QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Colin Wayne Blair**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2015/4522
DELIVERED ON:	6 September 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	19 March; 27 August 2018 – 31 August 2018
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody; Indigenous prisoner; risk assessment; hanging; high dependency unit; supervision of prisoners; prison support and mental health services; information sharing between Queensland Corrective Services and Prison Mental Health Service employees

REPRESENTATION:

Counsel Assisting:	Mr Daniel Bartlett; Miss Emily Cooper
Queensland Corrective Services:	Mr Matthew Hickey (instructed by Queensland Corrective Services)

Prison Mental Health Service West Moreton Hospital and Health Service:	Ms Anna-Maria Lofaro (Minter Ellison)
GEO Group Australia Pty Ltd:	Ms April Freeman (instructed by Ashurst Lawyers)
Ms Shirley Dunrobin:	Mr Mitch Rawlings (instructed by Anderson Fredericks Turner Lawyers)
Ms Lesley Macgillivray:	Ms Sally Robb (instructed by Roberts & Kane Solicitors)

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Introduction

1. Colin Wayne Blair was aged 44 years when he died in the High Dependency Unit (HDU) of the Brisbane Correctional Centre (BCC) on 13 November 2015.

2. Mr Blair was being held in cell 6, unit S3 in the HDU, which was identified as a "suicide resistant" cell. His cell was equipped with a CCTV camera in the top corner. The CCTV footage showed that at 12:53pm, Mr Blair was given a meal by correctional officers in his cell and he started eating that meal. At 12:59 pm, Mr Blair began the process of using an electrical cord attached to the cell's television set to fashion a noose. At 1:02pm, the CCTV footage captured Mr Blair position himself under the desk in the cell, from which he did not get back up. While his legs could be seen in the footage, his upper body and head could not. After 1:07pm, there was no apparent movement from Mr Blair.

3. Although Mr Blair was required to be observed hourly, it was not until 2:48pm that a correctional officer entered the cell and called a code blue. Mr Blair was located under the desk next to the bed hanged from the electrical cord. He was cut down and medical staff and QAS paramedics attended. At no stage after being located did Mr Blair exhibit any signs of life. He was unable to be resuscitated and was pronounced deceased.

4. These findings:

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

    - Consider the adequacy of the mental health treatment provided to the deceased in the lead up to his death, and whether the referral to the Prison Mental Health Service made on 5 November 2015 was dealt with appropriately in all of the circumstances;

    - Consider the adequacy of the decisions made at the Risk Assessment Team meeting on 12 November 2015;

    - Consider the adequacy of the observations regime of the deceased in his cell on the day of his death;

    - Consider the adequacy of the communication between the Risk Assessment Team and the Sentence Management Team over 12-13 November 2015;

    - Consider the adequacy of the response by Arthur Gorrie Correctional Centre and the Brisbane Correctional Centre to the recommendations made as a result of the investigations conducted by the Office of the Chief Inspector; and

- Consider the adequacy of the cells within the dependency unit of Brisbane Correctional Centre with regard to hanging points and the availability of aids to suicide.

The Investigation

5. Investigations were conducted into the circumstances leading to the death of Mr Blair by the following agencies:

    1. The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU); and
    2. The Office of the Chief Inspector (OCI).

6. The QPS investigation was led by Detective Senior Constable Richard Fry. He submitted a report which was tendered at the inquest. Detective Senior Constable Fry attended BCC with several other CSIU officers. He inspected the HDU and oversaw the forensic examination of all points of interest.

7. CSIU officers commenced the process of taking statements from correctional staff. They took steps to seize all relevant records and interrogated the BCC Information and Offender Management System (IOMS). Detective Senior Constable Fry spoke to intelligence officers at BCC and made arrangements for statements to be obtained from senior officials at the prison. He also seized CCTV footage of the cell where Mr Blair was being held. Scenes of crime officers took a series of photographs of the scene. At the inquest Detective Senior Constable Fry noted that the observations log from 13 November 2015 for unit S3 was not able to be located as part of the investigation.

8. The Chief Inspector, Queensland Corrective Services, appointed investigators to examine the incident under the powers conferred by s294 of the *Corrective Services Act* 2006. Those investigators prepared a report which was submitted to the Office of the Chief Inspector (OCI Report). It examined some matters beyond the scope of the coronial inquest. The report was tendered at the inquest and was of assistance in the preparation of these findings. The OCI Report identified a number of root causes for Mr Blair's death and contained associated recommendations to QCS.

9. I am satisfied that these investigations were thoroughly and professionally conducted and that all relevant material was accessed.

The Inquest

10. As Mr Blair died while in custody an inquest was required under s 27 of the *Coroners Act*. A pre-inquest conference was held in Brisbane on 19 March 2018. Mr Bartlett appeared as counsel assisting and leave to appear was granted to Queensland Corrective Services, GEO Group Australia Pty Ltd, West Moreton Hospital and Health Service (WMHHS), and Mr Blair’s mother, Shirley Dunrobin.

11. The inquest was held from 27 – 31 August 2018. Miss Cooper appeared as counsel assisting at the inquest. All of the statements, records of interview, medical records, photographs, CCTV footage and materials gathered during the investigations were tendered at the inquest, comprising over 250 exhibits. The inquest heard evidence from 18 witnesses. Submissions were received from the represented parties following the conclusion of the evidence.

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

The evidence

Personal circumstances and correctional history

13. Mr Blair had a longstanding history of polysubstance use including alcohol, cannabis and amphetamines. He had a limited criminal history in Queensland involving a number of community supervision orders relating to breaches of domestic violence orders between 1995 and 2008. Mr Blair had previously served short periods of incarceration in 1999 and 2009 following the suspension of community supervision orders.

14. Ms Dunrobin said that while her son was not a saint, he is sorely missed by his family. She felt that his life had been lived in the shadow of the grief and trauma he felt after the loss of his son when Mr Blair was in his late teens. She said that he was someone who had "fallen through the cracks". Mr Blair was estranged from his other children. I extend my condolences to Ms Dunrobin and to Mr Blair's extended family.

15. On 1 October 2015, Mr Blair was remanded in custody at the Arthur Gorrie Correctional Centre (AGCC) for offences involving the use of a carriage service to make threats to kill and making an improper emergency call. For the ensuing six weeks, Mr Blair showed continuing frailty concerning his mental health and had repeated contact with mental health and psychological services while in prison and in the community.

16. Though he was assessed as a low risk of self-harm when first admitted, a notice of concern (NOC) was raised four days later on 5 October 2015 concerning Mr Blair's behaviour. A further notice of concern was raised on 7 October 2015, when Mr Blair attempted to hang himself in the Medical Unit at AGCC using a sheet. He was observed standing against the toilet door with a sheet tied around his neck, supporting his own body weight with no load on the sheet. He reported to be communicative and responsive after being located and removed the sheet when directed to do so.[1] He was then placed on 30 minute observations.

[1] Exhibit B34, para 21

17. On 8 October 2015, Mr Blair was located with a sock around his neck that was tied to a door handle in the Medical Unit. He was assessed by the Prison Mental Health Service (PMHS) and deemed a high risk of suicide. He was then placed on continuous observations.

18. On 9 October 2015, Mr Blair was dealt with in the Brisbane Magistrates Court and sentenced to six months imprisonment, with a parole release date of 23 October 2015.

19. On 12 October 2015, a Risk Assessment Team (RAT) at AGCC determined that Mr Blair's behaviour was stabilising and reduced his observations to intervals of 15 minutes. On 15 October 2015, Mr Blair was transferred to BCC. He was assessed by a senior psychologist, and remained on 15 minute observations. On his return to BCC, he was housed in unit S3 which catered for vulnerable and at risk inmates.

