment and three

[8] Ex. A3- Autopsy Report at page 17.
[9] Ex. B1- Coronial Report at pages 1, 4 and 12.
[10] Ex. B1- Coronial Report at page 4; Ex. C7.19- IOMS- ADDRESS.
[11] Ex. B- QPS Investigation- QPS Coronial Report Appendices at Attachment G-- Queensland Court Outcomes for Garry Reginald Dubois.
[12] *R v Dubois* [2018] QCA 363 at [1] per Sofronoff P.

years' imprisonment with 955 days of pre-sentence custody deemed to be time served.[13]

[17] Mr Dubois's appeal of these convictions was unanimously dismissed by the Court of Appeal on 21 December 2018.[14]

[18] Attempts to prosecute Mr Dubois for the same murders had occurred previously in 1981 but these were discontinued by the prosecution by way of *nolle prosequi* on 27 February 1981.[15]

[19] At the time of Mr Dubois' arrest in October 2014, he was 67 years old and a pensioner.[16] He was held at the Brisbane Watchhouse before appearing before the Brisbane Magistrates Court that day and being remanded into custody.[17]

[20] On 22 October 2014, Mr Dubois was transferred and held initially on remand in protective custody at the Arthur Gorrie Correctional Centre (**AGCC**).[18] He was medically and psychologically assessed and referred to the Prison Mental Health Service. No mental health concerns or risks were identified.[19]

[21] On 21 December 2016, Mr Dubois was transferred and held on remand at MCC whilst awaiting trial. Following his conviction and sentencing, he was transported back to the MCC where he remained from 7 June 2017 onwards.[20] Due to the notoriety of his offences, Mr Dubois was classed as a protected prisoner and housed in a single occupancy cell.

[22] Mr Dubois had ongoing heart-related issues for which he had a family history. His medical history included:

a) Syncope potentially due to bradycardia diagnosed in 2017;
b) Ischaemic heart disease;
c) Myocardial infarction occurring in 1992 and 1999;
d) A quadruple coronary artery bypass graft in 1993. Three grafts were assessed as being occluded in 2013 but were deemed to have collateral blood supply, meaning further surgery was not indicated;
e) Refractory hypertension diagnosed in 2013;
f) Hyperlipidaemia; and
g) Previous smoking.[21]

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[13] Ex. B- QPS Investigation- QPS Coronial Report Appendices at Attachment G-- Queensland Court Outcomes for Garry Reginald Dubois; Ex. C3- IOMS offender file- Part 2 at pages 36- 42 (Sentencing remarks of Applegarth J in *The Queen v Garry Reginald Dubois and Vincent O'Dempsey* dated 1 June 2017); Ex. C7.16- WARRANTS AND OFFENCES.
[14] *R v Dubois* [2018] QCA 363.
[15] Ex. B- QPS Investigation- QPS Coronial Report Appendices at Attachment G-- Queensland Court Outcomes for Garry Reginald Dubois.
[16] Ex. B1- Coronial Report at page 4.
[17] Ex. B1- Coronial Report at page 4.
[18] Ex. B1- Coronial Report at page 4; Ex. C2- IOMS offender file- Part 1 at page 152.
[19] Ex. D1- WBHHS records- Vol 1 at pages 10-34, 52-53 and 115-125.
[20] Ex. B1- Coronial Report at page 4; Ex. C7.9- Movement History at page 2.
[21] Ex. A3- Autopsy Report at pages 15-16; Ex. A1- Form 1 at page 11.

[23] Mr Dubois was medicated in relation to these conditions during his time in custody. He had regular access to nurses, visiting medical officers (**VMO**) clinicians and hospital-based care, and he was treated when he presented or consented to treatment/review. Care largely related to his cardiac conditions, dizziness and occasional syncope, treatment of basal cell carcinomas and squamous cell carcinomas in 2018 and 2019 and other minor health issues. Health Service records indicate that treatment was sought by Mr Dubois on a sporadic basis.[22]

[24] In the lead up to his death, Mr Dubois accessed medical care on 25 May 2021, and was reviewed by locum VMO Dr Gardon. Progress notes reflect that:

a) Each of his long-term medications were reviewed. Prochlorperazine, which he had been taking for vertigo, was ceased on a trial basis given he had not had vertigo for over a year. When Mr Dubois' long-term dual antiplatelet therapy (**DAPT**) medication was reviewed, Mr Dubois advised the VMO that his cardiologist had recommended they continue;

b) Mr Dubois denied chest pain and shortness of breath and advised he was walking daily;

c) Age-appropriate health screens for bone mineral density and foecal occult blood tests were offered to Mr Dubois but he declined these;

d) Observations were taken. He was found to be bradycardic to 40 and had a hypotensive blood pressure of 95/60. Mr Dubois also reported that he had intermittent presyncope and felt fatigued. Dr Gardon considered that his long-term atenolol and prazosin were contributory to these conditions, and it was resolved that these would be reduced .[23] The planned reductions were from 25 mg to 12.5mg of atenolol and from 1mg to 0.5mg of prazosin;[24] and

e) Aside from the planned changes to Mr Dubois' medications, it was resolved that he would have bloods taken and further changes would be considered on review in one week if he had not improved.[25]

[25] These medication changes were implemented immediately.[26]

[26] At 1:00pm on 27 May 2021, further progress notes under the hand of Dr Gardon recorded that 12.5mg atenolol was not available so 12.5mg of metoprolol was prescribed to be taken twice daily. This commenced on 28 May 2021 twice daily. [27]

[22] Ex. D1- WBHHS records- Vol 1; Ex. D2- WBHHS records- Vol 2.
[23] Ex. D2- WBHHS records- Vol 2 at page 4.
[24] Ex. D2- WBHHS records- Vol 2 at page 28.
[25] Ex. D2- WBHHS records- Vol 2 at pages 4 and 8- 12.
[26] Ex. D2- WBHHS records- Vol 2 at pages 28 and 30.
[27] Ex. D2- WBHHS records- Vol 2 at page 4.

[27] Health Service records indicate Mr Dubois declined to attend his follow-up appointment on 1 June 2021.[28]

[28] Mr Dubois' medical records confirm his medications at the time he passed away were:

a) Clopidogrel 75mg taken once daily (an antiplatelet medication and part of his DAPT);

b) Aspirin 100mg taken once nightly (part of his DAPT);

c) Diltiazem 100mg taken once nightly (a calcium channel blocker to treat his high blood pressure and for chest pain prevention);

d) Isosorbide 120mg taken one daily (a drug for chest pain management);

e) Atorvastatin 80mg taken once nightly (a cholesterol reducing drug);

f) Prazosin 0.5mg taken twice daily (an antihypertensive used to lower blood pressure); and

g) Metoprolol 12.5mg taken twice daily (medication for high blood pressure and chest pain prevention).[29]

[29] Given the proximity of Mr Dubois' medication changes to his death, his medical care was considered in these proceedings, and is dealt with below.

