QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Gina Valera**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2018/3991
DELIVERED ON:	8 September 2025
DELIVERED AT:	BRISBANE
HEARING DATE(s):	26 October 2023, 5-6 March 2024
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, family violence, suicide, mental health risk assessment.

REPRESENTATION:

Counsel Assisting:	Ms S Lane
Queensland Corrective Services:	Ms A Freeman KC, instructed by QCS
West Moreton Hospital and Health Service:	Ms P Fairlie, West Moreton Health

Contents

Introduction

1. Gina Valera was aged 49 years when she died at Brisbane Women's Correctional Centre ('BWCC'). She was on remand for charges including attempted murder. These charges related to her husband, from whom she was separated.

2. In May 2018, a domestic violence order was put in place between Gina and her husband for the first time. The order required, among other things, that Gina receive written consent from her husband before going to the family home.

3. On 9 August 2018, Gina went to the family home with consent to visit her children. Later that night, after examining her husband's phone, she attacked him with a golf club. Gina was subsequently charged with attempted murder and other offences. She had no criminal history.

4. Although Gina was arrested, police took her to the Prince Charles Hospital ('TPCH') after she told them she was going to suicide. She stayed at TPCH for just under two weeks. She was then remanded in the watch house, before being taken to BWCC. This was Gina's first time in custody.

5. Gina spent about a week in a secure induction unit at BWCC. It was noted she was anxious and had previous suicide attempts. However, she was assessed as being a low imminent risk of self-harm or suicide. On 4 September 2018, she was transferred to a residential unit. She shared the unit with seven other women but she had her own cell. Early in the morning on 6 September 2018, she was found hanged in her cell.

Personal Background

6. Gina was born on 8 June 1969 in Ormoc City, Philippines. She had one sister and moved to Australia in the 1980s. In 1996, Gina married her husband, Kreskin.[1] They had three children together - a son, and twin daughters.[2]

7. Gina was committed to her family and worked hard to support them. She is sadly missed by them and by her many friends and workmates. I extend my sincere condolences to them.

8. In late 2017, Kreskin and Gina separated.[3] They stayed living together with their children, but occupied separate rooms.[4] Following separation, Gina attempted suicide on at least three occasions.[5] In early 2018, Gina had several mental health referrals to hospitals.[6]

Protection Order May 2018

[1] Exhibit B15 at [2].
[2] QP9 of attempted murder charge, CO 1800 143 928.
[3] Exhibit B15 at [13].
[4] QPRIME records.
[5] Exhibit B15 at [13].
[6] Screenshot of Queensland public hospital contact.

9. From late April to early May 2018, Gina had been drinking heavily. On 6 May 2018, she was at home with her three children. Mr Valera was at work. Gina got into an argument with her son. She began packing her belongings into boxes. She tore up photographs and damaged other property. There was a scuffle between her and her son.[7]

10. On 7 May 2018, Gina got into an argument with Mr Valera. She demanded her car keys from him. He was reluctant to give them to her as he was concerned she was intoxicated. She slapped Mr Valera, took her keys, and drove to purchase more alcohol.[8]

11. Police subsequently applied for a protection order against Gina. Mr Valera was listed as the aggrieved. Their three children were also named on the order.[9] On 9 May 2018, a temporary protection order was put in place. On 1 August 2018, the protection order was granted. The order contained conditions requiring Gina to be of good behaviour and prohibited her from attending the family home except in circumstances where she had Mr Valera's written consent.

Hospital admissions in May and June 2018

12. From 19 to 21 May 2018, Gina was voluntarily admitted to Redcliffe Hospital. From 27 to 29 June 2018, she was admitted to the Mental Health Unit at TPCH. She was noted as having the impression of intentional polypharmacy overdose, combined with comorbid depression in the context of relationship discord and inability to see her children (due to the domestic violence order), and underlying personality vulnerabilities. Follow up was arranged with the Acute Care Team and her General Practitioner for a mental health care plan, as well as continued input from a private psychiatrist.[10]

Arrest in August 2018

13. On 9 August 2018, Gina received permission from Mr Valera to attend the family home to visit their daughters. Mr Valera left the house during the visit, and asked Gina to leave by a certain time. Later that evening, Mr Valera returned home, but Gina refused to leave. Mr Valera then went to bed.[11]

14. Sometime during the early hours of 10 August 2018, Gina began examining Mr Valera's phone. She later told police she found photographs of Mr Valera with another woman and she "blew up". She took a golf club, went to Mr Valera's bed, and struck him on the back of the head, causing a laceration behind his left ear.. She was restrained by Mr Valera and her son.[12]

[7] QPRIME records, QP 1800 834 703.
[8] QPRIME records, QP 1800 834 703.
[9] Police protection notice dated 07/05/2018.
[10] Exhibit B7 at [8].
[11] QPRIME records, QP 1801 466 521.
[12] QPRIME records, QP 1801 466 521.

15. Police arrived and found Gina still being restrained. Gina told police she was depressed and wanted to kill herself. She indicated she had a gas bottle in her car and was planning to take her own life. She told police she had been off her medication for two months.[13] She was charged with assault occasioning bodily harm (domestic violence offence) and contravention of the protection order. Given her apparent suicidal intent, police transported her to TPCH.[14]

16. On 11 August 2018, police spoke to Gina while she was in the mental health ward at TPCH. She told police she was depressed and had been struggling to sleep for months. She indicated that while looking through Mr Valera's phone, she found photographs of him with another woman. She had planned to gas herself with the gas bottle. She blamed Mr Valera for her depression.[15]

17. While in the hospital, Gina also disclosed to a nurse that she had crushed Seroquel tablets and mixed them with Mr Valera's protein powder. When asked whether she intended to kill Mr Valera, she answered "yes and no".[16]

18. Gina was subsequently charged with attempted murder (domestic violence offence) of Mr Valera and stupefying in order to commit an indictable offence (domestic violence offence).[17]