20. While he was on a 15-minute observations regime because of a heightened risk of suicide, Mr Blair was released on parole on 23 October 2015. His release late on a Friday afternoon limited the immediate capacity of QCS to supervise his successful transition into the community. As he was subject to court ordered parole, there was no capacity to delay his release, or to release him at an earlier date.

Mental Health History

21. Evidence was heard at the inquest about Mr Blair's time at AGCC and BCC, and various safety orders implemented to manage his behaviours. He also had a history of self-harm outside correctional facilities and a history with public sector mental health services dating back to 2009. Diagnoses over that time included personality disorder and substance abuse disorders. He also self-reported suffering from depression.

22. Mr Blair also had a lengthy mental health history within AGCC and BCC, as demonstrated by the PMHS file. His last appointment with the PMHS was scheduled to occur on 25 November 2015.

23. At the time of Mr Blair's death, Ms Beverley Russell was the Team Leader for the PMHS. She had no direct involvement with Mr Blair. Ms Russell said that Mr Blair was an open patient with PMHS from 8 to 23 October 2015, when he was released from custody. He was then referred to the Homeless Health Outreach Team and placed in Cliveden Mansions, an inner city hostel in Spring Hill, by the PMHS Indigenous Mental Health Worker.[2]

24. Ms Russell said that Mr Blair was originally referred to the PHMS from AGCC on 1 October 2015 because on reception he had disclosed a past history of treatment by mental health services and ongoing treatment with antipsychotic medication.[3]

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[2] Exhibit B26

[3] Exhibit B26

25. Mr Blair was first seen by a PMHS Clinical Nurse on 8 October 2015, the date he had attempted to hang himself with a sock. He was assessed as being at high risk of suicide if not monitored and being of chronic low mood. He was opened to the PMHS and referred to the PMHS Indigenous Mental Health Worker program.

26. When Mr Blair attended court on 9 October 2015, a recommendation for assessment under the *Mental Health Act 2000* was made by PMHS clinical coordinator, Narelle Green, having regard to his high suicide risk and possible release from custody. It was noted that Mr Blair appeared to be experiencing a major depressive episode and required immediate assessment at an Authorised Mental Health Service. Mr Blair was subsequently remanded in custody and transferred back to AGCC.

27. On 15 October 2015, Mr Blair was transferred to BCC and an appointment was made for him to see a consultant psychiatrist on 20 October 2015. On that date he was transferred to hospital because of cardiac issues. The recommendation for assessment subsequently expired on 16 October 2015.

28. On 20 October 2015, the Prince Charles Hospital advised PMHS that a bed would be available for Mr Blair's psychiatry admission later that week. On 21 October 2015 the PMHS (Clinical Coordinator Leanne Peel) advised the Consultation Liaison Psychiatry Service at the PAH that the recommendation for assessment had expired, and that a further assessment would be required. Mr Blair was assessed by a psychiatrist but was considered not to meet the criteria for assessment on that date. Mr Blair was not feeling suicidal or depressed and as a consequence, he was not admitted to the Prince Charles Hospital but was returned to BCC on 23 October 2015.

29. On Friday, 23 October 2015, after Mr Blair was discharged from the BCC to live at Spring Hill, he was reviewed by Ms Peel who noted that he was upset regarding the loss of his community housing accommodation. He was going to live in a hostel and was future oriented with no current suicidal ideation. He was aware that he had been referred to the HHOT and could present to the RBWH if he was in crisis.

30. On Tuesday, 26 October 2015, Mr Blair was transported by James Bond, indigenous mental health worker, to Cliveden Mansions. An appointment was made for him with a GP at Nundah and he was assisted with a Centrelink emergency payment. Ms Russell stated that usual practice was for a person to be closed to the PMHS on release from custody.

31. On 28 October 2015, Mr Blair was reviewed by the HHOT and found not to be a psychotic but at medium risk of suicide. It was considered that he was stating he was suicidal in order to gain admission to hospital. He had made threats to kill 'bikies' and family members and his parole officer was contacted and informed of those threats.

32. Mr Blair also self-presented to the Psychiatric Emergency Centre (PEC) at the RBWH on 28 October 2015. He was kept in hospital overnight and a recommendation for assessment was made by a psychiatry registrar. When reviewed the following morning the psychiatry registrar documented:[4]

> *Well established diagnosis of PSA, antisocial and borderline personality disorder. Currently making homicidal threats and should be held accountable for these actions. Nil evidence of pervasive mood or psychotic disorder. Chronic suicide risk due to impulsivity and drug use. No indication for mental health admission, and can be released back to police custody. Likely possibility of secondary gain in seeking hospital admission to avoid jail. Needs input from prison MHS in this time of increased stress.*

33. The recommendation for assessment made the previous day was subsequently revoked. The psychiatry registrar noted that Mr Blair could be referred back to hospital if it was considered that his suicide risk "becomes too high". Mr Blair was returned to custody on 29 October 2015, as his parole officer had issued a warrant for his arrest following the information received related to the threats against family members made by Mr Blair the previous day.

34. Mr Blair was assessed by the Court Liaison Service on 30 October 2015 and 2 November 2015 at the Brisbane watchhouse and found not to be suicidal. He was returned to custody at BCC on 5 November 2015.

Management of Mr Blair from 5 – 13 November 2015

Risk assessment on Reception at BCC

35. On reception at BCC on 5 November 2015, Mr Blair was assessed by Ms Anna Howlett, a QCS psychologist, for the purpose of an Immediate Risk Needs Assessment (IRNA). Ms Howlett had commenced work at BCC on 15 May 2015.

36. Ms Howlett said that on 5 November 2015, she saw five prisoners in reception for the purpose of an IRNA. Twenty-four prisoners had been received at BCC on that day. Ms Howlett recalled that Mr Blair presented as "flat". He was well groomed and quiet, and required prompting to answer questions.

37. Following consultation with Kimberley McIvor, acting Manager of Offender Development and senior psychologist, Ms Howlett assessed Mr Blair as being at moderate risk of suicide. Various factors were weighed in reaching this conclusion – static and dynamic. Ms Howlett said she took a conservative approach to risk assessment.

[4] Exhibit D2, p9

38. While Ms Howlett was aware that Mr Blair had recently been on a high level observations regime at AGCC and had presented to the PEC at the RBWH, there was no current suicidal ideation noted or observed at the time of this assessment. Mr Blair was assessed as being future oriented and his family was seen as a strong protective factor. Mr Blair was placed on 60 minute observations which reflected a moderate risk level in accordance with the Risk Level Observation Guidelines tendered at the inquest.[5]

39. Mr Blair was placed in unit S3. I heard evidence that this unit was a High Dependency Unit for vulnerable persons. Not all prisoners in this unit were on an at-risk observations regime, although from the evidence I accept that the majority of prisoners were. The unit would also be used to house prisoners who might have a medical need, or were vulnerable in some other way.

40. Ms Howlett confirmed that in conducting the IRNA on Mr Blair she did not have access to mental health records from Queensland Health, including the PMHS. She confirmed that in order to find out if Mr Blair was an open patient with the PMHS, she would need to call the PMHS. She did have access to the Integrated Offender Management System (IOMS), and she was able to recall that Mr Blair had three previous suicide attempts. Ms Howlett said that she did not call Probation and Parole or the RBWH for collateral information about Mr Blair as that was not part of her training.

41. Information on IOMS from Mr Blair's previous period of custody at AGCC in October 2015 was available to Ms Howlett. She was asked in her evidence about a variety of additional information, relating to Mr Blair's criminal charges and a Domestic Violence Order being in place, of which she was not aware at the time of conducting her assessment.