[30] Cardiac issues aside, Mr Dubois was otherwise reportedly very fit for his age, happy and healthy. QCS records are to the effect that he had no diagnosed mental health issues and no history of making suicidal gestures or threats. At the time he passed away, he was not on suicide watch and QCS staff had not observed any changes in his behaviour.[30] These aspects of Mr Dubois' supervision and care were considered in QPS and QCS investigations, and in these proceedings. I will deal with these in more detail subsequently in these findings.

[31] At the time of his death, Mr Dubois was housed in cell 41, level 2 of block S2 (protection block). The single occupancy cell contained a bed, shelving, toilet and basin.[31]

Day of death

[32] At around 6:00pm, on 6 June 2021, Mr Dubois was locked down in his cell, as were inmates in the other cells. A head count was conducted at 8:20pm. Mr Dubois was observed, alive and well, through the door's viewing window by

[28] Ex. D2- WBHHS records- Vol 2 at page 5.
[29] Ex. A1- Form 1 at pages 1 and 11; Ex. A3- Autopsy Report at pages 15-16; Ex. D1- WBHHS records- Vol 1 at page 3.
[30] Ex. A1- Form 1 at pages 11-12.
[31] Ex. A1- Form 1 at page 11; Ex. C7.1- BED HISTORY.

Custodial Correctional Officer (**CCO**) Steven Butchart at 8:40pm.[32] The electronic door log of Mr Dubois' cell confirmed the door was not unlocked until the next morning.[33]

[33] At 4:45am on 7 June 2021 during the next head count, CCO Kadin Poulter observed Mr Dubois lying on the floor of his cell with his feet near the toilet, unresponsive and with blood on his bedding and the floor. CCO Poulter called for assistance by way of a Code Blue. Other staff including ranking officer Correctional Supervisor Shostakowski, and CCOs Ward, Realph, Lowien, Butcher, and Zemek arrived and entered the cell. He was observed to have two deep lacerations to the inside elbow of his right arm, approximately 2-3 cm in length. His eyes were open and he was cold, pulseless, not breathing and unresponsive. CS Shostakowski initially declared the cell as a crime scene, but directed staff to pull Mr Dubois towards the door and eventually commence chest compressions and then CPR They continued until the Queensland Ambulance Service (**QAS**) and QPS arrived on scene at 5:10am. QAS took over resuscitation attempts and assessed he was in cardiac arrest. He was declared deceased at 5:20am.[34]

Investigation

QPS

[34] When QPS arrived on scene QPS observed Mr Dubois was lying supine on the floor of his cell, clothed in a prison issue t-shirt and shorts. The blood on the bedding and floor appeared to have seeped into the bedding and was drying. They also noted the laceration marks on Mr Dubois' arms. After Mr Dubois was declared life extinct, his body was left untouched in situ and the scene was secured.[35] The Criminal Investigation Branch (**CIB**) and Scenes of Crime (**SOC**) attended.[36] Officers located a small metal razor blade on Mr Dubois' bed. Jan Dubois was advised of her husband's death by QCS staff at 7:00am.[37]

[35] QPS canvassed the scene but did not locate a suicide note or letter.[38] SOC and CIB officers noted that Mr Dubois had incised wounds on both arms and his left calf. The razor blade that was located was thought to have been removed from a prison-issued disposable shaver.[39]

[36] The reporting officer from QPS noted that at the time of his death, Mr Dubois was not subject to any emergency examination authorities, Forensic or MHA-based Orders, and had no known mental health history including no diagnosed mental illnesses, no recent attendances at a mental health unit (voluntary or

[32] Ex. A1- Form 1 at page 11.
[33] Ex. C15- QCS Electronic door log.
[34] Ex. A1- Form 1 at pages 8 and 11; Ex. B4- Supp Form 1- Investigations + scene info + interview summaries at pages 3-4; Ex. A3- Autopsy Report at page 16; Ex. C18- OIMIRG Report at pages 8-9; Ex. C5- Various documents (1)- Form 312s regarding Code Blue at pages 33-34 and 40-45, 51-56, 61-63, 67-68 plus contemporaneous notes at page 60.
[35] Ex. A1- Form 1 at page 11; Ex. B1- Coronial Report at page 3.
[36] Ex. A1- Form 1 at page 9; Ex. B1- Coronial Report at pages 3 – 5.
[37] Ex. B3- Supp Form 1 at pages 1-2; Ex. B1- Coronial Report at page 3.
[38] Ex. A1- Form 1 at page 15.
[39] Ex. B1- Coronial Report at pages 3 and 5.

otherwise), was not taking any medication for psychiatric illness and was not demonstrating any behaviour suggestive of undiagnosed mental illness.[40]

[37] A large volume of letters and documents in brown paper bags were located in Mr Dubois' cell shelves. QPS seized them along with the razor blade and disposable razor.[41]

QCS

[38] Two debriefings were conducted on 7 June 2021, with counselling offered to the involved QCS staff. No issues were identified, and no actions were required to be initiated in respect of the incident.[42]

[39] An Incident Report was furnished by QCS on 7 June 2021. It was recommended that no breaches of discipline or criminal charges be instigated.[43]

CSIU

[40] Detective Senior Constable Martin Payne from the QPS Corrective Services Investigation Unit (**CSIU**) conducted a coronial and criminal investigation and completed a Coronial Report dated 21 July 2021 that outlined the circumstances of Mr Dubois' death.[44]

[41] After being notified of the death, CSIU attended Mr Dubois' cell with CIB and SOC. Recorded interviews were conducted with prisoners in Mr Dubois' unit. QCS staff involved in locating Mr Dubois were interviewed and provided officer reports. QCS, QPS, medical, forensic pathology and Court records relating to Mr Dubois were obtained. This Report was included in the brief of evidence.[45]

[42] Without repeating the facts relating to Mr Dubois' day of death, DSC Payne's investigation found:

a) Following the usual final headcount and lock down at about 5:00pm, CCO's were only required to perform welfare checks on the prisoners twice during the night at about 8:15pm and 4:15am, and only checked high risk prisoners who were confined within high dependency cells constantly per individual recommendations. Mr Dubois was seen alive at the final headcount and at the 8:15pm check, and found deceased at the 4:15am check;[46]

