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 to 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: the recommendation is implemented.

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.

On 7 May 2019 the Minister for Health and Minister for Ambulance Services and the Minister for Police and Minister for Corrective Services responded:

Metro North Hospital and Health Service improved timeframes for non-urgent medical consultations for prisoners by initiating strategies to address the physical space limitations in the health centres and challenges associated with recruiting medical officers. Actions taken to date include:

- recruitment of a fulltime nurse practitioner in June 2016 at Woodford Corrections Health (WCH)
- the use of nursing agency staff to replace shifts if required
- recruitment of senior medical officers in May 2017 through the rural general practitioner practice for Kilcoy Hospital to provide medical services one day each week at Woodford Corrections Health

- development and implementation of an escalation process to respond to medical service timeframes not being met.

The majority of prisoners are now being seen by a doctor or nurse practitioner within the seven-day timeframe. The refurbishment of a second health centre at Woodford Corrections Centre in 2019 will provide additional consulting rooms and further alleviate pressure on existing resources. Additional nursing staff will be recruited when the consulting rooms become available.

On 12 December 2019 the Minister for Health and Minister for Ambulance Services and the Minister for Police and Minister for Corrective Services responded:

A second medical centre (D2) at Woodford Correctional Centre opened on 29 July 2019, providing increased consulting rooms for prisoner review. Additional nursing staff were and continue to be, recruited by Queensland Health and additional security officers were supplied by Queensland Corrective Services to assist with the operation of D2.

Visiting medical officer cover in D2 is now provided 5 days per week, along with a robust on-call system. A telehealth unit was set up in each medical centre to allow consultation with Caboolture Hospital Emergency Department and Telehealth Emergency Management Support Unit. All acute issues are now seen within seven days and intake interviews are done on arrival. Routine medication reviews may still take 7-14 days.

Increases are also being made by Queensland Health in the Woodford Correctional Centre's staffing so that it will have a visiting medical officer or senior medical officer on site five days per week compared to the current three days per week. This increase in medical staffing is separate from the additional staff associated with the opening of D2.

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: the recommendation is implemented.

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 responded:

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

On 7 May 2019 the Minister for Health and Minister for Ambulance Services and the Minister for Police and Minister for Corrective Services responded:

Queensland Health and Queensland Corrective Services recognise that by working collaboratively they can improve the treatment and well-being of prisoners by both correctional and health institutions. The Office of the Chief Inspector (within QCS) will continue to seek information from relevant hospital and health services established under the *Hospital and Health Boards Act 2011 (Qld).*

Additionally, the Office for Prisoner Health and Wellbeing, Queensland Health, can assist to advance discussions between the Office of the Chief Inspector and relevant hospital and health services in particular situations.

These mechanisms will minimise duplication and enable collaboration to facilitate learnings from incidents, including joint reviews and investigations.

Queensland Corrective Services and Queensland Health are working towards the best option for implementing the recommendation.

On 12 December 2019 the Minister for Health and Minister for Ambulance Services and the Minister for Police and Minister for Corrective Services responded:

The new memorandum of understanding (MOU) between Queensland Health and Queensland Corrective Services was drafted.

Under the relevant sections of this MOU, there are proposed strategies to allow the Office of Prisoner Health and Wellbeing (within Queensland Health) and the Office of the Chief Inspector (within Queensland Corrective Services) to respond to incidents that occur in correctional facilities more holistically. This will improve capacity to conduct joint investigations, enabling a mechanism for each party to provide relevant information during investigations as required, and working collaboratively to establish shared responses to recommendations following investigations.

The MOU will be approved, finalised and implemented. The Office of Prisoner Health and Wellbeing and the Office of the Chief Inspector will continue to work collaboratively to operationalise the MOU.

On 30 April 2020 the Deputy Premier and Minister for Health and Minister for Ambulance Services, and the Minister for Police and Minister for Corrective Services responded:

The draft MOU is progressing through a joint Queensland Health and Queensland Corrective Services stakeholder consultation phase, amendments and possible changes are currently being discussed. Both agencies are committed to finalising the MOU in 2020.

On 24 September 2020 the Deputy Premier and Minister for Health and Minister for Ambulance Services, and the Minister for Police and Minister for Corrective Services responded:

A MOU was developed between Queensland Corrective Services and Queensland Health. Within this MOU, clause 9 specifically relates to collaboration and information sharing following sentinel events (an adverse event that results in the death or serious harm to a patient) in a Queensland Correctional Centre.

In practice, Queensland Health and Queensland Corrective Services now submit information requests to each other to gather information required to complete their respective investigations. Queensland Corrective Services implemented a consultation process so that Queensland Health receive a copy of death in custody investigation reports and are given the opportunity to provide feedback prior to the report being finalised.

Queensland Health and Queensland Corrective Services will finalise the operational practice directive which will include timeframes and responsible officers, for information sharing requests and conducting investigation interviews with Queensland Health staff.

On 8 July 2021 the Minister for Police and Corrective Services, and Minister for Fire and Emergency Services, and the Minister for Health and Ambulance Services responded:

The memorandum of understanding is in place to provide for the sharing of health-related information between Queensland Health and Queensland Corrective Services.

Recent investigations completed by the Office of the Chief Inspector have included a review of Queensland Health records, particularly as they pertain to prisoners' prison mental health records. The exchange of information occurred throughout this process though it was identified that further consultation and finalisation of the operational practice directive outlining the steps to be taken when seeking to engage Queensland Health staff in the Queensland Corrective Services interview process and stipulated timeframes was required to operationalise the memorandum of understanding.

Consultation to be undertaken with Queensland Health in finalising the operational practice directive outlining the steps to be taken and relevant timeframes when seeking to engage Queensland Health staff in the Queensland Corrective Services interview processes.

On 31 May 2022 the Minister for Police and Corrective Services, and Minister for Fire and Emergency Services, and the Minister for Health and Ambulance Services responded:

Further investigations completed by the Office of the Chief Inspector have benefited from the collaboration and information sharing with Queensland Health. The establishment of the Operational Inspection and Major Incident Review Group (OIMIRG) within the Professional Standards and Governance Command will deliver incident investigation and incident review activities.

Queensland Corrective Services and Queensland Health will continue to work together to successfully operationalise the information sharing process provided for by the memorandum of understanding.

On 7 July 2022 the Minister for Health and Ambulance Services and Leader of the House, and Minister for Police and Corrective Services, and Minister for Fire and Emergency Services responded:

Since the Prisoner Health Service MOU was executed on 27 May 2020, the Department of Health and Queensland Corrective Services' have continued to collaborate to improve the treatment and well-being of prisoners in both correctional and health facilities. The sharing of health records and particularly mental health records has enabled the Operational Inspection and Major Review Group (OIMIRG) within Queensland Corrective Services to respond more holistically to investigations.

Queensland Corrective Services are currently working with relevant business units to determine if the Queensland Government Enterprise Architecture's Information Management Policy Framework (Framework) may be used to identify and define the various domains that contribute to effective information management across the Queensland Government. Queensland Corrective Services will explore if the Framework is a suitable platform to support the MOU and will collaborate with the Department of Health if the option is considered suitable.

As the Prisoner Health Service MOU has been implemented and explicitly requires collaboration and sharing of information following sentinel events (clause 9), it is understood that this recommendation has been fully implemented and can now be closed. Queensland Corrective Services and Queensland Health will continue to work together to sustain the improvements gained from activities that have been undertaken to implement this recommendation.