Prince Charles Hospital - August 2018

19. From 10 to 22 August 2018, Gina was hospitalised at TPCH. She was thought to be suffering from a situational crises and an adjustment disorder. She recommenced antidepressant medication. [18]

20. On 22 August 2018, Gina was discharged from TPCH after an improvement in her mood. She was released to police custody and transferred to the watch house at Pine Rivers. On assessment at the watch house, she denied any suicidal thoughts or intent.[19]

Incarceration in August 2018

21. From 22 August 2018 until her death Gina was incarcerated. On 22 August 2018 she was in the custody of police at the Pine Rivers watch house.[20]

22. On 23 August 2018, Gina appeared in the Magistrates Court at Pine Rivers. She was remanded in custody to next appear on 7 September 2018.[21]

23. On 23 August 2018, the Pine Rivers Court Liaison Service phoned Justine Fagan. Ms Fagan was a Registered Nurse with the West Moreton Hospital and Health Service. She was the Clinical Coordinator for BWCC. Her role was to help facilitate and coordinate referrals to the Prison Mental Health Service ('PMHS').[22]

---

[13] Emergency Examination Authority dated 10/08/2018.
[14] QPRIME records, QP 1801 466 521.
[15] QPRIME records, QP 1801 466 521.
[16] QPRIME records, QP 1801 466 521.
[17] Exhibit C5, Queensland court outcomes.
[18] Exhibit B7 at [9].
[19] Exhibit B7 at [9].
[20] Presentence custody certificate dated 30/08/2018.
[21] Exhibit G1.2, VJR and criminal history.
[22] Exhibit B7 at [3].

The PMHS provides specialist mental health care to prisoners who have been referred. The purpose of the call to Ms Fagan from the Court Liaison Service was to ensure Gina was referred to the PMHS.[23]

Autopsy results[24]

24. On 7 September 2018 Forensic Pathologist, Dr Phillips, conducted an autopsy consisting of an external and full internal examination of the body. Toxicology samples were taken. Dr Phillips was also provided with the ligature.

25. Toxicology showed alcohol was not detected. Levels of mirtazapine (antidepressant), diazepam (benzodiazepine), and nordiazepam were detected.

26. Internal examination showed fractures on both sides of the upper thyroid cartilage (being the structure in the upper neck). There was associated bleeding with the thyroid cartilage fractures. External examination revealed abrasions around the neck. Dr Phillips concluded the cause of death was hanging.

The Investigation

Office of the Chief Inspector[25]

27. In September 2019, the Office of the Chief Inspector produced a final Incident Investigation Report. That investigation included interviews with prisoners, prison staff, review of closed-circuit television footage, review of prison documentation.

28. The investigation noted that since Gina's death, a new Elevated Baseline Risk ('ELBR') Custodial Operations Practice Directive ('COPD') had been implemented. The purpose of the ELBR COPD is to ensure prisoners who pose a chronic risk of suicide are managed in accordance with their presenting risks and needs. Had the EBLR process been in place at the time, Gina would have been assessed by an additional panel before moving into residential accommodation.[26]

29. The report made seven findings and ten recommendations which are summarised as follows:

Finding	Recommendation
Finding 1: An email sent by PMHS might have been misinterpreted. A reference to there being no strong recommendation in relation to mental illness (while in hospital) was potentially misunderstood to mean that Gina was not at risk of suicide, despite her now entering a new and different environment.	**Recommendation 1:** The Assistant Commissioner, Strategic Futures, liaise with police to implement a process aimed at achieving consistent information exchange between watch houses and correctional centres.

[23] Exhibit B7 at [10]-[11].
[24] Exhibit A4.
[25] Exhibit G1.
[26] Exhibit G1, at p 5.

Finding 2: Gina's IRNA at the Correctional centre identified a significant number of risk indicators as opposed to protective indicators. Although, it was acknowledged the individual weighting accorded to risk and protective indicators would ultimately be a matter for a reasonable professional judgement.	**Recommendation 2:** The Assistant Commissioner, Strategic Futures, revise the COPD At Risk Management to provide clarity in relation to what constitutes a 'recent' suicide attempt.
	Recommendation 3: The Assistant Commissioner, Strategic Futures, ensure when staff are assessing a prisoner's risk of self-harm or suicide they document risk factors and protective factors, and information as to how they have assessed the balance of these factors.
Finding 3: Personality disorders and psychotropic medication non-compliance is information that is important to be provided to psychologists for undertaking at-risk assessments.	**Recommendation 4** The Assistant Commissioner, Strategic Futures, ensures that the Information Sharing Memorandum of Understanding between Qld Health and Corrective Services maintains capacity for information about personality disorders, psychotropic medication non-compliance, and other relevant information be provided to QCS psychologists when undertaking at-risk assessments and management.
Finding 4: The current and approved Elevated Baseline Risk process was not in place at the correctional Centre until 18 September 2018. Gina would have been assessed by the EBLR panel before progression to Residential.	
Finding 5: Gina progressed quickly to residential accommodation, which was particularly relevant given the IRNA recommended she be accommodated within a suicide resistant cell.	**Recommendation 5:** The Assistant Commissioner, Strategic Futures, ensure that the accommodation pathways process be revised with a view to ensuring more detailed information in relation to a prisoner's case notes and at-risk history is included with the Accommodation Committee Decision Record to better inform the committee's decision.
	Recommendation 6: The Assistant Commissioner, Women's Estate ensure that Brisbane Women's Correctional Centre cease the practice of Correctional Supervisor completing Accommodation Pathway forms and the Correctional Centre Officers be tasked with that responsibility, as per COPD Case Management.