[40] Ex. A1- Form 1 at pages 5-7.
[41] Ex. B4- Supp Form 1- Investigations and interviews at page 2.
[42] Ex. C18- OIMIRG Report at page 14; Ex. C17.2- DEBRIEF- Form 193.
[43] Ex. C1- QCS INCIDENT REPORT 308752 (07.06.2021) at page 5; Ex. C18- OIMIRG Report at page 8.
[44] Ex. B1- Coronial Report.
[45] Ex. B1- Coronial Report.
[46] Ex. B1- Coronial Report at page 2.

b) Review of QCS records did not provide any evidence that Mr Dubois had expressed any suicidal or self-harm ideation during his interactions with QCS staff;[47]

c) Mr Dubois was referred to MCC psychologists on 21 December 2016 and 7 June 2017. No concerns or risks were identified at these times;[48]

d) MCC CCTV covered the common areas of S2 unit including the front cell door of Mr Dubois' cell. There were no cameras that captured the interior of prisoners' cells in S2. A review was conducted of the available footage from lockdown at 5:15pm on 6 June 2021 through to the location of Mr Dubois in his cell on 7 June 2021 in any event;[49]

e) CS Schostakowski indicated at interview that Mr Dubois was not identified or subject to any risk plan and was therefore not subject to more frequent CCO checks. She stated that to her knowledge, Mr Dubois never presented to staff as being at risk. None of the other five CCOs interviewed indicated there were any pre-existing concerns with Mr Dubois;[50]

f) Of the six inmates housed in S2 who agreed to be interviewed, Greg Shean advised that:

    i. Mr Dubois had confided in him over the five years they had known each other, and about 12 months prior to his death told him he wanted to commit suicide. Mr Shean advised he stopped Mr Dubois from doing it by talking to him and continuing to do artwork for him;

    ii. Mr Dubois had told him he did not want to put his family through the upcoming inquest, and had also told him that he was going to commit suicide by cutting himself and bleeding out;

    iii. He was aware that Mr Dubois' family visited him on 6 June 2021 and he thought that the family were aware of Mr Dubois' plan to commit suicide. He further thought that Mr Dubois' family attended that day to say their goodbyes to him;

    iv. He believed Mr Dubois was showing early signs of dementia and would lose his train of thought during conversations regularly; and

[47] Ex. B1- Coronial Report at page 5.
[48] Ex. B1- Coronial Report at pages 5-6; Ex. C13- Psychologists- CASE NOTES.
[49] Ex. B1- Coronial Report at page 6.
[50] Ex. B1- Coronial Report at pages 6-10.

v. Mr Dubois' medication had been recently changed and a few weeks ago he had reported to Mr Shean that he felt funny for a few days but then was fine;[51]

g) The information Mr Shean provided about the family visit and knowledge appeared to be corroborated by the following interactions between Mr Dubois and his family on 6 June 2021, the summary of which was:[52]

Time and date	Interaction
8:30am 6/6/21	In person visit between Jan Dubois, Nicole Dubois, Allan Hoffman and Mr Dubois at MCC.
11:51am 6/6/21	Arunta call with Nicole Dubois- Mr Dubois said goodbye to her several times, Nicole Dubois replied, *"I'm proud of you Dad"* and *"I love you Dad"*, and repeatedly said goodbye. Mr Dubois said "*you know why…I don't want to say too much*" and Nicole Dubois said "*you mean the world to me…I understand everything..Dad. I love you*".
11:53am 6/6/21	Arunta call with Jan Dubois- Mr Dubois repeatedly said, *"I love you"* and *"goodbye"*. Jan Dubois responded with *"I love you"* repeatedly. Mr Dubois said "*as long as youse [sic] understand*". Jan Dubois said "*I don't like it…I get it…you know. You're sick and tired of being sick and tired".* Mr Dubois said "*it's been too long…I've done my best…this is hard for me*".
2:48pm 6/6/21	Arunta call with Nicole Dubois- Mr Dubois again said, *"I love you"* and *"goodbye"* repeatedly. He also stated "*I've got nothing to say…I'll always be thinking of you. I'm not going to prolong this battle"*. Nicole Dubois stated, *"I don't think you should*" and Mr Dubois said, "*you take care kid*".
2:59pm 6/6/21	Arunta call with Jan Dubois- again Mr Dubois said *"goodbye"* and *"I love you"*. Jan replied *"I love you"* but commented she could not say goodbye. Jan Dubois commented it was probably because *"they reduced your medication"*. Mr Dubois disagreed and said, *"I've just had enough".* Jan Dubois asked, *"you can't just dig yourself out of it?"* to which Mr Dubois stated he could not.

h) Attempts to contact and interview Jan Dubois were refused by Jan Dubois;[53]

i) Mr Dubois had been in custody since October 2014. During his incarceration, he did not present as being at risk of self-harm, and presented with no indicators that he might self-harm. S2 unit prisoners reported he was well-liked and respected, and was noted for being healthy and regularly exercising;[54]

[51] Ex. B1- Coronial Report at pages 10-11.
[52] Ex. B1- Coronial Report at page 12; Ex. C7.15- VISIT HISTORY; Ex. C18- OIMIRG Report at page 7; Ex. B- QPS Investigation- QPS Coronial Report Appendices- Attachment Q- Arunta calls.
[53] Ex. B1- Coronial Report at page 13.
[54] Ex. B1- Coronial Report at page 13.

j) Mr Dubois had been supervised by CCOs per usual procedures and no unusual incidents or occurrences were noted on his file;[55] and

k) There had been compliance with all relevant policies and procedures relating to Mr Dubois' custody and supervision. Mr Dubois appeared to have used a prison-issued razor blade to self-harm but there were no policies preventing him having possession of razors at the material time.[56]

[43] Ultimately, DSC Payne concluded:

a) Mr Dubois died from self-inflicted wounds, and that he made a decision to self-harm with the intention to bleed until death;

b) Mr Dubois was aware of an upcoming coronial inquest regarding murders resulting from the 1973 arson of the Whiskey Au Go-Go nightclub in Fortitude Valley. This was due to commence on 14 June 2021. DSC Payne opined that it was probable that Mr Dubois believed he would be summonsed to give evidence;

c) Mr Dubois took medication for various previous heart-related conditions, including anticoagulants. DSC Payne opined that his increased likelihood of bleeding may have influenced him choosing to use the razor blade to end his life;

d) There was no evidence implicating any person in the death of Mr Dubois;

e) No negligent acts or omissions by any persons resulting in Mr Dubois' death could be found; and

f) Mr Dubois was provided with adequate medical care whilst in custody.[57]

