Inquest into the death of Zachary James David Holstein

Zachary James David Holstein died in hospital after he hanged himself in his cell at the Woodford Correctional Centre.

Deputy State Coroner John Lock delivered his findings on 20 June 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
Metro North Hospital and Health Service urgently consider additional resourcing of Offender Health Services within Woodford Correctional Centre (both staffing and number of consultation rooms) to ensure prisoners are able to see a doctor:

- within at least seven days after they have been triaged and identified as requiring a non-urgent medical consultation, and ideally within a few days

  and/or

- within a timeframe that is commensurate with those timeframes experienced by members of the general public in the community.

Response and action: implementation of the recommendation is under consideration.

Responsible agency: Queensland Health (lead) supported by Queensland Corrective Services.

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

Metro North Hospital and Health Service, senior management and clinical leaders will review the recommendation. The outcome of the review team consideration will be reported in 2019.

Recommendation 2

The Office of Chief Inspector, Queensland Health and all hospital and health services who provide health services to prisoners jointly consider ways for ensuring that, where a prisoner dies and health services provided to that prisoner are relevant to the Office of Chief Inspector's investigation into that death, there is a mechanism for gathering relevant Queensland Health and hospital and health services information to inform that investigation, including through interviews with Queensland Health and hospital and health service staff.

Response and action: implementation of the recommendation is under consideration.

Responsible agency: Queensland Corrective Services (lead) supported by Queensland Health.

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

Queensland Corrective Services and Queensland Health initiated contact and will work together to consider the coroner's recommendation.