Finding 6: The induction process for Gina did not comply with COPD Admissions and Assessment as she did not receive a facility induction upon her arrival.	**Recommendation 7:** The Assistant Commissioner, Women's Estate, ensure there is a suitable peer support prisoner to provide support to another prisoner when it is their first incarceration.
	Recommendation 8: The Assistant Commissioner, Women's Estate, ensure BWCC management take steps to ensure all prisoners receive their unit facility and system inductions within the required timeframe.
	Recommendation 9: The Assistant Commissioner, Women's Estate, undertakes an audit within the Induction Unit to determine there is an adequate level of engagement with prisoners, sufficient advice/information is provided, and staff comply with COPD requirements to case management, admission, an induction.
Finding 7: The induction program/presentation at BWCC does not include all of the required elements as set out with Appendix R9.	**Recommendation 10:** The Assistant Commissioner, Women's Estate, ensure that BWCC Induction Program is reviewed and expanded to meet the minimum standards as set out with the R9 Minimum Standards Inductions.

Corrective Services Investigation Unit[27]

30. On 14 June 2020, Detective Sergeant Carr of the Queensland Police Service Corrective Services Investigation Unit finalised his report into Gina's death in custody. Attached to the report were documents from QCS, statements from CCOs and other prisoners living in the same unit as Gina.[28]

31. Detective Sergeant Carr noted:

    1. Gina had spent nine days on remand and was not known to have suffered any serious physical or mental injuries or episodes.29
    2. Gina appeared to have been supervised by CCOs as per normal procedures. There were no unusual incidents or occurrences noted on her file.30
    3. It appeared all policy and procedures relating to Gina's care had been complied with.31
    4. Gina had apparently used shoelaces to form a ligature. Ultimately, this led to her death.32

[27] Exhibit A5.
[28] Exhibit A5 at [16].
[29] Exhibit A5 at [11].
[30] Exhibit A5 at [12].
[31] Exhibit A5 at [13].
[32] Exhibit A5 at [13].

32. Detective Sergeant Carr concluded that Gina appeared to have been provided with adequate medical care while a prisoner in the care of Corrections.[33] No recommendations for future preventative measures were made.[34]

QCS response to OIMERG recommendations and availability of ligature points

33. The Court requested QCS to provide a response to the 10 recommendations made in the OIMERG Report, as well as to comment on the availability of shoelaces to prisoners and any policies/considerations relevant to those.

34. QCS provided two statements in response:

    1. Assistant Commissioner Hamlett, Central and Northern Region Command. Assistant Commissioner Hamlett provided a response to four of the ten recommendations: Recommendations 1, 4, 5 and 6.

    2. Chief Superintendent Fleming, General Manager, BWCC. Chief Superintendent Fleming provided a response to four of the ten recommendations: Recommendations 2, 3, 7 and 8, 9 and 10, as well as questions regarding shoelaces.

35. The responses to all recommendations are set out in the table below. Recommendations which have been implemented are shaded. In respect of the remainder, implementation work is ongoing for the reasons given:

Recommendation	Response
Recommendation 1: Liaise with QPS to implement a process aimed at achieving consistent information exchange between watch houses and correctional centres.	Acknowledged recommendation by State Coroner in inquest of MALONE and APPLETON in respect of improvement of 'front end services' at the Brisbane City Watchhouse and collaboration between QH, QPS and the PMHS. Referred to response to that recommendation and the State Custody Officer Watchhouse Inquiry, advising that: *QCS continues to work closely with QPS in order to evaluate our current and new processes for prisoner transfers from the [WHs], with a focus on the individual prisoner's needs and health, safety and wellbeing of prisoners.*[35] This includes standardising the documents provided by QPS to QCS upon a prisoner's reception to a CC. In addition, noted recent Women's Safety and Justice Taskforce recommendations relating to establishing independent review into issues impacting on time women and girls are held in WHs. QCS has recently established the Women's Program Management Office to support the implementation of Women's SJT reforms.

[33] Exhibit A5 at [14].
[34] Exhibit A5 at [15].
[35] B8 – para 10.

Recommendation 2: Revise the COPD At Risk Management to provide clarity in relation to what constitutes a 'recent' suicide attempt.	*The Operational Practice and Policy Group, in consultation with Psychological Services, Specialist Operations, have removed the wording of 'recent suicide attempt' in the documents and replaced it with 'previous suicide attempt'. The Appendix to the COPD, namely AR2 Periods of Critical Risk, was updated and published on 16 September 2021.*[36]
Recommendation 3: Ensure when staff are assessing a prisoner's risk of self-harm or suicide they document risk factors and protective factors, and information as to how they have assessed the balance of these factors.	Amendments have been made to: a. *COPD – Reception Process: Administration and Assessments; and* b. *COPD – At Risk Management: At Risk* *The amendments made to the documents ensure that when practitioners are assessing a prisoner's risk of self-harm or suicide, the practitioner must detail a list of* ***both*** *protective factors and risk factors and provide a summary of how these factors are weighted in the overall assessment of the prisoner's risk…* *Correspondingly, when staff are making a decision relating to the accommodation of a prisoner as part of the prisoner's admission process, staff are required to consider the risk and the needs requirements of the prisoner. Amendments also reflect that staff are required to record the times that they undertake observations of prisoners.*[37]
Recommendation 4: Ensure that the Information Sharing MOU between QH and QCS maintains capacity for information about personality disorders, psychotropic medication non-compliance, and other relevant information be provided to QCS psychologists when undertaking at-risk assessments and management.	*…QH and QCS are in the final stages of developing an Information Sharing Agreement and Operating Guidelines.*[38] In its current (draft) form, the Agreement facilitates the sharing of confidential information such as that mentioned in the recommendation. *The Agreement aims to facilitate information sharing where consent cannot be obtained or it is not practicable to request it, and where other legislative avenues for sharing the information have not enabled disclosure or do not apply in the circumstances.* *…* *Once the documents are finalised, both agencies will commence implementing them into everyday practice to continue to provide better outcomes and a more holistic approach to treating prisoners in Queensland.*[39]

[36] Exhibit B7 - para 50 and Exhibit B7.7 - DF 07 AR2-Periods-Of-Critical-Risk.
[37] Exhibit B7, paras 54 – 56, Exhibit B7.9 - DF 09 reception-processes-admission-and-assessments and Exhibit B7.10 - DF 10 at-risk-management-at-risk-v5.
[38] Exhibit B8, para 21.
[39] Exhibit B8, paras 24 and 26.

