

Inquest into the death of Franky Houdini

Franky Houdini died on 2 June 2015 in his cell at the Wolston Correctional Centre. Mr Houdini hanged himself using a thin piece of nylon cord similar to that used on tennis court nets.

State Coroner Terry Ryan delivered his findings of inquest on 16 May 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

Noting that an existing working group is examining the memorandum of understanding (MOU) and operating guidelines, I recommend Queensland Health and Queensland Corrective Services consider whether amendments are required to legislation to supplement the release of information (including documents) under the MOU on confidential information disclosure to optimise the health care provided to persons in custody; and protect health practitioners from liability when sharing prisoner health information appropriately.

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

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

On 25 October 2018 the Minister for Health and Minister for Ambulance Services and the Minister for Police and Minister for Corrective Services responded:

The ministers acknowledge the recommendations from the investigation are for both Queensland Health and Queensland Corrective Services and that Queensland Health is leading the work.

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

Recommendation 2

Noting that an existing working group is examining the memorandum of understanding (MOU) and operating guidelines, I recommend Queensland Health and Queensland Corrective Services consider amendments to the operating guidelines under the MOU on confidential information disclosure to provide more relevant contextual information in relation to the sharing of information in correctional settings.

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

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

On 25 October 2018 the Minister for Health and Minister for Ambulance Services and the Minister for Police and Minister for Corrective Services responded:

The ministers acknowledge the recommendations from the investigation are for both Queensland Health and Queensland Corrective Services and that Queensland Health is leading the work.

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