Inquest into the death of Benjamin Ware

On 7 October 2005, Mr Ware was found apparently intoxicated and lying on the footpath at the front of a hotel in Cairns. Police attended and he was taken to and admitted into the care of the Lyons Street Diversionary Centre. Mr Ware settled and was allowed to sleep. Regular observations were carried out on Mr Ware and he was thought to be asleep. At about 2pm, he was found unconscious and transferred by ambulance to Cairns Base Hospital. He was found to have sustained a serious head injury from which he later died on 8 October 2005.

Coroner Kevin Priestly delivered his findings of inquest on 28 March 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 department named in the response.

Recommendation 1

The Department of Communities facilitate a collaborative project with current providers of diversionary centres to review and update of the *Diversionary centre handbook* to provide guidance about the standards of care and how they are to be achieved.

Response and action: the recommendation is implemented.

Responsible agency: Department of Communities, Child Safety and Disability Services

The *Guide and information kit – cell visitors, diversion centre workers and watchhouse*, authored by the Queensland Police Service in 2000, was updated and new draft guidelines and supporting tools developed in collaboration with all diversion services and regional departmental staff. The draft guidelines and toolkit for diversion services were trialled by diversion service organisations in the department's North Queensland Region from April to June 2014.

The Department of Communities, Child Safety and Disability Services coordinated feedback on the content and useability of the guidelines. All centres began using the guidelines from 1 July 2014.

Recommendation 2

The new diversionary centre handbook be incorporated into the funding arrangements so as to be enforceable.

Response and action: the recommendation is implemented.

Responsible agency: Department of Communities, Child Safety and Disability Services

The *Guide and information kit – cell visitors, diversion centre workers and watchhouse*, authored by the Queensland Police Service in 2000, was updated and new draft guidelines and supporting tools developed in collaboration with all diversion services and regional departmental staff. The draft guidelines and toolkit for diversion services were trialled by diversion service organisations in the department's North Queensland Region from April to June 2014.

Department of Communities, Child Safety and Disability Services notified service providers of the review and the North Queensland trial of the guidelines and toolkit.

Finalised guidelines and tools were implemented across all diversion services, and service agreements will be varied to include the requirement to comply with the guidelines.

In current agreements, providers are required to have a 'working knowledge of the guidelines'. In future agreements, this will be strengthened to require providers to adhere to the guidelines, enabling contract managers to audit compliance and require breaches to be rectified.

Recommendation 3

The department develop new auditing tools based on the handbook to assist departmental officers in monitoring and measuring compliance with the new standard.

Response and action: the recommendation is implemented.

Responsible agency: Department of Communities, Child Safety and Disability Services.

Department of Communities, Child Safety and Disability Services developed an audit tool which will include a checklist for regional staff or human service quality framework auditors to monitor compliance with a specific focus on client needs, risk identification and client observation documentation compliance, reporting frequency and storage of records.

The auditing tools were successfully trialled and business processes for annual audits are being developed. Continued successful use of auditing tools will be monitored.