Inquest into the deaths of Terrence Michael Malone and Garry Ronald Appleton

On 8 May 2019 State Coroner Terry Ryan delivered his findings into the deaths of Terrence Michael Malone and Garry Ronald Appleton. Mr Malone and Mr Appleton died in separate events from self-inflicted injuries caused by prison-issued razor blades at the Brisbane Correctional Centre. The state coroner examined the men’s mental health assessment at the correctional centre and the availability of razor blades. The state coroner made identical recommendations at both inquests.

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 departments 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**

Queensland Corrective Services develop a policy in relation to the management of the risks associated with the provision of razor blades to prisoners within the first month of entry to prison, particularly where a prisoner has recently expressed suicidal ideation or has recently been discharged from a hospital emergency department following an emergency examination authority.

Response and action: the recommendation is agreed in part and implementation is complete.

Responsible agency: Queensland Corrective Services.

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

Queensland Corrective Services is currently considering if and how such a policy regarding the provision of razor blades to prisoners could be managed. Factors requiring careful consideration include (but are not limited to):

- Queensland Corrective Services has implemented a process for identifying and managing prisoners identified as being an elevated risk of self-harm or suicide at any time during their custodial episode.
- Queensland Corrective Services already have a process of the removal of all property which may pose a risk inclusive of razor blades if a prisoner is under observation because of suicide ideation/self-harm.
- Assessment of the benefits or otherwise of such a requirement being imposed on a broader group of prisoners as recommended.
- Balancing the advantages and disadvantages of whether to continue with a focussed targeted approach with higher risk prisoners or develop a blanket approach with such prisoners considering the difficulties which would be associated with the management of this issue.
- The appropriateness of such a requirement being imposed on the prisoners, particularly given considerations under the Human Rights Act and also Optional Protocol to the Convention against Torture (OPCAT).

The recommendation will be considered by the Queensland Corrective Services suicide management and governance working group.
On 30 April 2020 the Minister for Police and Minister for Corrective Services responded:

Queensland Corrective Services acknowledges, in particular, that the access to razor blades whilst a prisoner is in a period of heightened risk of suicide/self-harm, or critical risk period, is an increased risk and should not be permissible.

Accordingly, Queensland Corrective Services manage their high risk areas where prisoners are accommodated during a period of critical risk of suicide or self-harm, as razor free areas. When certain situations arise and are appropriately assessed, this can include, under strict supervision, the provision of an alternative to razor blade shavers (e.g. a rechargeable Medline surgical clipper with safety blades) which ensures safety in such high risk circumstances.

An assessment is undertaken at the point of entry to custody to assess a prisoner’s risk and prisoners undergo an induction during the first days in custody in each centre. This further focuses on the prisoner’s transition and any presentation of risk. Additionally, Queensland Corrective Services implemented a process for identifying and managing prisoners as being an elevated base line risk of self-harm or suicide at any time or multiple times during their custodial episode.

On 17 September 2018, Queensland Corrective Services updated the At-Risk Custodial Operations Practice Directive (COPD), the Safety Order COPD and implemented the Elevated Baseline Risk COPD. These address the prompt identification of, and strategies to address, risk to prisoners, particularly those posing a chronic risk of suicide and/or self-harm.

The emphasis is on assessment of individual risk, needs and circumstances rather than a blanket approach being routinely imposed. Restricting a prisoner from access to sharps whilst in his/her first month in custody as a general rule is contrary to section 30(1) of the Human Rights Act 2019 with specific reference to proportionality expressed within section 13(d). Prisoners are accommodated in general population units so as to not restrict their access and movement, and without unnecessarily restricting access to privileges. Queensland Corrective Services has balanced the prisoner’s risk with proportionate access to basic rights.

Recommendation 2

Queensland Corrective Services, in partnership with Queensland Health, review its approach to suicide risk assessment and assertive responses to suicide risk in the context of best practice approaches.

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

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

On 11 December 2019 Minister for Police and Minister for Corrective Services and the Minister for Health and Ambulance Services responded:

Queensland Corrective Services will commence scoping a project to undertake this work in consultation with Queensland Health.

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:

Queensland Corrective Services is currently developing a series of training products focused on suicide risk processes for a broader staffing group to build capability in safe, holistic suicide risk assessment (as a factor noted by the coroner in the findings of Mr Appleton’s and Mr Malone’s deaths). Queensland Corrective Services’ oversight of suicide and at-risk procedures sits within the Suicide Management and Governance Working Group to ensure evidence-based and holistic approaches to procedural management in this area.
This working group contributes to the broader strategy of improved information sharing between Queensland Corrective Services and Queensland Health.

Queensland Corrective Services will invite Queensland Health representatives to participate in this working group to ensure their input in any future procedural changes and to have input into any new training and capability building strategy.

**Recommendation 3**

These findings be provided to the Queensland Mental Health Commission and the strategic leadership group overseeing the implementation of the Mental Health, Alcohol and Other Drugs Strategic Plan with a view to informing the enhancement of responses to persons with co-occurring mental illness and substance use disorders who are at risk of entering or have entered the criminal justice system.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 11 December 2019 the Minister for Health and Minister for Ambulance Services responded:

The Queensland mental health commissioner met with the state coroner to discuss the findings, following this the findings were tabled by the Queensland Mental Health Commission at the *Shifting minds* strategic leadership group meeting on 29 May 2019 for noting.