42. Ms Howlett's evidence was that she was not sure that knowledge of those additional factors would have changed her assessment. However, I accept that in the context of the IRNA assessments conducted, the more information available to the assessing psychologist, the better.

43. Ms McIvor told the inquest that based solely on his presentation at reception, Mr Blair would normally have been placed in the general population at BCC. However, the historical risk factors led to the decision to place him on a moderate observations regime. Ms McIvor also referred to the fact that Mr Blair had been asked to leave his previous accommodation, leading to the loss of his child's ashes and his belongings as additional stressors. Mr Blair's family informed me that he was only 19 years of age when his son died. He had carried the ashes wherever he went for the ensuing 25 years.

[5] Exhibit B34.11.

44. Ms McIvor told the inquest that IOMS was the primary source of collateral information but psychologists could ask the PMHS or the watch-house for further background information where required. She said that there were weekly meetings with the PMHS where all prisoners on observations regimes were discussed. Ms McIvor agreed that it would be helpful for prison psychologists to have access to Consumer Integrated Mental Health Application (CIMHA) records.

PMHS Referral

45. A referral was made to the PMHS by the registered nurse conducting the medical assessment at reception, Chris Wallis.[6] However, because Mr Blair was already known to PMHS, evidence was heard from a number of sources that his referral was not dealt with in the usual way. The usual process required that the referral be triaged and, if it was considered that the referral was appropriate, the person would be listed for an intake assessment with a PMHS nurse or allied health practitioner.[7]

46. After Mr Blair was received back at BCC, an email was sent on 6 November 2015 from Narelle Green, the PMHS Clinical Coordinator at AGCC, to Lesley McGillivray and James Bond of the PMHS at BCC (among others), advising that Mr Blair had arrived at BCC. The email said to Mr Bond specifically "*due to the quick turnaround, Beverley* (a reference to Beverley Russell)*, may suggest its ok to continue support without another referral*"[8]. I am satisfied that this led to Mr Bond seeing Mr Blair for a cultural support assessment on 12 November 2015, although he had not been triaged by the PMHS.[9]

47. Mr Bond's evidence[10] was that when he saw Mr Blair on the afternoon of 12 November 2015, he was tired and his speech was slurred. He told Mr Bond that he was worried about his future accommodation. Mr Blair asked Mr Bond for his mother's phone number and said that he would like to go to stay with her. Mr Bond told Mr Blair that he had discussed this with Ms Dunrobin, who had advised that she did not want him to live with her at that time. Mr Bond said that he had planned to follow up with Mr Blair after two weeks to consider transition needs at release, with a focus on accommodation.

48. Ms Lesley McGillivray's evidence was that on 9 November 2015, she had returned from a period of leave to in excess of 300 emails. Her position had not been backfilled in a full-time capacity while she had been away. Clinical Coordinators from other correctional centres had been required to cover her work as the BCC Clinical Coordinator during her leave. She perused the spreadsheet containing names of prisoners open to the PMHS, and saw Mr Blair's name. I am satisfied that, based on the usual course of a referral to the PMHS, Mr Blair's name should not have appeared on this list.

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[6] Exhibit B30.

[7] Exhibit B26.

[8] Exhibit B26.8.

[9] Exhibits B2 – B2.1.

[10] Exhibit B2.

49. Ms McGillivray saw there was no psychiatry appointment booked for Mr Blair and made an appointment for 25 November 2015 with Dr Cassandra Griffin, again bypassing the normal triage process. This was the next available appointment. I heard evidence from Ms McGillivray and Dr Aboud that this timeframe for a psychiatry appointment was not out of the ordinary. I accept that it was also possible that Mr Blair could have been transferred out of BCC before being seen by the PMHS psychiatrist.

50. Ms McGillivray said that prioritisation by the PMHS was based on all available collateral information, including CIMHA and information from stakeholders such as prison medical and psychology staff. She said that exchange of information occurred informally and formally via a weekly interagency meeting to discuss inmates of concern.

51. Ms McGillivray told the inquest that although a 16 day wait for a psychiatry appointment was very common, appointment bookings were fluid and could be moved forward. Ms McGillivray said that at the 11 November 2015 interagency meeting there was no representation from the QCS psychologists at BCC. Following Mr Blair's death a more formal arrangement for the interagency meetings was implemented and all members receive a prompt to attend each Friday at 9:30am.

52. BCC Cultural Liaison Officer, Mr Don Williams, told the inquest that he saw Mr Blair daily following his return to custody on 5 November 2015. Mr Williams had worked with Mr Blair during his earlier period of custody at BCC in October 2015. As Mr Blair was being evicted from his accommodation at Nundah, where he had lived for five years, Mr Williams had agreed to retrieve his son's ashes. All of his other personal belongings had to be abandoned. Mr Williams said that Mr Blair's post-release accommodation options were limited as he was estranged from his family, given the nature of his charges.

53. After his return to prison, Mr Blair told Mr Williams that he could not live at Cliveden Mansions as people were accessing his room with a key card without his permission. Mr Williams' evidence was that Mr Blair told him that his life was in danger and he was being threatened by family, and asked that he not be moved from unit S3 until he was released from BCC.

54. When he saw Mr Blair on 12 November 2015, Mr Williams assessed that he could be reduced to 120 minutes observations as he reported that he was sleeping better, and assumed he would be staying in S3. Mr Blair was keen to access a telephone number to contact his mother but Mr Williams was not able to locate that before he commenced leave on 12 November 2015. Mr Williams also referred to "men's business" he had spoken with Mr Blair about, but was he not able to detail the content of that for cultural reasons.

RAT meeting 12 November 2015

55. As Mr Blair was classified as an at-risk prisoner, he was required to be reviewed by the Risk Assessment Team (RAT) on a weekly basis. His first review (in terms of his last period of incarceration) took place on 12 November 2015. I am satisfied that, prior to that first review, there had been no specific incidents involving Mr Blair that supported the raising of a NOC, or otherwise caused any of the witnesses concern for Mr Blair's immediate wellbeing.

56. Evidence was heard from members of the RAT who met on 12 November 2015. The result of their assessment was for Mr Blair to remain on 60 minute observations and, in particular, it was recommended that he was to remain accommodated in unit S3.

57. Evidence was heard from the chair of the RAT, Ms Narelle O'Brien, that she completed minutes for the meeting and that these were uploaded to IOMS, kept in a physical folder within Sentence Management, and copied to the medical unit.[11] A Queensland Health representative was also present at the meeting. Ms O'Brien said this led to the RAT being provided with a much richer history for each prisoner.

58. Ms O'Brien told the inquest that she did not specifically recall a lot about the discussion about Mr Blair's risk assessment at the RAT meeting. There were six prisoners reviewed on that date. She had no direct contact with him but was aware of his vulnerabilities, including his Indigenous status, homelessness, association concerns, offending background and prior PMHS involvement. She recalled that Mr Blair had reported that he was safe in unit S3 but would self-harm if moved from that unit. No information was given to the RAT by about the planned move from unit S3.

59. I am satisfied from the evidence that the only reason Mr Blair was kept on 60 minute observations was so that he could remain in unit S3. If accommodation had not been raised as an issue during the RAT meeting, Mr Blair would have had his observations reduced to low (120 minutes). The RAT procedure requires that the team accepts the most conservative assessment in terms of the frequency of observations. However, accommodation decisions were ultimately matters for BCC management, and unit S3 was not normally available for prisoners on 60 minute observations.

60. Ms O'Brien was not aware that a transfer decision had been made for Mr Blair or how those decisions were made. Offender Development staff were involved in advising the receiving centre of the current level of observations and any concerns. She said that knowledge of the pending transfer would not likely have changed the RAT assessment as his presentation was the same as the previous week. She said that if she was concerned about such a transfer she would have advised prison management. A NOC could have been raised by anyone in the prison, including RAT members, if they were aware of a pending transfer from unit S3.

