Inquest into the death of Hazel Marie Lalara

Ms Lalara died from natural causes on 29 January 2009 while remanded in custody and the subject of an involuntary treatment order in the high security section of The Park Centre for Mental Health.

The then State Coroner, Michael Barnes, delivered his findings of inquest on 16 May 2013.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported. Further information relating the implementation of recommendations can be obtained from the responsible agency named in the response.

**Recommendation 1**

I recommend the clinical director of the high security inpatient service at The Park Centre for Mental Health review the procedures to ‘code blue’ calls to ensure that equipment and procedures are at least the equal of those available to medical staff in other correctional facilities.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

The Park Centre for Mental Health’s emergency (‘code blue’) procedures and equipment was reviewed in 2013 by the emergency department staff from Ipswich Hospital.

Additional emergency medications were provided, bringing the equipment and procedures at The Park Centre for Mental Health equal to medical staff in other correctional facilities.