[44] On 23 July 2021, Detective Senior Sergeant Anthony Buxton forwarded DSC Payne's Coronial Report to the Coronial Support Unit (**CSU**). DSS Buxton confirmed the investigation found no suspicious circumstances surrounding Mr Dubois's death. In drawing this conclusion, DSS Buxton noted that:

a) Review of footage and swipe access to the cell, along with sightings of the last person to see Mr Dubois alive supported the death as being intentional on Mr Dubois' behalf; and

b) Review of prisoner telephone calls indicated Mr Dubois said *"goodbye"* to his wife and daughter in a series of calls on 6 June *2021 "with veiled references to the forthcoming Whiskey Au Go-Go Inquest which was due to start on 14 June 2021. Mr Dubois was expected to provide evidence at the Inquest"*.[58]

[55] Ex. B1- Coronial Report at page 13.
[56] Ex. B1- Coronial Report at page 13.
[57] Ex. B1- Coronial Report at pages 13-14.
[58] Ex. B2- Report DSS Buxton CSIU to DI CSU at page 1.

[45] No recommendations were made by QPS in relation to the circumstances of Mr Dubois' death.

[46] At this juncture, it is convenient to note that the Pre-Inquest Conference (**PIC**) for the *Inquest into the deaths of fifteen people who died in the Whiskey Au Go-Go* (**the Whiskey Au Go-Go Inquest**) was heard at the Brisbane Magistrates Court on 29 April 2021. Counsel Assisting advised the Court that Mr Dubois would be called to give evidence. His name was the final name read into the record.[59]

[47] At the conclusion of the PIC, the Inquest was adjourned to 14 June 2021. As is readily apparent on the public record, the Whiskey Au Go-Go Inquest was heard in three tranches, being between 14 June 2021-25 June 2021, 24 January 2022-11 February 2022 and 9 May 2022-17 May 2022.

[48] No evidence was put before me to suggest that Mr Dubois was summonsed or formally required to give evidence at the Whiskey Au Go-Go Inquest following the conclusion of the PIC on 29 April 2021. Particularly, evidence provided by QCS was to the effect that there was no information in Mr Dubois' files to indicate that he was formally being called as a witness to the Inquest, and it had not received any Orders to produce or transfer Mr Dubois for any Court attendances pursuant to s.69 of the *Corrective Services Act 2006* at any material time up to and including his time of death.[60] I accept the evidence of QCS on this point.

[49] It follows that while I find that the QPS investigation into Mr Dubois' death was conducted thoroughly and professionally, I consider there is insufficient evidence before me to make a determination that Mr Dubois was motivated to end his life due to the impending Whiskey Au Go-Go Inquest and/or the prospect he may be required to give evidence at it.

OIMIRG

[50] A parallel review was conducted by the Operational Inspection and Major Incident Group (**OIMIRG**) of QCS.[61] The review was by and large conducted by Inspector Janelle McHaffie, who also prepared a Desktop Review Report.[62] In drafting this review, the Inspector considered QCS records, policies and procedures, CCTV and BWC footage, Arunta and recorded interviews with prisoners and CCOs, plus further interviews with CCOs.[63]

[51] Relevantly, Inspector McHaffie found:

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[59] *In the matter of a Pre-Inquest Conference into the cause and circumstances surrounding 15 deaths arising from a fire at the Whiskey Au Go-Go nightclub on 8 March 1973* - T1-14 at lines 46-47.
[60] Ex. C18- OIMIRG Report at page 7; Ex. G1- Eloise Hamlett at page 9, [77]- [79].
[61] The equivalent current department is the Corrective Services Inspectorate and Review Group (**CIRIG**).
[62] Ex. C18- OIMIRG Report.
[63] Ex. C18- OIMIRG Report at pages 4-5.

a) At the time of his death, Mr Dubois had a parole eligibility date of 20 October 2029;

b) Mr Dubois was classified as a high security prisoner and had the following warning flags activated:

   i. Victims Register;
   ii. Enhanced Security Offenders;
   iii. High Profile;
   iv. Protection;
   v. Serious Offender Unit; and
   vi. Offender File Restricted Access;[64]

c) Mr Dubois had no issues, breaches or incidents prior to his death and was not being managed under at-risk observations. He was employed in S2 as a unit cleaner and had maintained that employment since 2018, with no major issues recorded other than two minor occasions where Mr Dubois was provided coaching from staff in relation to the performance of his employment duties. He was identified as being polite, compliant, and someone who generally kept to himself but who had a few friends;[65]

d) An Immediate Risk Needs Assessment **(IRNA)** was completed when Mr Dubois was initially taken onto custody in October 2014, and again in December 2016 upon reception to the MCC. It indicated Mr Dubois had no history of self-harm or suicidal ideation. Mr Dubois denied any history to these effects and no information to the contrary was evident;[66]

e) Mr Dubois was managed as a protection prisoner and his Protection Needs Assessment (**PNA**) was completed on 23 October 2014, the day after he was admitted to the AGCC. The PNA was granted due to the nature of his offences and the extensive media attention surrounding his case; [67]

f) Mr Dubois was subject to two Temporary Safety Orders (**TSO**) whilst in custody, namely:

   i. On 27 November 2015, he was placed on a TSO following his return from Court after he reportedly displayed some self-harm

[64] Ex. C18- OIMIRG Report at page 6; Ex. C7.25- WARNINGS AND FLAGS; Ex. C7.1- BED HISTORY; Ex. C7.12- SECURITY CLASSIFICATION; Ex. C5- Various Documents (1) at page 1-no recorded self-harm or suicide history and no evidence to suggest risk to himself at 15.7.20. Earlier assessments confirm the same view; Ex. C6- Various documents (2) at page 2- *CPOR* offender.
[65] Ex. C18- OIMIRG Report at pages 6 and 8; Ex. C7.6- EMPLOYMENT; Ex. C7.3- CASE NOTES- per regular IOMS reviews of risk and counselling- final review prior to death 17/9/20, nil at risk behaviours; Ex. C7.13- SELF HARM; Ex. C6- Various documents (2)- Prison behaviour case reports at pages 43- 76.
[66] Ex. C18- OIMIRG Report at page 6; Ex. C7.3- CASE NOTES at pages 1 and 19; Ex. C3- IOMS offender file- Part 2 at pages 81- 83 and 87-88; Ex. C6- Various Documents (2) at pages 31-36; Ex. C13- Psychologists- CASE NOTES; Ex. D1- WBHHS records- Vol 1 at pages 20-29- medical history taken also.
[67] Ex. C18- OIMIRG Report at page 6; Ex. C7.10- PNA 2014.