[11] Exhibit B24.2.

61. Ms O'Brien said that following Mr Blair's death a local procedure had been introduced at BCC requiring a psychologist to accompany Sentence Management staff whenever they advised an at risk prisoner of a transfer out to another correctional centre. If there were any concerns a notice of concern was raised and the prisoner could be reassessed. Psychologists also ask prisoners on at risk observations about their transfer preferences when completing risk assessments.

62. Ms O'Brien agreed that the RAT's risk assessment was made at a point in time based on risk and protective factors, including medication compliance. She said that the initial phase allowed observations of the person to occur and to allow them to settle in custody after practical concerns were addressed. An updated risk management plan was generated to advise on the management strategy until the next RAT meeting could conduct a review. A review was held every seven days.

63. Ms O'Brien agreed the initial assessing psychologist at BCC might have considered that more frequent observations were required, based on the matters that had occurred while Mr Blair was in the community, including his admission to the RBWH PEC and the assessment of him at that hospital as being at "chronic risk" of suicide. This would have resulted in a stronger chance that observations would have been more frequent than hourly following the 12 November 2015 RAT meeting.

64. Nicole Stagnitti was a psychologist at BCC at the time of Mr Blair's death, and had been employed in that capacity since 2014. She attended the RAT meeting in order to present the report on Mr Blair generated by fellow psychologist, Ms Christine McGillivray, on the morning of 12 November 2015.[12] Ms Stagnitti had responded to a NOC in relation to Mr Blair while she was employed at the AGCC, but did not see him at BCC. Ms Stagnitti recalled that Mr Blair had safety concerns within BCC but was not aware of any particular threat. She recalled that the RAT specifically discussed Mr Blair's fears in relation to leaving unit S3, and he was kept on 60 minute observations to enable him to stay in that unit.

65. Ms Christine McGillivray's report noted that Mr Blair was assessed as euthymic (having a relatively stable mood state). He indicated that he had a formal mental health diagnosis and was inadequately medicated. He said he would request a medication review from the PMHS. Mr Blair had told Ms McGillivray that he preferred to stay in the High Detention Unit because of his fear of association with other Indigenous prisoners. He reported that his mood was good, on the basis that he would stay in S3, and denied any self-harm ideation, plan or intent. Ms McGillivray recommended that observations be reduced to 120 minutes, contingent on Mr Blair staying in S3, and that Mr Blair be reviewed by PMHS "as soon as operationally viable".[13]

[12] Exhibit B12

[13] Exhibit B25

66. Ms Stagnitti told the inquest that the RAT chair now sends the minutes of the meeting to Sentence Management and they are filed in a physical file. She also said that CIMHA access would be useful for psychologists conducting risk assessments as it contained information about mental health diagnoses.

67. Paul McWaters was employed by QCS as a Correctional Supervisor at the time of Mr Blair's death, and conducted a risk assessment of Mr Blair in that capacity for the 12 November 2015 RAT meeting. This was his first contact with Mr Blair. He was aware of Mr Blair's self-harm history from IOMS. It appeared to Mr McWaters that Mr Blair's time at AGCC was turbulent but that he had settled at BCC.

68. Mr McWaters recalled that Mr Blair was focused on accommodation. While he was open to discussing a range of topics, including contact with prisoners in unit S5, he was adamant that he did not want to leave unit S3. He said that this was clearly his major concern.[14] Mr Blair told Mr McWaters that he was worried he would "get hurt" in other units, and indicated he would self-harm if that was a means to stay in unit S3. Mr McWaters said that his initial preference was to keep Mr Blair on 60 minute observations, but after discussions with staff in unit S3 he determined to recommend that he move to 120 minute observations and remain in S3.

69. Mr McWaters said that he assured Mr Blair that he had no intention of moving him from unit S3. Mr McWaters told the inquest that Mr Blair was aware that he could have to move to another unit within BCC or another centre, but that his need for observations was a relevant consideration in determining which centre he should move to. He said that there was bed capacity within BCC at the time to continue to accommodate Mr Blair.

70. Mr McWaters said that the major factor in maintaining Mr Blair on 60 minute observations after the RAT meeting was the inconsistent accounts of Mr Blair's presentation that were given by the different team members, together with the desire to keep him accommodated within unit S3.

71. Mr McWaters said that the needs of specific prisoners, such as Mr Blair, may be the topic of discussion at morning management team meetings at the prison but that he was not in attendance at all of those meetings. Ultimately, transfer decisions were a matter for Sentence Management staff.

72. Mr McWaters explained that he had completed the *Instruction - at risk observation* for Mr Blair after the RAT meeting. A physical observation was required every 60 minutes as well as visual CCTV observations during that period. CCTV was not to replace physical observations. Correctional staff were required to ensure prisoners were not engaging in any self-harm behaviors, and to see that the prisoner was in good health. This did not always require a verbal interaction with the prisoner.

[14] Exhibit B20

Events of 13 November 2015

73. On the morning of Friday, 13 November 2015, Mr Blair was seen by Natasha McLennan, a Sentence Planning Advisor with Sentence Management, which was a separate unit within BCC.

74. Ms McLennan said that at the Sentence Management Classification and Placement meeting on 13 November 2015 she was told that Mr Blair was a priority for classification and placement assessment. She later saw Mr Blair in order to assess him as "high risk" or "low risk", which would then determine which corrective services facility would be suitable for him to transfer to. As Mr Blair had been returned to custody after committing further offences he was deemed to be "high risk" for the purpose of sentence management.[15]

75. Ms McLennan's evidence was that as BCC is primarily a reception prison, most prisoners are not housed there on a long term basis and it has a high turnover of prisoners. Notwithstanding, I am satisfied from her evidence at the inquest and from the evidence of Don Williams that the length of a prisoner's stay at BCC could be for up to 12 months.

76. Ms McLennan said that before 13 November 2015 she had no knowledge of Mr Blair. She was advised by her supervisor that he was an at-risk prisoner in unit S3 and was also on protection. She also had access to limited information from IOMS. She said that his status as an at-risk prisoner did not alter her approach to the interview but she was alert to "warning signs" during the interview.

77. Ms McLennan did not have a detailed knowledge of the RAT process, having commenced with QCS on 3 August 2015. However, she was aware of a similar process from her employment in the NSW prison system. She was not aware of the assessment of the RAT from the day before, or that part of the RAT recommendation was for Mr Blair to remain in unit S3. She was also not aware that RAT minutes were stored in Sentence Management. Ms McLennan told the inquest that had she been aware of the RAT outcome she would not have interviewed Mr Blair at all on 13 November 2015.

78. Ms McLennan clarified in her evidence that her assessment that day was not a final decision. The final decision as to where Mr Blair would be placed was to be made by her superiors, informed by the intelligence office at BCC. Mr Blair did not exhibit any signs or behaviours to Ms McLennan that caused her any concern during the interview. Ms McLennan said that if a prisoner was to stay at BCC she would also make a recommendation about employment in an industry at that prison. Although she was not given any reasons, she had been informed that Mr Blair was to be transferred to the Wolston Correctional Centre.

[15] Exhibit B37

79. Ms McLennan said that when she met with Mr Blair at unit S3 he was not sure whether he had outstanding court appearances. Neither was he aware of his current legal status. However, he was aware of his release date and was waiting for the reasons for his parole suspension. Ms McLennan said that she asked Mr Blair whether he had any issues with other prisoners and his response was that he had no concerns.

