

Inquest into the death of Kenneth Douglas Wright

Mr Wright died on 20 March 2015 whilst in custody at the Southern Queensland Correctional Centre. Mr Wright sustained significant head and other injuries in an attempted suicide six months prior. The injuries contributed to his death from aspiration bronchopneumonia. The coroner investigated the appropriateness of care provided to Mr Wright on the day of his death.

State Coroner Terry Ryan delivered his findings of inquest on 3 August 2018.

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

Serco, in conjunction with Queensland Corrective Services, conduct a review of the process for calling for ambulance attendance at the Southern Queensland Correctional Centre, and the priority given to those requests. Consideration should be given to authorising clinical staff to directly requests urgent ambulance assistance.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Corrective Services.

On 7 May 2019 the Minister for Police and Minister for Corrective services responded:

Serco implemented the following remedial actions at Southern Queensland Correctional Centre (SQCC).

- SQCC follows the Queensland Prison Health Ambulances Services policy which sets out triage categories and describes the process to facilitate transfer to a secondary/tertiary facility for ongoing medical care for ill or injured prisoners. This policy includes the calling for ambulance attendance and priority to be applied in accordance with the patient transport categories.
- SQCC documented a local process for Code Blue (Medical Emergency) – Ambulance Services. This process is in accordance with the health services policy and details centre-specific information in regard to response requirements, staff responsibilities etc. The local process also indicates that ambulance services are to be called in a timely manner and appropriate to the situation

These actions were subject to Queensland Corrective Services and ministerial oversight and were tested by independent auditors within the centre. These processes were found to be fully implemented and ongoing.

In addition, Queensland Corrective Services completed a review of the relevant appendix to the Custodial Operations Practices Directive (COPD) Incident Management. Within the confines of usual COPD protocols, amendments more clearly define the guidelines on a statewide basis for calling an ambulance. The process includes the relaying of the priority appropriate to the medical emergency in progress, and who may make the call (both clinical staff and custodial staff included). This appendix was published and is now the expected practice to be followed by all centres.