indicators in Court. He was placed on 15-minute observations until he could be assessed by BCC psychological staff. Assessment deemed him not to be at risk and the TSO was cancelled;[68] and

ii. On 28 November 2016, he was placed on a TSO after being found guilty in his high-profile case, with no psychologist available to assess him. Subsequent assessment deemed him not to be at risk and the TSO was cancelled;[69]

g) The Arunta recordings with Jan and Nicole Dubois from 6 June 2021 indicated his *"family were emotional"* and *"knew of his intention to commit suicide"*;[70]

h) Mr Shean did not share Mr Dubois' disclosures about his suicidal intent and planning with anyone prior to Mr Dubois' death. At interview he also stated Mr Dubois did not tell him exactly when he would carry the suicide out;[71]

i) QCS IOMS records did not indicate any recent intelligence activity, with no new intelligence reports or information notes entered since March 2018;[72] and

j) There was no information in Mr Dubois' QCS files indicating he was formally being called as a witness to the Inquest or any pending trials.[73]

[52] Inspector McHaffie's review of the IOMS regarding incidents revealed Mr Dubois was involved in one emergency medical episode when he became ill and fainted during a visitation session on 5 November 2017. Three other incidents were recorded but these related to positive indicators for illicit substances identified during routine scans of Jan and Nicole Dubois.[74]

[53] Custodial Operations Practice Directions (**COPDs**) relating to Incident Management (Death in Custody) and Daily Operations Night Shift were considered in the review. The various Incident Management COPDs that were nominated by the Inspector as being relevant included Code Blue Emergency

[68] Ex. C18- OIMIRG Report at page 6; Ex. C7.3- CASE NOTES at pages 9-11.
[69] Ex. C18- OIMIRG Report at page 6; Ex. C7.3- CASE NOTES at pages 16- 19; Ex. C2-IOMS offender file- part 1 at page 141; Ex. C2- IOMS offender file- Part 1 at pages 141-145; Ex. D1- WBHHS records- Vol 1 at pages 94-103.
[70] Ex. C18- OIMIRG Report at page 7.
[71] Ex. C18- OIMIRG Report at page 7.
[72] Ex. C18- OIMIRG Report at page 7.
[73] Ex. C18- OIMIRG Report at page 7.
[74] Ex. C18- OIMIRG Report at page 8; Ex. C7.2 BREACH AND INCIDENT HISTORY; Ex. C5- Various documents (1)- Form 312 Positive Ionoscan on Jan DUBOIS at page 36 and 57; Ex. C6- Various documents (2) at pages 94-95 regarding Code Blue and pages 96-100 regarding positive ionoscans; Ex. D1- WBHHS records- Vol 1 at pages 38-39.

(IM 7), Requirements for Preservation of a Crime Scene (IM 12), and Requirements for Incident Debriefing and Post Incident Analysis (IM 17).[75]

[54] In reviewing Mr Dubois' death in the context of these relevant COPDs, no significant issues of note were identified by Inspector McHaffie. The following two minor issues of concern were identified by the Inspector, however:

a) The failure of staff to immediately commence CPR as required, with a delay of nine minutes between the location of Mr Dubois unresponsive in his cell, and the commencement of CPR compressions only; and

b) CS Schostakowski incorrectly declared the cell a crime scene prior to the declaration of life extinct but then, realising her mistake, instructed that the cell be opened, and CPR commence.[76]

[55] The Report adopted the cause of death nominated in Mr Dubois' autopsy certificate. It concluded:

a) There were no indications QCS staff had any information to suggest Mr Dubois intended to commit suicide, or any information that would raise concern in relation to his state of mind or behaviour;

b) Reviews of the Arunta recordings following Mr Dubois' death identified that Mr Dubois had telephoned his wife and daughter and the content of the calls indicated that they may have had knowledge of Mr Dubois's intentions to end his life that evening, but they did not report this to the MCC or any other authority; and

c) Mr Dubois' behaviour viewed from CCTV footage on the day prior to his suicide indicated regular daily occurrences, and he was seen participating in daily exercise in the exercise yard, socialising with peers, attending medication rounds in the accommodation unit and using the prisoner telephone systems.[77]

[56] Inspector McHaffie ultimately recommended that no further review be undertaken in this matter.[78] While the Inspector did not determine that more prompt resuscitation efforts could have prevented Mr Dubois' death, mask suitability issues were considered internally and an amended first aid training instruction about rescue breaths was delivered.[79]

[57] I find that the OIMIRG review of Mr Dubois' death was conducted thoroughly and professionally. I am not, however, persuaded on the evidence before me

[75] Ex. C18- OIMIRG Report at page 10; Ex. C17.1- Death in Custody- COPD-clean; Ex. C17.3- IM7-Code-Blue-clean; Ex. C17.4- Incident-management-death-in-custody.
[76] Ex. C18- OIMIRG Report at page 12.
[77] Ex. C18- OIMIRG Report at page 12.
[78] Ex. C18- OIMIRG Report at page 5.
[79] Ex. C18- OIMIRG Report at pages 12-13. The amendment was to require rescue breaths to commence if the rescuer is willing and able.

that Mr Dubois' family knew of his intention to end his life, and I decline to make any findings to that effect.

Expert medical evidence

[58] The Court obtained expert evidence from Dr Margaret Purcell, Senior Medical Officer employed by Cairns and Hinterland Hospital and Health Service, Mareeba Hospital, Dimbulah Primary Health Centre and Lotus Glen Correctional Centre. Dr Purcell was asked whether the change in Mr Dubois' medications had an adverse effect on Mr Dubois' physical and mental health, whether this change should have been subject to review and she was also asked about the appropriateness of the care Mr Dubois received in general.

[59] In her report dated 4 October 2023, Dr Purcell expressed the following opinions.