Recommendation 5: Ensure that accommodation pathways process be revised with a view to ensuring more detailed information in relation to a prisoners' case notes and at-risk history is included with the Accommodation Committee Decision Record to better inform the committee's decision.	The QCS Prisoner Accommodation Management Cell Allocation Custodial Operations Practice Directive (COPD) has been amended as follows: a. *Clarification that a prisoner's suitable accommodation following admission is assessed based on their identified needs and risks;* b. *Amendments under various heading s requiring IOMS to be updated as soon as practicable following a prisoner being allocated/reallocated…;* c. *Separating placement considerations for prisoners with self-harm episode history indicators and those subject to at-risk observations with references to different COPDs;* d. *A requirement for a review of information detailed in case notes on IOMS and a review of a prisoner's incident and breach history to be undertaken during a suitability assessment for residential accommodation;* e. *Additional considerations added to the suitability assessment for residential accommodation including consideration of the prisoner's history of attempted suicide or self-harm [etc.]…;* f. *The requirement for advice to be sought from a psychologist…when assessing a prisoner's suitability for residential accommodation, who has a history of attempted suicide or self-harm [etc.]…*[40]
Recommendation 6: Ensure that BWCC cease the practice of Correctional Supervisor completing Accommodation Pathway forms and the CCOs be tasked with that responsibility, as per COPD Case Management.	*While the Case Management COPD outlines that CSOs are best positioned to monitor the behaviour of prisoners, at BWCC it is often Correctional Supervisors who will play a key role in the intake of a prisoner by virtue of BWCC's complex prisoner population and role as the only female remand and reception centre in SEQ.* *…* *Accordingly, the management and accommodation of women at BWCC requires a recognition of the intricacies of accommodating female offenders and an understanding of the bespoke infrastructure at BWCC. QCS is still determining whether CCOs or Supervisors will be best place to fulfill this role at BWCC.* *…In certain circumstances, CCOs may not necessarily have the requisite skill to understand the complexities of the remand and reception environment, and of the women transitioning through the centre.* *…Ultimately, any decision relating to the progress and accommodation of prisoners will have the wellbeing and welfare of prisoners at the forefront*

[40] B8, para 32 and exhibit EH-01.

	of any consideration [in the unique BWCC context].[41]
Recommendation 7: Ensure there is a suitable peer support prisoner to provide support to another prisoner when it is their first incarceration.	*In early 2021, a Local Instruction titled 'Peer Support Worker Program' was reviewed…Peer Support Workers are now rostered to attend Secure Unit 7 on a daily basis. The purpose of this attendance is to support ne transfers to BWCC….in addition…, Peer Support Workers are also rostered to attend the Inductions of new Prisoners.*[42]
Recommendation 8: Ensure BWCC management take steps to ensure all prisoners receive their unit facility and system inductions within the required timeframe.	*In response to [recommendations 8, 9 and 10] the Manager, Offender Development, BWCC has revised and developed updated processes regarding inductions. These updated processes ensure that all prisoners received their unit, facility and system inductions within the required timeframe. The updated process also ensures that the inductions are adequately documented.*
Recommendation 9: Undertake an audit within the Induction Unit to determine there is an adequate level of engagement with prisoners, sufficient advice/information is provided, and staff comply with COPD requirements to case management, admission, an induction.	*These new processes are reflected in a Local instruction and updated Unit Induction. These documents meet the R9 Minimum Standards induction outlined in the COPD – Admission and Assessments.*[43]
Recommendation 10: Ensure that BWCC Induction Program is reviewed and expanded to meet the minimum standards as set out with the R9 Minimum Standards Inductions.	

36. With respect to the availability of ligatures, Chief Superintendent Fleming advised as follows:

> *As far as I am aware, there are no BWCC specific documents, policies or local instructions which relate to prisoners being provided with shoelaces, however the presence of shoelaces may be considered on a case-by-case basis to account for the safety and security of a corrective services facility, and for the welfare of all prisoners.*[44]

37. Chief Superintendent Fleming advised that the shoe laces which Gina used as a ligature came from prison-issued running shoes. Prison issues running shoes either have Velcro fastening or laces. These are issued upon admission and the type provided depends on sizing and availability. While the admission records do

[41] B8, paras 40, 46 - 48.

[42] Exhibit B7, paras 62 – 63, Exhibit B7.13 - DF 13 LI-Peer-Support-Worker-Program and Exhibit B7.14 - DF 14 AR5-Peer-Support-Worker-Program-v2.1

[43] Exhibit B7, paras 70 – 1, Exhibit B7.16 - DF 16 LI - Centre-Induction V6, Exhibit B7.17 - DF 17 Brisbane Women's Correctional Centre Induction Booklet and Exhibit B7.18 - DF 18 Induction book - S6 Nov 2022.

[44] Exhibit B7, para 11.

not specify the type of running shoe issues to Gina, it is assumed she was issued with the laced shoes as there is no other record of shoes being issued to her.

