

Inquest into the death of David John Cooper

David John Cooper died in custody between 5 April 2016 and 6 April 2016 from pneumonia after experiencing flu like symptoms for 11 days. The coroner found Mr Cooper deteriorated rapidly due to a process involving *Staphylococcus aureus*.

Deputy State Coroner John Lock delivered his findings of inquest on 9 September 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 departments 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

The review currently underway by a working group of Queensland Health and Queensland Corrective Services examining the existing memorandum of understanding and operating guidelines and referred to in two recent inquests also include consideration of the circumstances of Mr Cooper's death and relevant coronial findings.

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

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

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

The memorandum of understanding (MOU) between Queensland Health and Queensland Corrective Services is currently under review.

An information sharing operational working group will progress agreement of the revised MOU and develop detailed operational guidelines to support sharing of information between hospital and health service staff and Queensland Corrective Services officers. The operational guidelines will consider the circumstances of Mr Cooper's death and relevant coronial findings.

Recommendation 2

Where a hospital and health service conducts a root cause analysis in relation to the death of a prisoner who was receiving a health service, and concerns/opportunities for improvement are identified in relation to Queensland Corrective Services' policies and practices, the health service (for instance in this case Cairns and Hinterland Hospital and Health Service) liaises with Queensland Corrective Services to jointly review and take appropriate action (which may involve further investigation and/or development of recommendations) and ensure there is a mechanism for gathering relevant Queensland Corrective Services information to inform that investigation, including through interviews with Queensland Corrective Services staff.

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

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

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

The Department of Health and Queensland Corrective Services will establish a memorandum of understanding (MOU) regarding the provision of health services for prisoners. The MOU will include provisions regarding investigations including collaborating, referring matters where lawful and practical to each other, and drawing upon each other's expertise in investigations and root cause analysis processes.

Once the MOU is finalised it will be distributed to hospital and health services that operate health services for prisoners. The Department of Health will work with Queensland Corrective Services to establish relevant processes to operationalise the provisions of the MOU.