[60] Firstly, that the changes to and reductions of Mr Dubois's medications of 25 May 2021 did not have an adverse effect on his health. In drawing this conclusion, Dr Purcell noted:

a) There were no notes in any records (QCS or medical) suggesting there were any changes to Mr Dubois' physical or mental health;

b) Mr Dubois was assessed at reception (31 October 2014) by mental health clinicians. At that time, he had no past or present mental health issues and had never had or requested medication or assistance for his mental health;

c) None of the medication changes would have impacted his mental health; and

d) Whilst there were no measures of his physical health after the review of 25 May 2021, the heart rate and blood pressure medication changes were minor adjustments only.[80]

[61] Secondly, that Mr Dubois was appropriately re-booked for a review of his medication changes, but he subsequently declined to attend. There were no notes on why he declined or whether he was re-booked.[81]

[62] Thirdly, in considering whether Mr Dubois received appropriate care, Dr Purcell noted that:

a) Long term DAPT is not standard. This was questioned by Dr Gardon, but Mr Dubois asserted his cardiologist recommended ongoing DAPT and this was accepted. Postmortem findings demonstrated significant stenosis in his native and grafted vessels, and this justified the need for the ongoing DAPT. Whether Mr Dubois was on one or two antiplatelet agents, bleeding would have been greater from a wound than if he was

[80] Ex. E1.1- Expert report- Dr Purcell at page 3.
[81] Ex. E1.1- Expert report- Dr Purcell at page 3.

on no antiplatelet agents in any event. Dr Purcell observed that Mr Dubois had minor skin surgery in 2019 and this occurred on DAPT without complication;

b) In terms of the frequency of medical and nursing review, Mr Dubois' death occurred during the COVID pandemic, and possibly impacted routine reviews. That being said, Mr Dubois was seen in response to his HSRFs in previous years, and there were no HSRFs from Mr Dubois in 2020 and 2021;

c) In terms of the appropriateness of Mr Dubois' medication and the changes made on 25 May 2021:

i. Bloods taken on 25 May 2021 indicated that Mr Dubois was not diabetic, his prostate-specific antigen was acceptable, his full blood examination and Chem 20 were all normal, his atorvastatin was achieving LDL target, and his lipids were at target for a man with his history of ischaemic heart disease;

ii. **The medication reduction of 25 May 2021 was entirely appropriate** (my emphasis); and

iii. There was nothing to indicate any occult illness at the time. Postmortem findings indicating the absence of hidden disease supported the correctness of this clinical decision making; and

d) Nothing in the records indicated Mr Dubois had a mental illness. [82]

Issue Two: Whether the supervision of Mr Dubois was adequate and appropriate in the three months leading up to his death

[63] Mr Dubois' supervision was considered in the CSIU investigation and the OIMIRG review. As I have already outlined these considerations, I do not propose to repeat them.

[64] Nothing put before me in oral evidence at inquest challenged or impeached the integrity of the considerations and findings made in the CSIU investigation and the OIMIRG review regarding Mr Dubois' supervision at the MCC.

[65] CS Shostakowski, the ranking CCO who was supervising Mr Dubois' cell block the morning he was located, gave evidence at inquest. She advised that across 6 and 7 June, she was working a 6:00pm to 6:00am shift as Correctional Supervisor, a leadership role entailing overseeing daily operations, managing staff, and ensuring the safety and security of the facility and inmates. She told the Court that during the handover at the start of her shift, no issues about Mr Dubois were raised with her. Mr Dubois and the other inmates were locked down for the night in their cells at 6:00pm per usual procedure with no concerns.

[82] Ex. E1.1- Expert report- Dr Purcell at pages 3-4.

[66] To the best of CS Shostakowski's recollection, the scheduled headcount occurred at around 8:20pm with no concerns about Mr Dubois raised. She advised the Court that standard procedure at this time was for CCOs to check through the viewing windows to the cells and sight the inmates inside them. Following this check, standard procedure in Secure Unit was that the next check would not occur until around 4:15am the following morning. Inmates were not checked more frequently unless they were on observations or on an at- risk management plan. CS Shostakowski was aware that Mr Dubois did not require any extra checks or monitoring.

[67] CS Shostakowski told the Court that when she and the other officers breached Mr Dubois' cell, she observed Mr Dubois lying on the floor surrounded by blood, and immediately could smell a strong metallic odour consistent with heavy blood loss. She explained that her initial reaction to declare the cell a crime scene was because given what she saw, she immediately believed Mr Dubois was deceased.

[68] CS Shostakowski's evidence was that the scene itself was distressing, and unexpected. Other attending staff echoed this latter sentiment at interview, stating that they were shocked to find Mr Dubois had taken his life. CS Shostakowski properly conceded that once she gathered herself and recalled QCS protocol about incident management, she instructed staff to commence chest compressions until an Oxybag (a resuscitator that allows for artificial ventilation without requiring mouth to mouth) could be located.[83]

[69] At inquest, Dr Purcell was asked for her view on whether the nine minute delay by CCOs in commencing chest compressions was outcome changing for Mr Dubois. Dr Purcell's opinion was that it was not. I accept her opinion.

[70] Given Mr Dubois' calls to his family the night prior to his death, the Court obtained evidence from QCS in respect of its monitoring of the Prisoner Telephone System (**PTS**). Acting Deputy Commissioner Eloise Hamlett of QCS Custodial Operations, Central and Northern Region Command stated in oral and documentary evidence that it is not operationally viable for QCS to monitor inmate calls on a *"live"* basis and monitoring is generally conducted on a retrospective basis following particular intelligence briefings. In Mr Dubois' case, at the time of his death, there were no recent or relevant intelligence holdings indicating threats had been made on his life, and intelligence teams had not been directed to monitor his calls.[84] Inspector McHaffie's oral evidence was congruent with this evidence.

[71] I accept this evidence and, to the extent it relates to the appropriateness of his supervision, find that there was nothing put before me in evidence to suggest his calls should have been monitored.

[83] Ex. C18- OIMIRG Report at pages 6 and 9.
[84] Ex. G1- Statement of Eloise Hamlett at [46]-[55].

[72] Unsurprisingly, all QCS witnesses at inquest consistently advised the Court that Mr Dubois' death was not one that could have been predicted or prevented. I accept those opinions.

[73] Counsel Assisting proposed that the supervision outlined in the CSIU investigation and OIMERG review would enable me to draw a conclusion that the supervision provided to Mr Dubois in the three months prior to his death was adequate and appropriate. Counsel Assisting submitted that there was nothing put before the Court in oral or documentary form that suggested or invited determination that Mr Dubois should have been subject to more rigorous supervision or management.

[74] I accept those submissions and find that in the three months prior to his death, Mr Dubois' supervision was adequate and appropriate.