80. Mr Blair told her that he wanted to be transferred to Wolston Correctional Centre to be close to family and because it also had a protection unit. Ms McLennan told Mr Blair that she would be recommending that he be transferred to Wolston and he said that he had no issues with that. She did not discuss a timeframe for the transfer with him. After her interview with Mr Blair had finished, Ms McLennan advised an officer in S3 that Mr Blair wanted to be moved to Wolston and that would be her recommendation.

81. After meeting Ms McLennan, Mr Blair had a conversation with Sian Williams, a Cultural Liaison Officer who was seeing another prisoner in unit S3. He told her he was concerned about going to Wolston and he had his bus ticket. It is apparent that Mr Blair had concluded after his conversation with Ms McLennan that he had been given his 'bus ticket' out of BCC to Wolston, and that he would be moving out of S3.

82. Ms Williams told Mr Blair she would raise his concerns with the Senior Cultural Liaison Officer, Don Williams, who had gone on leave that day, to see if the decision could be altered. She told Mr Blair that she would return and speak with him about it on Monday. Ms Williams' then left Mr Blair to go to an Indigenous art class, which went from 1:00pm to 3:00pm. Her evidence was that he did not appear to be particularly distressed about the move.

83. Ms Williams' evidence was that she intended to contact Sentence Management about Mr Blair after the art class had finished. Ms Williams had no indication from Mr Blair about what he was about to do, and said that she thought she had time to contact Sentence Management later that day.

84. The correctional officers working in unit S3 on 13 November 2015 were Mark Byrn and Farley Clements. After hearing their evidence at the inquest I accept that they were the primary officers in unit S3 over the course of the relevant period.

85. Officer Byrn's evidence was that there were 16 prisoners in unit S3 on 13 November 2015. Prisoners were on observations ranging from 15 minutes to 120 minutes. Officer Byrn said that physical observations were conducted by looking through the window of the cell door to check on the welfare of the prisoner. He said that if the prisoner was asleep he would not wake them. He said that prisoners in S3 were vulnerable and he thought it important not to cause upset by disturbing their sleep. If the prisoner was awake he would get an acknowledgement from the prisoner. His method to ascertain whether a prisoner was still alive was to check their body positioning, the presence of blood or other fluids and to attempt to see the rise and fall of the prisoner's chest.

86. Officer Byrn told the inquest that that physical observations were recorded on an individual log for each prisoner and signed by the officer conducting the observation. The log for Mr Blair could not be located after his death, but should have been on a clipboard outside his cell.

87. Officer Byrn said that while individual cells were monitored by CCTV from the office of unit S3, constant monitoring was not possible as staff were not always in the office. Officer Byrn was not aware of any issues relating to Mr Blair, such as recent notices of concern, which warranted closer scrutiny when conducting observations. He did not have any specific concerns about Mr Blair following his interactions with him during the course of 13 November 2015.

88. Officer Clements said that he knew Mr Blair as he had accompanied him to the PAH after he experienced chest pains on 6 October 2015. He recalled that on 13 November 2015, Mr Blair had asked for individual yard time and to speak with the Cultural Liaison Officer. He said that after Mr Blair spoke with the CLO he returned him to his cell. He said that Mr Blair was quiet and polite, and he had no concerns for his well-being.

89. At 12:53pm Mr Blair was delivered a meal. Officers Byrn and Clements were captured on the CCTV footage[16] delivering that meal to Mr Blair in his cell. After receiving the meal, Mr Blair began to eat it sitting on his bed. Officers Byrn and Clements gave evidence that meal delivery was the means by which the hourly observation was effected (referred to as the 1:00pm observation). Both officers' evidence, which I accept, was that there were no concerns apparent to them about Mr Blair at the time.

90. At 12:59pm, the CCTV footage captured that Mr Blair had started to adapt the electrical cord attached to his cell's television to fashion a ligature. At 1:02pm, Mr Blair can be seen to take position under the desk in the cell from which he does not get back up. While his legs can be seen in the footage, his upper body and head cannot. I am satisfied from the footage, that by 1:07pm, Mr Blair had ceased all movement. Evidence was heard at the inquest from Dr Collins that this fact in and of itself does not mean this is the point that Mr Blair died. In Dr Collins' opinion, Mr Blair could have survived for up to 20 minutes from the point when compression was first applied to his neck.

91. However, Dr Collins was unable to be any more specific than to say that the process of hanging could take anywhere from seconds to as much as 20 minutes, depending on the extent and positioning of compression on the neck. Dr Collins' evidence was that even if Mr Blair had been found by 1:15pm he could not say whether he might have been revived, or comment on the extent of any hypoxic injury he might have suffered.

[16] Exhibit E1.

92. Mr Blair was not found by Officer Clements until 2:48pm, when he was asked to speak with Mr Blair about a possible move to unit S5. Officer Clements did not recall that Mr Blair had also spoken with Sentence Management on that day. Resuscitation efforts by that stage were unsuccessful. Evidence tendered from medical staff, particularly Nurse Christine McConkey[17] and paramedic Matthew Modulon[18], is consistent that Mr Blair displayed no signs of life and returned no shockable rhythm at any stage.

93. Evidence was heard at the inquest that a muster had been conducted at 1:30pm, during which no issues relating to Mr Blair's condition were raised. I accept the submission of counsel assisting that although it was highly concerning that this muster did not locate Mr Blair hanged in his cell, I am satisfied that it is also highly unlikely that Mr Blair was medically retrievable by that time.

94. Evidence was also heard at the inquest that there was an observation conducted at approximately 2:00pm by Officer Clements. This was the next hourly observation after the 1:00pm lunch time observation. Officer Clements' evidence was that during the 2:00pm observation he saw Mr Blair, who appeared to be asleep on the floor beside his bed. He said that it was not unusual for prisoners to sleep on the floor of their cells as it was cooler and darker there.

95. Officer Clements said that he could not see the electrical cord around Mr Blair's neck, and recalled that Mr Blair was lying on his left side with his feet pointed towards the door. The positioning of the television (on the far left side of the desk) was not something that attracted his attention. He told the inquest that he observed a movement of Mr Blair's leg or arm, but he could not recall which. He said he would not have moved on to the next observation unless he noticed some movement from Mr Blair.

96. While Officer Clements maintained that he saw some movement at 2:00pm the CCTV footage clearly shows that his evidence about movement by Mr Blair during this observation must have been mistaken.

97. It was simply impossible, given the evidence of Dr Collins and the CCTV footage, that Mr Blair would make any voluntary or involuntary movement at the 2:00pm observation. Officer Clements was asked by counsel assisting how he was able to see the ligature on Mr Blair's neck at 2:48pm when he was not able to see it at the 2:00pm observation. He said that at 2:48pm he had to physically step inside the cell and look under the desk in order to sight the position of the cord. In contrast, the 2:00pm observation was conducted by looking through the clear window on the cell door.

98. As with the 1:30pm muster, I accept the submission of counsel assisting that although it was highly concerning that the 2:00pm observation did not locate Mr Blair deceased, from the evidence provided I am satisfied that Mr Blair would not have been medically retrievable if he had been found at 2:00pm.

[17] Exhibit B17.
[18] Exhibit B22.

Autopsy results

99. An external autopsy examination with associated CT scanning and toxicology testing was carried out on 17 November 2015 by experienced forensic pathologist, Dr Rohan Samarasinghe. Dr Samarasinghe's findings were peer reviewed by forensic pathologist, Dr Rebecca Williams. Following a request from Mr Blair's family, Dr Byron Collins conducted a second autopsy on 1 December 2015 involving a full internal examination. I heard evidence from Dr Collins at the inquest.