The *Shifting minds* strategic leadership group is a cross-agency group which consists of senior level officers from state government agencies and is responsible for the collective implementation of *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*. This strategic plan includes a priority action to expand responses to people involved in the criminal justice system through better coordination across mental health, alcohol and other drugs, justice, housing, disability, employment and psychosocial supports.

The findings will continue to be considered by the *Shifting minds* strategic leadership group through the development, implementation and evaluation of the *Shifting minds* implementation roadmap which includes this priority action. The *Queensland Mental Health Commission Act 2013* also requires the commission to report to the Minister for Health and the Minister for Ambulance Services on the implementation of the strategic plan.

**Recommendation 4**

The Queensland Government consider an increase in funding to enable Queensland Corrective Services (QCS) to enhance the integrated offender management system (IOMS) to support the recommendations of the Office of the Chief Inspector to enable risk assessment information to be displayed and accessible for QCS staff within a drop down menu.

Response and action: the recommendation is agreed in part and implementation is complete.

Responsible agency: Queensland Corrective Services.

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

Queensland Corrective Services intend to modernise the IOMS system and include this recommendation in an updated or replacement system. A business case for government consideration is due early in 2020. Until then Queensland Corrective Services is assessing short term options that may fulfil the coroner’s recommendation.

On 30 April 2020 the Minister for Police and Minister for Corrective Services responded:
Following the recommendation from the coroner to enable risk assessment information to be displayed and accessible to Queensland Corrective Services staff within a drop down menu, Queensland Corrective Services has implemented procedures and processes that supersede this recommendation.

Modifications to the at-risk management process have been implemented including the introduction of the Elevated Baseline Risk (EBLR) procedure and an EBLR warning flag.

The EBLR procedure ensures prisoners with chronic or an elevated baseline risk of suicide and/or self-harm are managed in accordance with their presenting risks and needs. Prisoners can be identified as being at an elevated baseline risk at any point within a custodial period.

If a prisoner presents with an elevated risk of self-harm and/or suicide, the prisoner may be referred to a multidisciplinary team for consideration for management under the EBLR procedure. The multidisciplinary team will review the referral and determine the prisoner’s suitability to be managed under the EBLR procedure.

An EBLR plan must be developed within four weeks of the prisoner being placed on EBLR and is to include identified clinical needs, risk mitigation strategies, specialised services or supports, review date/s, frequency of contact with case manager, summary of progress including any changes in risk or protective factors and reasons/rationale for exit from EBLR (if applicable).

The EBLR procedure requires that any staff member involved in the management of the prisoner be made aware of the prisoner’s EBLR status, reasons for EBLR, triggers, warning signs, risks, protective factors and plan. The correctional supervisor and/or psychologist must also brief staff responsible for the supervision, case management and intervention in relation to the contents and purpose of the EBLR plan. The EBLR plan is electronically saved and attached to the Integrated Offender Management System (IOMS) in addition to being placed on the offender file. The EBLR plan is readily accessible to all staff involved in the management of the prisoner.

Upon a prisoner being identified as being at an elevated baseline risk, the EBLR warning flag within IOMS is activated. The EBLR warning flag is displayed on the IOMS home screen and alerts staff that the prisoner has been assessed to be at an elevated risk of self-harm/suicide and that further information is available in IOMS. When raising the EBLR warning flag, the staff member is to ensure that sufficient comments are recorded in the warning on IOMS to describe the EBLR information obtained.

The EBLR procedure and warning flag are considered to be of significant benefit in mitigating the risk of prisoners and facilitating identification by staff of at-risk prisoners.

**Recommendation 5**

The Queensland Government consider an increase in funding to enable Queensland Corrective Services to be a competitive employer to attract and retain experienced psychologists and senior psychologists within custodial settings.

Response and action: the recommendation is agreed to in part and implementation is in progress.

Responsible agency: Queensland Corrective Services.

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

Queensland Corrective Services develop a workforce strategy which will examine the role of psychologists within custodial settings.
On 30 April 2020 the Minister for Police and Minister for Corrective Services responded:

The workforce strategy is anticipated for completion by midyear however a number of components are progressing separately. In addition to reclassification of base level psychologists in 2017 to remuneration equivalent to other government employers of psychologists, the approval for the reclassification of senior psychologists currently employed in correctional centres to align their remuneration to that received in other government departments was approved by the commissioner in January 2020.

**Recommendation 6**
The Queensland Government consider a trial program for ‘front end services’ of intake, health assessment and mental health assessment at the Brisbane City Watchhouse that involves collaboration between relevant stakeholders, including Queensland Corrective Services, Queensland Health, the Queensland Police Service and the Prison Mental Health Service.

Response and action: the recommendation is agreed to in part and implementation is in progress.

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

On 26 November 2019 the Minister for Police and Minister for Corrective Services and the Minister for Health and Minister for Ambulance Services responded:

Queensland Corrective Services, Queensland Police Service and Queensland Health will work together in considering the implementation of this recommendation.

In 2018, prior to the completion of the coroner’s findings into Mr Appleton’s and Mr Malone’s deaths, QCS conducted a brief trial program of Queensland Corrective Services front end services at the Brisbane Watchhouse.

The findings of the trial program are still being considered by Queensland Corrective Services and will inform how Queensland Police Service, Queensland Corrective Services and Queensland Health progress implementation of this recommendation.

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

In February 2020, representatives from the Queensland Police Service, Queensland Corrective Services and Queensland Health met to review and discuss the trial outcomes.

All agencies will continue to collaborate to determine the next steps for this recommendation.