[75] Unfortunately, prisoner self-harm and suicide is a very complex issue and it is not possible to predict or prevent occurrences with certainty. A range of factors contribute to suicide and self-harm risks, including individual, situational, environmental and psychosocial stressors, as well as a person's mental health and wellbeing. [85]

[76] In an effort to appropriately manage suicide and self-harm risk to prisoners, QCS employs best-practice suicide and self-harm prevention policies and practices which align with the World Health Organisation strategy for preventing suicides in prisons. Where self-harm risk factors are identified in a prisoner following admission, they are placed in suitable accommodation and put on observation and management regimes. I accept QCS continues to attempt to mitigate the risk of suicide and self-harm using its current resources such as continual assessment of risk, individual case management and careful consideration of a prisoner's placement within each unit and correctional centre across the State, but also accept that these strategies are not infallible in reality.[86]

[77] I am unable to determine on the evidence before me exactly when Mr Dubois used the razor to cut his limbs. The evidence is that this occurred at some time between approximately 8:40pm on 6 June 2021 (the final sighting of Mr Dubois alive by CCO Butchart that evening) and 4:45am on 7 June 2021 (the first sighting of Mr Dubois in his cell on the floor the following day), and I find accordingly.

Issue Three: Whether the medical care afforded to Mr Dubois was adequate and appropriate in the three months leading up to his death

Issue Four: Whether the mental health care afforded to Mr Dubois was adequate and appropriate in the three months leading up to his death

[85] *Inquest into the passing of ATJ* at [121] per State Coroner Ryan.
[86] This was discussed to some degree in *Inquest into the passing of ATJ* at [122] per State Coroner Ryan.

[78] It is convenient to deal with Issues Three and Four together.

[79] At the conclusion of oral evidence, I determined that nothing put before me in documentary or oral evidence suggested Mr Dubois' medical and mental health care in the three months prior to his death was anything other than adequate and appropriate. I advised the parties that I did not require oral submissions from them on these issues given my state of satisfaction about these Issues.

[80] The following should be stated, however.

[81] According to Health Service and QCS records, in the three months leading up to his death, Mr Dubois:

a) Only accessed medical care once. This occurred on 25 May 2021 when he was seen by Dr Gardon; and

b) Did not receive mental health care. Of this, I find that none was sought, and none was needed on the evidence before me. In this respect I consider it was adequate and appropriate that Mr Dubois did not receive any mental health care during this period.

[82] Dr Purcell's documentary and oral evidence was of great assistance to the Court in respect of these Issues. While Dr Purcell opined in her report that Mr Dubois' postmortem findings regarding multiple scars might suggest he was cutting himself, at inquest she appropriately conceded that, on review, Mr Dubois' scars were not suggestive of previous self-harm.[87]

[83] In oral evidence, Dr Purcell unreservedly advised the Court that her opinion was that Mr Dubois received appropriate medical and mental health care. I was particularly assisted by her oral evidence explaining the clinical appropriateness of Mr Dubois' medication changes.

[84] Accordingly, I find that:

a) In respect of Issue Three, the medical care afforded to Mr Dubois in the three months leading up to his death was adequate and appropriate; and

b) In respect of Issue Four, the mental health care afforded to Mr Dubois in the three months leading up to his death was adequate and appropriate.

Issue Five: Whether the provision of razors to Mr Dubois in the three months leading up to his death was appropriate

[85] While DSC Payne speculated that the razor used by Mr Dubois, *"appears to be sourced from prison issued razor blades"*, no purchase or entitlement records were provided or relied upon to cement this. Further, while DSC Payne noted that there *"was no policy that prevented [Mr Dubois] from having possession of prison issued razor blades"*, this conclusion was not explained

[87] Ex. E1.1- Expert report- Dr Purcell at pages 3-4.

further. The OIMERG review was silent about Mr Dubois' access to razor blades and the policies and procedures dictating razor blade access entirely.

[86] Consequently, the Court obtained a statement from Assistant Commissioner Hamlett that detailed the COPDs relating to access to razor blades, prisoner entitlements, records pertaining to the provision of razors to Mr Dubois and any assessments made about the appropriateness of that provision.

[87] AC Hamlett provided Mr Dubois' Prisoner Trust Accounting System Information to the Court. These records indicated that:

a) The last purchase of any razor blades made by Mr Dubois prior to his death was one packet of 10 razor blades on 18 March 2021; and

b) This particular purchase was the only purchase of razors made by Mr Dubois during the three month period contemplated by this Issue.[88]

[88] AC Hamlett's evidence was that Mr Dubois was provided the razors because he was not considered by QCS to be at risk of self-harm or suicide and therefore had unrestricted access to privileges including razor blades.[89]

[89] AC Hamlett stated, in effect, that there are no explicit QCS policies, procedures and/or COPDs in relation to prisoner access to razor blades. Summarily, the QCS position is that a prisoner is entitled to razors unless consideration of that prisoner's risk, needs and circumstances dictate otherwise. Obviously as far as entitlement to razors goes, one such circumstance is a recognised risk of self-harm or suicide. The intention of QCS to strike a balance between preserving human life and humane treatment of prisoners per the *Human Rights Act* (2019) (**HRA**) in these respects was and is readily apparent.

[90] Of the measures undertaken by QCS to achieve this balance and as directly relevant to Mr Dubois, AC Hamlett stated:

a) QCS staff receive training and are directed by the following COPDs in respect of how to identify and respond to prisoners at risk of self-harm or suicide:

i. At-Risk Management v09;
ii. Safety Unit v06; and
iii. Elevated Baseline Risk v07.

b) Following the issues raised regarding razor blades in the *Inquest into the deaths of Malone and Appleton*, the Queensland Government response provided on 30 April 2020 was accepted in part and implementation finalised. The response focused on the heightened risk during the first month of custody. This in itself is only of some relevance to Mr Dubois' death given he had been in custody for over six and a half years. Of note, however:

[88] Ex. G1- Statement of Eloise Hamlett at EH-27.
[89] Ex. G1- Statement of Eloise Hamlett at [70], [72]- [74], [76] and EH-27.

i. Even prior to the *Inquest into the deaths of Malone and Appleton*, QCS had in place multiple policies and procedures to identify and address the risk of suicide or self-harm to prisoners including assessing the prisoner's risk at the start of their sentence, inducting them into the centre appropriately and implementing the Elevated Baseline Risk COPD to manage those posing a chronic risk of suicide and self-harm;

ii. QCS position remains that restricting a prisoner from access to sharps within the first month of custody as a general rule is contrary to s.30(1) of the HRA with specific reference to proportionality per s.13; and

iii. It follows that restricting access to privileges such as razors at any stage during a prisoner's sentence must also be balanced with a prisoner's risk to ensure QCS is not in breach of the HRA.