100. Dr Samarasinghe's examination showed a prominent ligature mark around the neck, the origin of which was consistent with hanging. The pattern of the mark was in keeping with the accompanying ligature being made from an electrical cord. No injuries indicating possible third party involvement were observed.

101. The CT scan was unremarkable. Dr Collins, through internal autopsy, detected underlying ischaemic heart disease with up to 60% narrowing of the coronary arteries. His evidence to the inquest was that this was likely to have hastened the death.

102. Toxicology results revealed no alcohol or other drugs.

103. Dr Samarasinghe concluded that the formal cause of death was consistent with hanging.

Adequacy of mental health treatment and referral to the Prison Mental Health Service

104. The inquest investigated the adequacy of the mental health treatment provided to Mr Blair in the lead up to his death, and whether the referral made to the PMHS was dealt with appropriately in all of the circumstances.

105. The Clinical Director of the Prison Mental Health Service, Dr Andrew Aboud, provided a statement to the inquest and gave oral evidence. I accept Dr Aboud's evidence that earlier psychiatric intervention is unlikely to have prevented Mr Blair's death. Dr Aboud's evidence was to the effect that if there had been earlier psychiatric intervention for Mr Blair, it could have resulted in a change to his medication regime and/or or his hospitalisation.

106. Dr Aboud's evidence was that Mr Blair suffered from a personality disorder which could not be effectively treated with medication. Mr Blair also had a diagnosis of polysubstance abuse, and had a history of expressing suicidal ideation and thoughts of wishing to harm others when he presented to mental health services. Any change to his medication regime to respond to a diagnosis of depression would have taken at least two weeks before having any clinical effect – beyond the time of his death.

107. Dr Aboud's evidence was also that as Mr Blair did not have a mental illness, he would not have satisfied the requirements for a Recommendation for Assessment under the *Mental Health Act*, and was unlikely to have been hospitalised. Even if he did meet the requirements for admission it was unlikely that a hospital bed would have been available before the date of his death.[19]

108. Dr Aboud's evidence was that the seven day timeframe to triage for Mr Blair's PMHS referral from 5 November 2015 to 12 November 2015 was not ideal, and that the aim of the PMHS was to triage a new referral within two days of it being received. However, I accept the submission from counsel assisting that earlier PMHS triage is unlikely to have prevented Mr Blair's death.

109. The referral had been actioned outside the parameters of the usual PMHS process, starting with the email from the AGCC PMHS coordinator Ms Green which resulted in Mr Bond conducting an assessment on 12 November 2015. The referral was further actioned by Ms McGillivray upon her return from leave on 9 November 2015, with the booking of an appointment with a psychiatrist on the next available date of 25 November 2015. That would ordinarily not have occurred until the referral had been triaged and an intake assessment was conducted.

110. It was submitted on behalf of Mr Blair's mother that this issue needed to be considered in the context of the deterioration in his mental health immediately following his release on court-ordered parole, and not simply the final period of incarceration. He was reported to have barricaded himself in his room at Cliveden Mansions before he then self-reported to the RBWH, where he assessed as a chronic suicide risk. He was then was released by Dr Blenkin in the knowledge that he would be under the care of the PMHS.

111. Mr Blair was then housed in the watchhouse from 29 October to 5 November 2015 where he was also identified as at risk of suicide and placed in a suicide smock. A referral was made from the watchhouse to the PMHS by the court liaison service but this was placed on hold until Mr Blair was placed within a prison.

112. Ms Howlett said that she did not refer Mr Blair to PMHS as her assessment was that he did not meet the criteria for intake, notwithstanding his significant recent history of attempted self-harm and hospital admission.

113. Taking into account all the circumstances, including the fact that his PMHS referral did not follow the usual pathway, I am satisfied that Mr Blair was dealt with appropriately by the PMHS during his final period of imprisonment.

[19] Exhibit B39

114. During this inquest issues were raised by various witnesses relating to the sharing of information particularly between the QCS psychologists and Queensland Health, including the PMHS. This is a common issue examined in prison deaths in custody and, as noted below, is subject to ongoing consideration by those agencies. In this case, I am not satisfied that the relevant information would not have been given to the QCS psychologists if they had requested it from the PMHS.

115. While it is important not to equate a risk assessment with mental health treatment, there is also no evidence that the risk assessments provided by QCS psychologists to Mr Blair during his time at BCC were inadequate at the time they took place. Their assessment of risk could have been better informed had they accessed a wider range of information, including health and watchhouse records.

116. I agree with the submission of the family that although Mr Blair had been the subject of risk assessments by psychologists after his return to BCC and was waiting to see a PMHS doctor, limited therapeutic intervention had occurred by the time of his death almost two weeks after his return to custody following parole suspension.

117. This reflects that resource prioritisation is geared to ongoing risk assessment by different employees of differing agencies. While risk assessment is essential, there are insufficient interventions available within the prison environment to respond to identified and dynamic risks for prisoners, who may be highly impulsive, other than at risk observations, the support of Indigenous prisoners by cultural liaison officers and the maintenance of medication.

118. Having regard to the fluctuations in Mr Blair's mental state, there is no certainty that earlier triage or assessment by the PMHS would have changed the outcome for him. However, I consider that he would have benefited from a more immediate response within BCC to his concerns about his move from unit S3, and his perception of increasing estrangement from his family. The fact that Mr Blair reached out to the cultural liaison officer rather than a CCO after being told of his 'bus ticket' to Wolston highlights the importance of having culturally competent staff within prisons who can respond to the specific concerns of Indigenous prisoners.

Adequacy of the decisions made by the Risk Assessment Team on 12 November 2015

119. I accept the submission of counsel assisting and Mr Blair's family, that there is no evidence that the decisions made by the RAT on 12 November 2015 were anything other than adequate in the circumstances. As submitted by Mr Blair's family, those involved in this process applied the relevant policies appropriately and erred on the side of caution in their decision-making.

120. The evidence from the members of that team confirmed that a decision was made to keep Mr Blair on 60 minute observations in order to keep him accommodated in unit S3. I am satisfied that if there had been no accommodation issues raised, Mr Blair would have had his observations reduced to every 120 minutes.

121. It is also clear, particularly from the RAT assessment of Don Williams, that staying in unit S3 was of particular importance to Mr Blair, and he had expressed he would self-harm or suicide if he was moved.[20] This importance was highlighted in the evidence of Mr Paul McWaters, in his position as the A/Accommodation Manager, who took it upon himself to reassure Mr Blair that he would not be moved from unit S3 for the next seven days.

122. I agree with the submission from Mr Blair's family that it is likely that a higher level of observations would have been implemented if the RAT were aware that Mr Blair was facing an imminent transfer from BCC. It is also likely that the RAT might have assessed a different level of risk had they been aware of Mr Bond's communication with Mr Blair about the fact that he could not live with his mother, which appears to have coincided with the RAT meeting.

Adequacy of the observations regime on the deceased in his cell on 13 November 2015

123. I accept that the observations regime which required Mr Blair to be observed every 60 minutes was adequate in the circumstances.

124. In terms of how those observations were conducted, I accept the submission of counsel assisting that the absence of the observations log from 13 November 2015 does not lead to a conclusion that observations were not being performed at all.

125. The CCTV footage confirmed the 1:00pm observation at lunch time was carried out. In terms of the 1:30pm muster and the 2:00pm observation, I accept that Mr Blair would have been located deceased under his cell desk if those had been carried out effectively.

[20] Exhibit B31.4

126. I agree with the submission from the family that the 2:00pm observations were not adequately performed. This was likely based on Mr Clements' misapprehension of the context in which he saw Mr Blair on the cell floor. However, as noted previously it is highly unlikely that Mr Blair could have been medically retrieved if he had been found at either observation.

