

Inquest into the death of Warren Andrew Osborne

Mr Osborne died on 17 August 2015 at the Caboolture Hospital. He died from the combined effects of drugs and being restrained in a prone position by hospital security officers for 10 minutes.

State Coroner Terry Ryan delivered his findings of inquest on 29 January 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.

The department 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

A review be conducted in order to establish clear lines of communication and authority between Metro North Protective Services and the line managers within individual hospitals within that health district to ensure that mandatory training in occupational violence prevention is undertaken, particularly by those on emergency response teams, within the timeframes specified.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

The Metro North (MN) manager of protective services instructed his direct reports—who manage the security officers on a day to day basis—to conduct spot audits to ensure security officers are up to date regarding their occupational violence prevention mandatory training requirements. Officers who have not completed mandatory training will be reported to MN manager of protective services.

The MN manager of protective services reports to the director of patient services. The director established monthly performance meetings which includes compliance with mandatory occupational violence prevention training for security officers within protective services.

In addition to security officers, MN protective services conduct workplace risk assessments and provide recommendations and training plans to all other staff (operational / administrative / clinical) who may be involved in an emergency response capacity.

Metro North Hospital and Health Service (MNHHS) is currently implementing a learning management system which will assist the MN manager of protective services to audit compliance with mandatory training requirements for security officers across MNHHS in a more timely and efficient manner. Queensland Health expects the learning system will be implemented by early 2019.

On 2 June 2019 the Minister for Health and Minister for Ambulance Services responded:

A learning management system was rolled out by the Metro North Hospital and Health Service in 2018. The system increases staff access to professional development and improves the consistency of content, compliance and reporting. The learning management system is a system for delivering, booking, tracking and reporting on development activities of all staff. Staff who are deemed not yet

competent or have not undertaken mandatory training, particularly regarding emergency response and occupational violence prevention, are prohibited from engaging in any physical patient contact.

The learning management system will assist the manager of protective services to audit compliance with mandatory training requirements for security officers across Metro North Hospital and Health Service in a more timely and efficient manner.

Recommendation 2

Consistent with Queensland Police Service policy, hospital and health service officers who are members of emergency response teams who fail to demonstrate competence in restrictive practices training are not to be deployed to perform such practices.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

The MN (MN) manager protective services confirmed with his direct reports that any security officer who does not meet the required mandatory occupational violence prevention training will not be involved in any emergency response team in managing aggressive patients/visitors.

Written procedures are established to ensure security officers not competent in restrictive practices are not deployed to perform such practices. Additionally, where the training team determine that a security officer is not competent, this matter is then referred to respective site coordinators/MN manager protective services for management action. This will be managed through the usual human resources processes.

Recommendation 3

The Metro North Hospital and Health Service consider adopting aspects of the Queensland Police Service's practical training in relation to the physiological impacts of positional asphyxia to reinforce the risks of prone restraint to those engaged in this practice.

Response and action: implementation of the recommendation is in progress.

Responsible agency: Queensland Health.

On 1 November 2018 the Minister for Health and Minister for Ambulance Services responded:

Metro North Hospital and Health Service (MNHHS) executive director of operations requested a review of MNHHS's occupational violence prevention training program be undertaken to further investigate the feasibility of adopting aspects of the Queensland Police Service's (QPS) practical training in relation to the risks associated with prone restraint practices.

The metro north manager of protective services is engaging with QPS to identify possible options for the QPS operational skills section instructor to participate in MNHHS's occupational violence prevention training as a benchmark exercise/external observer regarding MNHHS's current training program relating to restrictive practices.

On 2 June 2019 the Minister for Health and Minister for Ambulance Services responded:

QPS's operational skills section and the manager protective services, Metro North Hospital and Health Service, will progress plans to enable QPS engagement and attendance at a review of occupational violence prevention procedures which could result in positional asphyxia.