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: the recommendation is implemented.

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.

On 23 June 2022 the Minister for Police and Corrective Services and Minister for Fire and Emergency Services responded:

The Queensland Police Service has continued to progress embedding the specific health questions into the QPRIME system and has undertaken consultation with police watchhouse managers and representatives from Queensland Health. The consultation stage caused a slight delay in scheduling the QPRIME updates. The previous Queensland Police Service instruction of 25 January 2021 stipulating the health questions that prisoners are to be asked on entry into watchhouse custody will remain in place until the QPRIME changes are implemented. The QPRIME system updates are being proposed for mid-2022.

On 7 May 2023 the Minister for Police and Corrective Services and Minister for Fire and Emergency Services responded:

The QPRIME updates were implemented in July 2022. The Queensland Police Service State Custody Unit has reiterated to watchhouse staff of the changes to QPRIME and the requirement stipulating the health questions that prisoners are to be asked on entry into watchhouse custody.

The Queensland Police State Custody Unit, in collaboration with Queensland Health's Clinical Forensic Medical Unit, will continue to monitor this new requirement for any concerns or issues raised by persons in custody.

Recommendation 2
The Queensland Government consider whether to commission an independent review of the current arrangements for the investigation of police-related deaths on behalf of the coroner and the oversight of those investigations.

Response and action: the recommendation is implemented.

Responsible agency: Department of Justice and Attorney-General.

The Attorney-General and Minister for Justice, Minister for Women and Minister for the Prevention of Domestic and Family Violence responded:

The Queensland Government has committed to implementing recommendation 2 of the inquest into the death of Cindy Leigh Miller by appointing a suitably qualified person to conduct an independent review to examine the current arrangements for the investigation and oversight of deaths in police custody or in the course of, or as a result of, police operations, to ensure transparency and public confidence is maintained.

The independent review will also examine the most appropriate mechanism to ensure that prior police involvement in domestic and family violence deaths is subject to independent, timely and transparent review in a way that does not prejudice other proceedings.

A report will be furnished to the Premier and Minister for Trade, the Attorney-General and Minister for Justice, Minister for Women and Minister for Prevention of Domestic and Family Violence, and the Minister for Police and Corrective Services and Minister for Fire and Emergency Services.