38. Following admission, "[i]f a prisoner is determined to be 'At Risk' and subject to observations, a psychologist or the Risk Assessment Team (RAT) may limit access to shoelaces if this is considered necessary for the safety of the prisoner".[45] Gina's Immediate Needs Risk Assessment (IRNA), conducted on 27 August 2018, determined that she should be placed in a suicide resistant, or 'safer design' cell, but did not make mention of shoelaces. Gina was subsequently assessed as safe to move to residential accommodation.[46]

39. Chief Superintendent Fleming said that:

> *I am of the understanding that no additional consideration was given as to whether Gina was allowed to have shoelaces in residential as there was no indication that she had previously used ligatures in her prior suicide attempts, Gina denied any current suicidal ideation, and she was afforded the same privileges as the other prisoners accommodated in the residential units.*
>
> *Had the facility been aware of any adverse information regarding Gina's risk of self-harm, then this information would be factored into the decision-making process when considering her accommodation and management at BWCC.*[47]

40. In respect of safer design cells, Chief Superintendent Fleming said that:

> *Ordinarily and in line with the At Risk Management COPD, prisoners who are assessed as having an Elevated Baseline Risk (which includes a risk of harm to themselves) are required to be in a safer design cell.*
>
> …
>
> *Residential cells are not classed as safer design cells. Residential cells at BWCC are designed to allow the female prisoners to be accommodated in the least restrictive environment possible, as part of QCS's trauma informed care and practices for female prisoners in our custody.*
>
> *QCS has also adopted the national 'Guiding Principles for Corrections in Australia' policy which was revised in 2018. Outcome 2 of these principles reflects a national intent of providing the safe and humane containment of prisoners, and that prisoners are accommodated in a safe, clean and liveable environment which considers both risk and individual needs, particularly the needs of those who are most vulnerable.*
>
> *While being accommodated in a residential unit, female prisoners are provided with a greater opportunity to self-manage and this includes unassisted access to and from their cell, which results in the cell doors and doorknobs inherently posing as potential hanging points.*[48]

[45] Exhibit B7, para 16.
[46] Exhibit B7, paras 12 - 43.
[47] Exhibit B7, paras 44 - 45.
[48] Exhibit B7, paras 26 and 28 – 30.

Family concerns

41. On 27 May 2020, Mr Valera provided a statement to police outlining his concerns.

42. He indicated since separating in around December 2017, Gina had attempted suicide three times.[49] He had not spoken to Gina since the night she attacked him.[50] He had spoken to Gina's counsellor and was told Gina was depressed and not taking medication.[51] He advised the counsellor Gina had previously been diagnosed with depression and was supposed to be taking medication.[52]

43. Mr Valera raised two main concerns:

    1. Queensland Health had not done enough to help Gina.[53]
        i. She had been admitted to hospital for mental health reasons several times, but each time was simply released.
        ii. It was this that led to her attacking him and subsequently being remanded in custody.

    2. Corrections had not done enough to look after Gina.[54]
        i. She had previous suicide attempts.
        ii. She was now locked away from her family and children.
        iii. She should have been monitored closer.

The inquest

44. Gina was detained under the *Corrective Services Act 2006* before her death. In accordance with s 10(2)(a) of the *Coroners Act 2003* her death was a 'death in custody' and an inquest was required.

45. In addition to the findings required under s.45(2) of the *Coroners Act*, the following issues were investigated at the inquest:

    1. Whether the mental health care and treatment given to Gina at TCPH, including suicide/self-harm risk assessments, was appropriate and sufficient;
    2. Whether the mental health care and treatment given to Gina at BWCC, including suicide/self-harm risk assessments, was appropriate and sufficient;
    3. Whether the assessment that Gina was suitable for residential placement was appropriate in the circumstances; and
    4. Whether the provision of laced running shoes to prisoners in Correctional Centres is appropriate.

[49] Exhibit B15 at [13].
[50] Exhibit B15 at [4]-[6].
[51] Exhibit B15 at [8]-[9].
[52] Exhibit B15 at [10].
[53] Exhibit B15 at [15]-[16].
[54] Exhibit B15 at [17].

46. The inquest was held from 5 to 6 March 2024. Over 400 exhibits were tendered and the following witnesses were called to give oral evidence:

    1. Dr Janet Bayley, Consultant Psychiatrist;
    2. Dr Andrew Aboud; Clinical Director, Prison Mental Health Service;
    3. Assistant Commissioner Eloise Hamlett, Central and Northern Region Command (QCS);
    4. Chief Superintendent Darryll Fleming, General Manager, BWCC (QCS);

Conclusions on Inquest Issues

Findings required by s. 45

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

Identity of the deceased – Gina Valera

How she died – Gina was alone in her cell after a headcount was conducted between 8:00 and 8:30pm on 5 September 2018. She was found by correctional officers at 4:20am on the morning of 6 September 2018. She was found hanged in her cell. Despite the efforts of prison and ambulance officers, Gina could not be revived, and was pronounced deceased at 4:45am on 6 September 2018.

Place of death – Brisbane Women's Correctional Centre WACOL QLD 4076 AUSTRALIA

Date of death– Between 10:00pm on 5 September 2018 and 4:45am on 6 September 2018

Cause of death – Hanging

48. In the coronial jurisdiction there is a presumption against a finding of suicide unless, in the circumstances of the case, there is clear evidence that the deceased intended to end her life. In this instance, I am satisfied that Gina was engaged in a voluntary or deliberate course of conduct in which she consciously intended to end her own life.

Whether the mental health care and treatment given to Gina at BWCC, including suicide and self-harm risk assessments, was appropriate and sufficient.

49. Gina had been admitted to BWCC from the Pine Rivers Watchhouse on 27 August 2018. She had been referred to the PMHS by staff from the Pine Rivers Watchhouse. On admission to BWCC, she was assessed by QCS Provisional Psychologist McDonald, who conducted an Immediate Risk Needs Assessment ('IRNA').

50. The purpose of an IRNA is to identify any immediate risks or needs of a prisoner that require attention. During the IRNA, it was noted that Gina had three previous suicide attempts in the context of her husband allegedly having an affair, but Gina denied any current self-harm ideation, plan, or intent. Gina appeared future oriented and willing to seek assistance. One outcome of the assessment, however, was that Gina would require placement in a suicide resistant cell, known as a 'safe design cell'.