c) At-risk management response determines the appropriate level of accommodation, level and frequency of observations, and special management conditions for any prisoner who is considered at risk of suicide or self-harm at any point during their custody. Chiefly this is achieved through the completion of the Initial Response Plan Administrative Form and the IRNA, the latter of which is conducted for each prisoner upon reception. Where risk is identified, adjustments are made including the removal of property from cells that could be used for self-harm. This includes razors. Nothing in Mr Dubois's IRNAs indicated he was at risk of suicide or self-harm. Mr Dubois was in any event assessed by Prison Mental Health due to his offence category and again no indications of risk were found to be present;

d) Staff training was reassessed in accordance with Recommendation 2 from the *Inquests into the deaths of Malone and Appleton* with a focus on engagement, assessment, responses and support for at-risk prisoners, and has been subsequently implemented. The training itself was developed by the Queensland Centre for Mental Health;

e) Pursuant to the At-Risk Management COPD, a self-harm/suicide risk assessment must be undertaken in the following circumstances:

i. An officer is alerted to indicative behaviours (per the At-Risk Behaviour Appendix AR1 v02 in this COPD);

ii. An officer becomes aware of an event that may elicit self-harm or suicide (per the Periods of Critical Risk Appendix AR2 v04 in this COPD);

iii. Following transfer, if a prisoner applies for protection status;

iv. If a prisoner demonstrates a self-harming behaviour or expresses an intent to self-harm or commit suicide; or

v. If other events arise for a prisoner that may be potentially distressing (per the At-Risk Behaviour Appendix AR1 v02 in this COPD);

f) Where staff identify risk, they are mandated to report them to their superior and keep the prisoner within their line of sight. A Notification of Concern Administrative Form 53 must be completed as soon as practicable and all notifications and referrals for assessment noted in IOMS;

g) A review of Mr Dubois' QCS records revealed no Notifications of Concern since 29 November 2016 and no indicators of at-risk behaviours since his appeal was dismissed on 21 December 2018;

h) The COPD relating to prisoner entitlements is Prisoner Entitlements, Prisoner Communications, the current version of which is v15.[90] The version in force at the time of Mr Dubois's death was v4;[91]

i) Razor blades are approved goods that can be purchased via the prison canteen which is operated at least once per fortnight. The process for purchasing approved goods is managed and administered by the General Manager of a corrective services facility. The relevant COPD is Prisoner Entitlements, Prisoner Purchasing v01.[92] Prisoners must have sufficient funds[93] and must fill out an order form. The order is then packed and provided;[94] and

j) Prisoners are also issued with amenities packs which include four disposable razors for male prisoners upon admission to custody.[95]

[91] AC Hamlett was cautious to advise that Mr Dubois was accommodated in a Protection Secure Residential Unit, a unit allowing freedom of movement throughout the unit during times the cells are unlocked. In her experience, this meant that prisoners can easily acquire or trade razor blades.[96] I accept this reality and do not consider it possible to make a finding particularising the details of when, where and how Mr Dubois acquired the razor blade located in his bedding in the circumstances.

[92] Both Counsel Assisting and QCS submitted it was open to me to make a finding that the provision of razors to Mr Dubois in the three months leading up to his death was appropriate.

[93] Of the singular purchase of a 10-pack of razor blades made by Mr Dubois on 18 March 2021, I accept there is no evidence to suggest Mr Dubois was at risk of self-harm or suicide, and no evidence to suggest his access to razor blades at that material time should have been restricted. Accordingly, I find that the

[90] Ex. G1- Statement of Eloise Hamlett at EH-09.
[91] Ex. G1- Statement of Eloise Hamlett at [11]- [45] and EH-10
[92] Ex. G1- Statement of Eloise Hamlett at [59]- [61].
[93] Ex. G1- Statement of Eloise Hamlett at [61].
[94] Ex. G1- Statement of Eloise Hamlett at [62]- [63].
[95] Ex. G1- Statement of Eloise Hamlett at [65].
[96] Ex. G1- Statement of Eloise Hamlett at [67] – [68].

provision of razors to Mr Dubois in the three months leading up to his death was appropriate.

[94] Counsel Assisting submitted that access to products such as razor blades that are in theory capable of causing harm, but are necessary for basic male hygiene and the preservation of dignity is prisoner specific, and contemporaneously so. It was further submitted that QCS's position in this respect is appropriate and nothing was raised in these proceedings that would warrant consideration of change. I accept these propositions.

Whether any changes to procedures or policies could reduce the likelihood of death occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

[95] Section 46 of the Act provides that a coroner may comment on anything connected with a death that relates to public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

[96] I note that recommendations pertaining to mask suitability and first aid training instructions were made in the OIMERG review, but these are outside of the scope of the Issues considered in this inquest.

[97] I am satisfied that there are no further recommendations required in any event.

Comments

[98] I consider that there are no comments required.

Findings required by Section 45 *Coroners Act 2003* (Qld)

[99] I make the following findings:

Identity of the deceased: The deceased was Garry Reginald Dubois (DOB: 11/03/1947)

How they died: From 7 June 2017, Mr Dubois had been serving sentences for various serious offences including murder, rape, manslaughter and deprivation of liberty at the Maryborough Correctional Centre. Prior to his conviction and sentencing, he had been held on remand since October 2014. Mr Dubois was classified as a protection prisoner due to the high profile status of his crimes and was housed in Cell 41, level 2 of Secure Unit 2, which was the protection block. At around 6:00pm on 6 June 2021, Mr Dubois was locked in his cell. Some time after 8:40pm, he intentionally cut the inner elbow of his right arm and the inner aspect of his leg above his ankle with a razor blade. He was found on his cell floor in a state of exsanguination by corrections officers at 4:45am on 7 June 2021. He was

	declared deceased at the scene at 5:20am by attending paramedics
Place of death:	Mr Dubois died in Cell 41, Secure Unit 2 at the Maryborough Correctional Centre, Stein Road, Aldershot QLD 4650
Date of death:	Between 6 and 7 June 2021
Cause of death:	Incised wounds to limbs, with other significant conditions being ischaemic heart disease and antiplatelet therapy

[100] I close the Inquest.

Stephanie Gallagher

Deputy State Coroner

BRISBANE