Adequacy of the communication between Sentence Management and the RAT over 12-13 November 2015

127. I accept the submission of counsel assisting that the lack of communication between the RAT and Sentence Management was the most significant issue identified in this matter.

128. Mr Blair's death soon after he met with Ms McLennan was not coincidental. I am satisfied that Mr Blair determined to end his life after information was given to him about his "bus ticket" to Wolston. That information was given to Mr Blair without any regard to the conclusions and recommendations of the RAT from 12 November 2015. Earlier that day he had been given an assurance that he would be kept in unit S3 for at least seven days.

129. Ms McLennan's evidence was that if she had known the RAT recommendation was that Mr Blair not be moved from unit S3, she would not have conducted her assessment on 13 November 2015. Accordingly, I conclude that the communication between the RAT and Sentence Management was inadequate.

Adequacy of the response by Arthur Gorrie Correctional Centre and the Brisbane Correctional Centre to the recommendations made as a result of the investigations conducted by the Office of the Chief Inspector

130. A large amount of evidence was tendered at the inquest from Ms Hannah Walton, Prisoner Development Manager at AGCC, regarding the responses by AGCC to the OCI recommendations.[21] After reviewing those materials, I am satisfied that the response of AGCC to those recommendations was adequate.

131. A number of statements were also tendered which detail the QCS response to the OCI recommendations.[22] Evidence was heard from Mr Joel Smith, Deputy General Manager of BCC regarding the most relevant recommendations. Mr Smith is also a registered psychologist with over 17 years' experience within QCS.

[21] Exhibits B34 – B34.27.
[22] Exhibits B35, B36 and B33.

132. The OCI Report recommended that BCC review its assessment practices at reception to enable assessment officers to carry out complete collateral checks as required, including that direct contact and liaison occur with Queensland Health and the PMHS by the assessing psychologist.[23]

133. Mr Smith said that a 2016 audit had found a 24% increase in the workload of psychologists and counsellors from 2014 to 2016. He said that BCC also operated an approved temporary staffing model which enabled additional psychologists to be appointed temporarily to assist with fluctuations in prisoner numbers.

134. Mr Smith said that an additional PO3 psychologist role had been created at BCC to assist with the gathering of collateral information for psychologists completing an IRNA. A similar model had also been approved for unit S3 which enables an extra staff member to be rostered to carry out observations when the number of prisoners on 15 minutes observations exceeds eight. A further staff member is allocated when the number of prisoners on such observations reaches 15.

135. During 2017, local instructions had been issued at BCC requiring that collateral information be obtained from watch houses where it was known that a prisoner was managed on observations prior to admission. Where a prisoner's watch house file was stamped "Suicidal" and collateral information could not be obtained, a notice of concern must be raised and the prisoner accommodated on 15 minute observations until either the information is obtained or a five day period has elapsed to enable observation of the prisoner's behaviour. Collateral information must also be obtained from the PMHS.

136. Recommendation 4 of the OCI report related to the training of psychology services staff on procedural requirements related to IRNA assessments. Mr Smith outlined that additional components were added to the training of psychologists after Mr Blair's death to provide accredited training in the operations of IRNA. Senior psychologists provide training sessions to refresh the more complex assessment considerations of the IRNA. This includes random monthly auditing of IRNAs by a senior psychologist for errors in procedural compliance and deficits in clinical skills.

137. With respect to communication between Sentence Management and the RAT in relation to at-risk prisoners, evidence was heard that this identified gap led to the issue of a local instruction at BCC relating to the transfer of prisoners. A copy of the local instruction was tendered at the inquest.[24] Mr Smith's evidence was that the instruction was issued as a direct result of Mr Blair's death and OCI recommendations 6 and 7.

[23] Recommendations 3 and 5
[24] Exhibit B34.4.

138. The effect of the instruction is that if a prisoner is being seen by a Sentence Management officer for the purpose of a classification and placement assessment, a psychologist will also attend the assessment to provide an assessment of the prisoner's reaction to the information. If needed, an assessment of the level of risk of the prisoner will be made at that time.

139. This is also the case when prisoners are notified by Sentence Management of their transfer to another prison. The instruction provides that a psychologist will also attend at that time, and review relevant materials before attending. Most importantly, the local instruction dictates the RAT minutes are to form part of this review.

140. Mr Smith also confirmed that as a direct result of Mr Blair's death, televisions were removed from all cells in unit S3. This decision was made because more prisoners are in unit S3 for at-risk observations than medical or other reasons. Other modifications were made to cells in the unit to remove potential hanging points associated with desks in cells that were not apparent prior to the death.

141. I am satisfied that this addresses issues concerning the adequacy of the cells within the High Dependency Unit of BCC with regard to hanging points and the availability of aids to suicide. At the time it may not have been apparent that there were risks associated with prisoners on observations regimes having access to a television with an electrical cable in a suicide resistant cell. However, hindsight dictates that it was not safe for such televisions to be deployed in the cells of at-risk prisoners. Wall mounted sets with no accessible cabling would have been a better way to manage this risk.

142. I accept that, on review of the evidence as tendered and upon hearing evidence from Mr Smith, the response from BCC to those recommendations was adequate.

143. The OCI Report also found that there was no capacity to manage the conditions and day of release of a Court Ordered Parole prisoner, and that Mr Blair was released into the community on Friday, 23 October 2015 without adequate support. He was released with only enough medication to last over the weekend.

144. The OCI Report recommended that QCS "review provisions for the delayed or early release of a prisoner under special circumstance where the release date is detrimental to the prisoner". The OCI Report noted that QCS had implemented a new model of through care. The Report's recommendation 2 was that QCS provide assurance that this model was appropriately resourced to deliver the following:[25]

[25] Exhibit C20, p 59

1. Supports late and weekend releases from custody;
2. Has a provision which links crisis support services 7 days per week; and
3. Provides needs assessments which directly link to support for prisoners being released from self-harm management.

145. I was assisted by a statement from Ms Keiren Bennett[26] in relation to the QCS response to recommendation 2. Ms Bennett advised that re-entry service providers work with offenders to offer planning and support as they transition from a correctional environment to living in the community. The model operating at the time of Mr Blair's death used a single service provider across Queensland.

146. Ms Bennett advised that QCS had increased accessibility to and the scope of re-entry services by the introduction of three new service providers since 2016, including CREST (Community Re-Entry Support Teams) for male offenders, apart from those exiting Borallon. The CREST service focuses on practical ways to reduce re-offending and assist prisoners with matters such as securing stable accommodation, substance abuse, social supports, and linkages to services providers to assist them to address their needs, including mental health needs.

147. Post-release managed stream services are available for prisoners who are subject to suicide observations in the week before discharge, and the service provider will undertake individual planning to address an offender's specific needs.

148. These changes are consistent with the recommendations contained in the 2016 Report of the Review of the Parole System in Queensland, which were largely accepted by Government and have resulted in significant reforms to the parole system, together with additional resources.

149. I was also provided with a statement from Sally-Ann Gray, Director, Office of the Chief Inspector in relation to the response to root cause 1. Ms Gray advised that the progress of the QCS response to the OCI recommendations was monitored by the Incident Oversight Committee (IOC) chaired by the Chief Inspector. In June 2018, the IOC noted that QCS has implemented changes and improvements since Mr Blair's death, which have resulted in increased access to, and scope of, re-entry services.

150. Ms Gray said that the IOC had accepted that that limitations to re-entry support services in general, and on day of release to court ordered parole, were being covered extensively under the Offender Management Renewal project as part of the broader Parole System Reform.

151. Having regard to the evidence of Ms Bennett and Ms Gray about these ongoing reform efforts, I accept that the QCS response to OCI recommendations 1 and 2 is adequate.