51. There was limited information about Gina's mental health history from Queensland Health at the time of the IRNA.

52. On 28 August 2018, Registered Nurse Fagan, Clinical Coordinator for PMHS triaged Gina and determined that due to the seriousness of the charge on which she had been remanded (attempted murder), and her recent admission to TPCH MHU, she was required to be assessed by a mental health clinician within one week of the triage - by 4 September 2018.

53. The same day, Ms McDonald conducted a follow up assessment. She found Gina to be anxious about her case and her relationship, but future oriented and she denied any current or recent deliberate self-harm or suicidal ideation. She was assessed as being minimal risk of harm.

54. On 30 August 2018, RN Fagan spoke to Gina to conduct a forensic intake assessment, the purpose of which was to identify Gina's mental health treatment needs. RN Fagan concluded Gina had low mood in the context of situational crisis but did not present with symptoms suggestive of a major depressive episode. She concluded Gina was a low imminent risk of deliberate self-harm or suicide.

55. Ms Fagan made handwritten notes during her assessment of Gina. However, these notes were not documented in the Consumer Integrated Mental Health and Addiction ('CIMHA') application until after Gina's death.

56. On 31 August 2018, Kirby Smith, a QCS Provisional Psychologist, interviewed Gina and noted she appeared agitated and anxious. Gina reported sleep disturbance and was asking legal questions about her incarceration. She detailed her history and difficulties with her husband. However, she presented as future oriented and denied any self-harm or suicidal ideation. Ms Smith assessed Gina as having minimal salient risk factors, and as suitable for accommodation in a residential unit.

57. On 3 September 2018, Gina appeared to be nervous and was seen hitting her head. A chaplain requested that a Correctional Counsellor, Vicki Tyrell, speak to Gina. Ms Tyrell showed Gina some calming exercises and this seemed to assist. Gina said that she did *not* want to hurt herself and that she was having difficulty dealing with not being able to contact her family.

58. This interaction was the last contact that Gina had with QCS psychologists or counsellors before her death two days later. By the time of her death, Gina had not had an appointment with a PMHS psychiatrist, despite having been triaged for an appointment.

59. I sought a review of Gina's medical records and an expert opinion from Dr Janet Bayley, Consultant Psychiatrist, with respect to Gina's mental health care and treatment while in prison. Dr Bayley provided a report of her review dated 20 June 2023. She identified the following issues with Gina's care and treatment at the BWCC:

- *The suicide and/or risk assessments conducted by both the Prison Mental Health Service and the QCS psychology and counselling service appear to have been inadequate and somewhat superficial. The PMHS reviewing clinician did not appear to complete standard Queensland Health CIMHA Risk Assessment and general Intake Assessment templates. Also, this clinician did not save the notes of her assessment into the system until after Gina's death.*

- *Clinical mental health care within BWCC appeared disjointed with multiple mental health clinicians from both PMHS and BWCC psychology services seeing Gina without apparent consideration of her broader clinical picture.*

- *There were deficiencies in identifying Gina's escalating distress, agitation, and despondency due to systemic issues and apparent staff workload concerns.*

- *it may have been helpful for [Gina] to have been restarted on the Quetiapine that she requested when she was received into the prison.*

60. During her evidence Dr Bayley qualified her concerns, advising that she was not completely familiar with QCS' internal processes for the assessment of prisoners and the available medical staff. However, she was aware that Correctional Centre staff were subject to busy workloads and resource shortages, and this may have affected their ability to conduct assessments and/or write comprehensive notes.

61. With respect to her concern about the disjointed nature of the care, Dr Bayley advised that she would have expected that a Consultant Psychiatrist from PMHS would have been the clinician in the best position to "step back" and "look at Gina's whole picture".

62. However, Dr Bayley accepted it may have been very difficult for Gina to have been seen by a psychiatrist in the short time she had been in prison (nine days), and there were likely other patients who had more acute mental health presentations who would have been prioritised for appointments.

63. Dr Bayley was also not aware whether Quetiapine was available in prison. However, if it had been made available to Gina, it may have helped to reduce her level of anxiety and agitation. Dr Bayley acknowledged that Quetiapine had not been included on the list of medications prescribed to Gina on her discharge from TPCH.

64. Ultimately, Dr Bayley's evidence was that the concerns she raised about Gina's care were a series of factors which could have been done better or dealt with sooner, but that even if these things had been done, she could not say that Gina's death would have been prevented.

Clinical review and Human Error and Patient Safety incident analysis report

65. On 9 April 2021, Dr Aboud, Clinical Director of the PMHS, provided a statement to the court in relation to Gina. Dr Aboud was part of a Human Error and Patient Safety ('HEAPS') Incident team that reviewed the case and treatment provided to Gina.

66. In his evidence before the court, Dr Aboud said that the HEAPS team identified there had been a delay RN Fagan's handwritten notes being typed/uploaded into the CIMHA. However, the team concluded this delay did not contribute to Gina's death. In addition, she would not have been scheduled to see a PMHS psychiatrist before her death.

67. The team identified several factors which influenced the delay in loading the intake assessment notes into the database. These included high workloads and lack of resources, including suitable rooms in which to see patients, access to computers and Wi-fi, and lack of administrative support. Dr Aboud's evidence was that, since Gina's death, significant improvements have been made with respect to workload and access to resources for PMHS clinicians.

68. Dr Aboud also confirmed that PMHS clinicians were reminded of the importance of keeping contemporaneous notes, and that progress notes are to be uploaded at the time of or as soon as possible after, attending a patient, and that ongoing emphasis was placed on the importance of these practices.

69. Overall, the HEAPS team concluded that, given Gina's presentation to staff at BWCC, there were no acute concerns for her mental health state. Timely and appropriate assessments had been undertaken and documented which supported this conclusion. There had been no signs that would have flagged this potential outcome for Gina, therefore, no opportunity for clinicians to intervene and prevent her suicide.

