Inquest into the death of Cindy Leigh Miller

Cindy Leigh Miller died on 21 April 2018 at the Ipswich Watchhouse from mixed drug toxicity.

State Coroner Terry Ryan delivered his findings of inquest on 22 January 2021.

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**
The Queensland Police Service consider revising the script that accompanies health questions asked on entry into watchhouse custody with a view to ensuring that prisoners understand that their answers are for the purpose of ensuring their health needs can be managed in the watchhouse. This should include an assurance to the prisoner that further charges would not result from their answers to questions about past consumption of drugs.

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

Responsible agency: Queensland Police Service.

On 29 November 2021 the Minister for Police and Corrective Services and Minister for Fire and Emergency Services responded:

The Queensland Police Service commenced work to embed the specific health questions into the Queensland Police Records Information Management Exchange (QPRIME) system. The QPRIME system has scheduled updates with the next available update to occur in February 2022.

The Queensland Police Service also sent an email instruction to all Watchhouses on 25 January 2021 stipulating the specific health questions to be asked on entry into watchhouse custody to include compliance with the coroner’s recommendation. This instruction will remain in-place until the QPRIME changes are implemented.