Inquest into the death of Dane Benjamin Sloan

Dane Benjamin Sloan died in hospital four days after he was found hanged in the exercise yard attached to the Maximum Security Unit of the Brisbane Correctional Centre.

State Coroner Terry Ryan delivered his findings of inquest on 10 February 2017.

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.

The departments named in this response will provide implementation updates until the recommendation is delivered. Further information relating the implementation of recommendations can be obtained from the responsible minister named in the response.

**Recommendation 1**

I recommend that in considering the replacement of current CCTV monitoring systems, Queensland Corrective Services take into account the evidence heard during this inquest, with a view to ensuring that any new recording system clearly displays all relevant camera angles. Consideration should be given to potential hanging points within the cells and exercise yards in the Maximum Security Unit, and ensuring that the best available camera angle, with reference to the potential hanging points, can be fed clearly to the main control room monitors.

Response and action: the recommendation is agreed to. How the recommendation will be implemented is under consideration.

Responsible agency: Queensland Corrective Services.

On 7 August 2017 the Minister for Police, Fire and Emergency Services and Minister for Corrective Services responded:

Queensland Corrective Services is currently reviewing this recommendation and will provide a more detailed response in December 2017.

**On 15 January 2018 the Minister for Minister for Police and Minister for Corrective Services responded:**

Queensland Corrective Services is reviewing the exercise equipment currently installed in the Maximum Security Unit exercise yard to determine how best to manage the risk of the equipment being used as a ligature point.

Queensland Corrective Services is also investigating a future technology upgrade to its video recording system (subject to the availability of funding). Any potential upgrade would continue to ensure the consideration of hanging points in selecting the best available camera angles, and that all relevant camera angles are clearly displayed to the control room monitors. In addition, the potential upgrade which would also reduce the risk of single camera to recorder failings from occurring by allowing cameras to be rerouted to alternative recorders, ensuring that control room monitors will continue to receive the camera feed in the event of this type of fault.
**Recommendation 2**

Having regard to the evidence about working in the control room I consider that it is likely that staff simply become fatigued, and lose focus, after looking at a large number of images on screens for an extended period of time. I recommend Queensland Corrective Services explore the merits of a policy of more frequent rotations of officers through the control room as a way of minimising that risk.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Corrective Services.

On 7 August 2017 the Minister for Police, Fire and Emergency Services and Minister for Corrective Services responded:

Queensland Corrective Services reviewed the recommendation in consultation with the general managers currently managing the operational Maximum Security Units (MSUs) in Queensland and their relevant staff. This review resulted in a Deputy Commissioners Instruction (DCI) being published regarding MSU Movement Control Room – Fatigue Breaks.

The instruction states “Staff performing duty in a MSU movement control room should be aware of their vulnerability to fatigue or loss of focus following an extended period of time undertaking movement control duties. Effective from the date of this instruction, if such circumstances do appear to present themselves officers may request a fatigue break at any time during their shift. In such circumstances, every effort should be made to accommodate such a request.

Staff should ordinarily be afforded a fatigue break after two hours of continuous duty in the MSU movement control.

Given that this is a specialised work environment, it is recognised that imposition of definitive two-hourly fatigue breaks may not be operationally achievable. In those circumstances, such breaks are to occur as soon as practicable thereafter.”

General managers of corrective services facilities with functional MSUs will ensure that all relevant staff are made aware of this requirement. This DCI will remain effective until such time that the relevant practice directives are amended to reflect the DCI.