70. On 4 December 2023, Dr Aboud also provided a statement in response to Dr Bayley's report.

71. Dr Aboud set out the distinction between the role of the PMHS, the Prison Health Service and the QCS Psychology Service, noting that the focus of the PMHS was to assess for and meet specialist mental health needs, usually for prisoners with more severe forms of mental illness and behavioural disturbances.

72. This is contrasted with the QCS Psychology Service, which Dr Aboud stated, "…has a specific risk assessment and management responsibility that exists irrespective of the nature of the underlying psychopathology".[55]

73. Given that the two agencies, in Dr Aboud's view, have differing roles and seek to complement rather than replicate one another, he disagreed with Dr Bayley's opinion that, "Clinical mental health care within BWCC appeared disjointed with multiple mental health clinicians from both PMHS and BWCC psychology services seeing Gina without apparent consideration of her broader clinical picture".[56]

[55] B2.1.1, para 13.
[56] I2, p 9.

74. Dr Aboud confirmed that it was unlikely Gina would have seen a psychiatrist during her short stay in prison, particularly as she was there over a weekend when consultant psychiatrists were not on site, and her symptoms were not as acute as other patients who would be referred to the PMHS more urgently.

75. Dr Aboud also confirmed that Quetiapine was available to prisoners, and may eventually have been prescribed to Gina by a psychiatrist if considered appropriate. However, it was not prescribed by a doctor from the Prison Health Service. Dr Aboud explained that there could be some difficulties in prison with the prescription of sedatives, as "night-time' medication is given in the late afternoon rather than at bedtime, which means a prisoner might not have the benefit of the sedative effect overnight – in which case their sleep problems would not be improved.

76. Dr Aboud confirmed that the PMHS practitioners, QCS psychologists and counsellors who were making decisions about Gina in this context would have been familiar with the particular conditions and limitations relevant to treating patients within BWCC.

77. Dr Bayley raised some shortcomings with Gina's mental health treatment and care in prison, Dr Bayley was of the view at inquest that none of these shortcomings was, in itself, or combined, outcome changing for Gina.

78. On the basis of Dr Aboud's response to Dr Bayley's concerns within a prison context, I am satisfied that the mental health care and treatment given to Gina at BWCC, including suicide/self-harm risk assessments, was appropriate and sufficient.

79. As submitted by QCS, during the nine days that Gina was at BWCC she had five separate contacts with mental health professionals. She was receiving medication to help manage her anxiety and support to facilitate contact with her family. She also had contact with Sisters Inside and with Legal Aid in relation to her forthcoming court appearance.

80. While there was an identified shortcoming with respect to the timely uploading of assessment notes to CIMHA, which has now been rectified and which was not outcome-changing in Gina's case.

Office of the Chief Inspector recommendations

81. Also relevant to this issue are four recommendations which were made by the then Office of the Chief Inspector following their investigation into Gina's death.

82. Recommendations 1 and 4 of the OCI report were aimed at improving information exchange between watchhouses and correctional centres, and information sharing between QH and QCS. QCS Assistant Commissioner Hamlett's statement advised that QCS was working with both QPS and QH on establishing agreements which will improve processes around information sharing and exchange.

83. Recommendations 2 and 3 were aimed at revising and improving medical staff understanding of the assessment and documentation of a prisoner's risk of self-harm or suicide. QCS Chief Superintendent Fleming confirmed during his evidence that each of these recommendations had been implemented.

Whether the assessment that Gina was suitable for residential placement was appropriate in the circumstances

84. On 4 September 2018, Gina was assessed by the BWCC Accommodation Committee as suitable for residential placement and was transferred to residential unit 1A.

85. The residential unit consisted of six cells for prisoners to sleep in, along with shared facilities including a kitchen, bathroom, and sitting area. There were seven other women in the residential unit. Gina had a cell to herself.

86. Gina had interactions with other prisoners in the residential unit on 4 and 5 September. At first she was teary and missing her family but later on 5 September she was observed laughing, dancing and singing. At about 7.00pm Gina went into her cell and shut her door for the night. She was last seen alive and well during the headcount at between 8:00 and 8:30 that night, and was found unresponsive the following morning.

87. In respect of the issue of the appropriateness of Gina's transfer to the residential unit, Dr Bayley raised the following issue in her report:

> *It was not appropriate for her to be transferred to a residential unit in light of the escalation of her symptoms and distress shortly before her transfer.*

88. Dr Bayley confirmed, in her evidence, that there were a lot of potential benefits for Gina in being moved to the residential area of the prison, giving her the opportunity to engage in meaningful activities such as work would have been a positive factor and to be encouraged.

89. Dr Bayley's view was that there were red flags in Gina's presentation since she had been in prison. Her risk of suicide mainly arose from her inability to deal with the situation she found herself in. Accordingly, time in a structured, more supervised and supportive environment (such as the Safety Unit or other appropriate facility within BWCC) in early September 2018 may have provided Gina with the foundation to regain resilience and bolster her healthy psychological defences to allow her to negotiate incarceration with less risk to herself.

90. However, Dr Bayley conceded that being transferred to a Safety Unit would result in Gina being socially isolated in a cell for long periods of time (up to 22 hours each day) and would provide Gina with no opportunity for employment, programs and activities. This may have been detrimental to her mental health rather than assisting her resilience.

91. Dr Aboud did not directly address this issue in either of his statements, although he did note in his second statement that it is QCS, and not PHMS, who make decisions about the placement and observations of prisoners.

92. During his evidence at inquest, Dr Aboud advised that, in his view, the assessment made by QCS Provisional Psychologist, Kirby Smith, on 31 August 2018, that Gina was suitable for accommodation in a residential unit, was correct based on Gina's history and her presentation at the time.