[26] Exhibit B33

Conclusions

152. Mr Blair died after he intentionally hanged himself in his cell. Mr Blair's death might have been prevented if Ms McLennan, the Sentence Management representative, had been alerted to the recommendations from the RAT made the day before his death.

153. This would likely have resulted in the deferral of his meeting with Sentence Management on 13 November 2015. However, the RAT recommendations were not known to Ms McLennan. I consider that the fact that he was told a recommendation would be made for him to leave unit S3 imminently contributed to Mr Blair's apparently impulsive decision to end his own life.

154. As Mr Blair's family submitted, this was amplified by the fact that Mr Blair had been informed, at around the same time as the RAT assessment, that his mother and sister were not able to assist him with accommodation. The two factors that had been identified as protective for him were no longer in place.

155. The observations conducted at the 1:30pm muster and at 2:00pm were inadequate in that they failed to locate Mr Blair on the cell floor with the ligature he had fashioned from an electrical cord. However, I am also satisfied that if Mr Blair had been located on either occasion he would not have been medically retrievable.

156. The first aid Mr Blair received once he was located was of a suitably high standard. Once he was found there is nothing that anyone could have been done that would have prevented his death.

157. After considering the QPS investigation report and the evidence of Detective Senior Constable Fry I am satisfied that Mr Blair's death was not suspicious, and that no other party was involved in his death.

Findings required by s45

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

Identity of the deceased – Colin Wayne Blair.

How he died - Mr Blair died in his cell while he was an inmate in the High Dependency Unit of the Brisbane Correctional Centre. He was placed in a suicide resistant cell. Mr Blair had a lengthy history of mental illness and polysubstance use. He had been assessed as being at risk of suicide on re-entry to the prison on 5 November 2015, and was on placed an hourly observations regime that was continued after a Risk Assessment Team meeting on 12 November 2015. Mr Blair had specifically expressed an intent to self-harm if he was moved from the High Dependency Unit. On 13 November 2015, Mr Blair was the subject of classification and placement assessment for the purpose of a transfer from the Brisbane Correctional Centre. The officer undertaking that assessment was not aware of the risk assessment undertaken by the Risk Assessment Team on 12 November 2015. Shortly after Mr Blair was told that it would be recommended that he be transferred to the Wolston Correctional Centre, he fashioned a ligature using an electrical cord, lay on the floor of his cell and hanged himself.

Place of death – Wacol in Queensland.

Date of death – 13 November 2015.

Cause of death – Hanging.

Comments and recommendations

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

160. The inquest investigated the adequacy of the response by AGCC and BCC to the recommendations made as a result of the investigations conducted by the OCI. At the inquest I heard evidence from Mr Smith regarding a number of measures that have been undertaken at the BCC since Mr Blair's death. I also had regard to tendered written material from Mr Smith, and others from BCC.

161. I note that not all recommendations were aimed at BCC. Some were directed at QCS. At the inquest I also had regard to tendered written material from QCS.

162. There were various comments made throughout this inquest about the workload and capacity of the PMHS in late 2015. Evidence was heard from Dr Aboud about an internal review conducted by the PMHS regarding that service as it was operational under the West Moreton Hospital and Health Service, which deals with the vast majority of prison mental health service delivery in Queensland.

163. Dr Aboud's evidence was that he was aware that the timeliness of the PMHS response was a recognised issue for the review. He also said that the PMHS had significantly increased the level of service provided to BCC in the two years following Mr Blair's death, including the allocation of an additional clinical coordinator and more intake and doctor sessions. It was reported that at the time of his death there were 263 outstanding referrals to the PMHS, with 74 clients on the waiting list to see a PMHS doctor for an initial review.[27] At the time of the death, the PMHS had 673 open clients.

164. With respect to the sharing of information between QCS psychologists and PMHS, Mr Smith's evidence referred to a potential advantage if access to the Consumer Integrated Mental Health Application (CIMHA) could be given for a person received into custody, to assist in categorising the notations that are of relevance to a person's level of self-harm, or suicide risk. This would provide an opportunity to identify any gaps that needed to be filled by the IRNA process. Similar views were expressed by other psychologists working at BCC.

[27] Exhibit B39.3

165. In the Inquest into the death of Franky Houdini, the Memorandum of Understanding (MOU) dealing with the sharing of information between QCS and Queensland Health was directly examined. Similar issues of information sharing were raised in that inquest. I made a recommendation that Queensland Health and QCS consider:

- *whether amendments are required to legislation to supplement the release of information (including documents) under the MOU on Confidential Information Disclosure to optimise the health care provided to persons in custody; and protect health practitioners from liability when sharing prisoner health information appropriately; and*
- *amendments to the Operating Guidelines under the MOU on Confidential Information Disclosure to provide more relevant contextual information in relation to the sharing of information in correctional settings.*[28]

166. On 2 June 2019, the Queensland Government response[29] to those recommendations indicated that the Queensland Health and Queensland Corrective Services information sharing and operational practice working group had found "current legislation does not prohibit staff in either agency from sharing relevant confidential information".

167. The response noted that the working group would "focus on enhancing working relationships through strengthening the MOU for confidential information disclosure", and that operational guidelines will be updated to support the MOU to provide more detailed guidance on sharing relevant confidential information between the agencies.

168. As noted above, in Mr Blair's case it appeared that QCS psychologists conducting risk assessments did not actively seek collateral information from the PMHS about Mr Blair, including CIMHA records. There was also a missed opportunity to gather relevant information when they missed the meeting with PMHS on 11 November 2015. Whether QCS psychologists require more access to CIMHA records than is already available is a matter that the working group could consider.

169. Mr Smith also raised in his evidence a possible recommendation surrounding the interface between Sentence Management and the QCS psychologists. It had become apparent from the evidence of Ms McLennan that she lacked orientation of a number of key functions within QCS, in particular the NOC process and the RAT process. I do consider that this is a matter that requires a recommendation from me as the orientation of new staff should be something carried out by QCS as part of business as usual.

170. In May 2019, I published my findings and recommendations in relation to the deaths of Mr Garry Appleton and Mr Terrence Malone. Mr Appleton and Mr Malone were also Indigenous men who died following suicides at the Brisbane Correctional Centre during 2014.

[28] Findings of inquest into the death of Franky Houdini, delivered on 16 May 2018.
[29] Accessed at www.courts.qld.gov.au/courts/coroners-court/findings

171. Unfortunately, in many respects the circumstances of their deaths were similar to Mr Blair's death. Both men had lengthy histories of mental illness and addiction. Like Mr Blair, they died within one month of being returned to prison following breaches of parole. The parole breaches were associated with deteriorating mental health. Both men were open, or should have been open, to the PMHS.

172. Like Mr Blair, Mr Appleton's death was associated with heightened anxiety about being transferred between units within BCC. In Mr Appleton's case, I found there was failure to adequately respond to his deteriorating mental health in that context.

173. A common issue arising in Mr Malone and Mr Appleton's circumstances was the inadequate communication of their recent mental health histories to the assessing mental health practitioners at the BCC. Like Mr Blair, Mr Malone had been assessed for risk of suicide at a hospital psychiatric unit and in the watchhouse in the days before his return to prison. In each case, there was a failure to make information about those assessments available to the staff tasked with assessing suicide risk within the BCC.

174. My findings in relation to the deaths of Mr Appleton and Mr Malone contained the following recommendations that are apposite on the context of Mr Blair's death:

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

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

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

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

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

175. As the relevant agencies are still considering those recommendations, and having regard to the similarities between the deaths of Mr Blair, Mr Malone and Mr Appleton, I make no additional recommendations.

176. I close the inquest.

Terry Ryan
State Coroner
Brisbane
6 September 2019