93. Dr Aboud noted that, at the time of Gina's transfer to the residential unit, she had told three different mental health clinicians, and a QCS Counsellor, that she did not have thoughts of suicide or self-harm, and there had been no indicators to any staff at BWCC during her time in prison that Gina was at risk of harm to herself.

94. Chief Superintendent Fleming provided information about cells in residential units. He confirmed in oral evidence that residential cells allow prisoners to be accommodated in the "least-restrictive environment possible" which is in keeping with QCS' "trauma informed care and practices" for prisoners.

95. However, if at any time while in a residential unit, Gina had advised a staff member that she was thinking of self-harm she would have been moved from the residential unit and placed in a safer design cell under observations. This would also have occurred if Gina was observed to be at risk while in a residential cell.

96. On the basis of the evidence, I find the assessment that Gina was suitable for placement in a residential unit was appropriate in the circumstances.

Office of the Chief Inspector recommendations

97. There were also recommendations made by the then Office of the Chief Inspector following the investigation into Gina's death which are relevant to this issue, being Recommendations 5 and 6.

98. Those recommendations were aimed at ensuring that more detailed information about a prisoner's risk history is included in the Accommodation Committee's Decision Record, and that CCOs rather than Supervisors complete Accommodation pathway forms in accordance with the relevant COPD.

99. Assistant Commissioner Hamlett advised that, with respect to Recommendation 5, the relevant COPD has been amended. In respect of Recommendation 6, QCS was considering the practicalities of the recommendation and the best way to implement the intent of the recommendation within the QCS operational framework.

Whether the provision of laced running shoes to prisoners in Correctional Centres is appropriate

100. Chief Superintendent Fleming advised that the shoe laces which Gina used as a ligature came from prison-issued running shoes. Prison issues running shoes either have Velcro fastening or laces. These are issued upon admission and the type provided depends on sizing and availability. While the admission records do not specify the type of running shoe issues to Gina, it is assumed she was issued with the laced shoes as there is no other record of shoes being issued to her.

101. Following admission, "[i]f a prisoner is determined to be 'At Risk' and subject to observations, a psychologist or the Risk Assessment Team (RAT) may limit access to shoelaces if this is considered necessary for the safety of the prisoner".[57] Gina's Immediate Needs Risk Assessment (IRNA), conducted on 27 August 2018, determined that she should be placed in a suicide resistant, or

[57] Exhibit B7, para 16.

'safer design' cell, but did not make mention of shoelaces. Gina was subsequently assessed as safe to move to residential accommodation.[58]

102. Chief Superintendent Fleming said:

> *I am of the understanding that no additional consideration was given as to whether Gina was allowed to have shoelaces in residential as there was no indication that she had previously used ligatures in her prior suicide attempts, Gina denied any current suicidal ideation, and she was afforded the same privileges as the other prisoners accommodated in the residential units.*
>
> *Had the facility been aware of any adverse information regarding Gina's risk of self-harm, then this information would be factored into the decision-making process when considering her accommodation and management at BWCC.*[59]
>
> *As far as I am aware, there are no BWCC specific documents, policies or local instructions which relate to prisoners being provided with shoelaces, however the presence of shoelaces may be considered on a case-by-case basis to account for the safety and security of a corrective services facility, and for the welfare of all prisoners.*[60]

103. Chief Superintendent Fleming advised the court that prison shoes are provided to correctional centres by two contractors, and that it can be difficult to source either type of shoe from those contractors.

104. In response to a suggestion that laced shoes should not be provided to prisoners because of the risk that shoelaces can be used as a ligature, Chief Superintendent Fleming advised that this would be impractical because of the difficulty of sourcing the number of shoes required, and the fact that there are already many other items in prison which may also be used as ligatures. Chief Superintendent Fleming also advised the court that this was the only incident he was aware of in which this had occurred.

105. The availability of ligatures and hanging points in prisons has been considered in a number of previous inquests. Relevantly, as noted in the matter of Farrin Vetters:

> *The death of Mr Vetters is analogous to many deaths confronted by coroners which show that even well designed and applied risk management processes cannot predict or prevent every suicide attempt. Suicidal ideation may only be fleeting or periodic and barring access to a ready means of suicide should be paramount in any prevention strategy.*[61]

106. Once Gina was in a cell with hanging points, she had access to a 'ready means of suicide' in the form of her shoe-laces. However, denying all prisoners, regardless of their risk profile, access to any items which might be used as ligatures, is not a reasonable or practicable safety measure.

---

[58] Exhibit B7, paras 12 - 43.
[59] Exhibit B7, paras 44 - 45.
[60] Exhibit B7, para 11.
[61] Findings in the inquest into the death of Farrin John Vetters, p 19.

107. Based on the evidence of Chief Superintendent Fleming, I agree that the provision of laced running shoes to prisoners is appropriate where there has been an assessment of the prisoner's risk and they have not been deemed at risk of self-harm.

Whether any preventative recommendations might be made

108. Section 46 of the *Coroners Act* 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.

109. Six recommendations made by the Office of the Chief Inspector have been implemented or are under ongoing consideration which aimed to amend or enhance processes and procedures which, following Gina's death, were identified as needing improvement.

110. There were four further recommendations made by the Office of the Chief Inspector relevant to Gina's death. Recommendation 7 related to introducing a peer support program for prisoners serving their first term of imprisonment. Recommendations 8, 9 and 10 related to unit inductions provided to prisoners, and improving the timeframes in which they are provided, staff compliance with relevant COPDs, and met the minimum standards set out in QCS documentation.

111. Chief Superintendent Fleming gave evidence that each of these further recommendations has been implemented.

112. Given the number of recommendations made and implemented in response to Gina's death, I am satisfied that no further practical recommendations can be made at this time.

113. I close the inquest.

Terry Ryan
State Coroner
BRISBANE