CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Zachary James David Holstein**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2016/624
DELIVERED ON:	20 June 2018
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HEARING DATE(s):	1 March 2018, 17-18 May 2018
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, Death in custody, hanging, communication between medical staff and Corrections staff, Root Cause Analysis, Chief Inspectors report

REPRESENTATION:

Counsel Assisting:	Ms M Jarvis
For Family:	Mr J Fenton i/b AW Bale & Son
For Queensland Corrective Services:	Mr M Hickey i/b DJAG
For the Office of Chief Inspector:	Mr J Tate i/b Crown Law
For Metro North Hospital & Health Service:	Mr J Allen QC i/b MNHHS
For Department of Health, Dr J Reilly & West Moreton HHS:	Ms S Gallagher i/b Corrs Chambers Westgarth

Contents

Introduction 1
Issues for Inquest 1
Background evidence 2
  Health Services Provided at Woodford Correctional Centre 2
  Personal circumstances and correctional history 3
  Medical and mental health history 4
Events Leading Up to Death 6
Autopsy results 7
The investigations 8
  Queensland Police Service 8
  Office of the Chief Inspector 9
  Key findings of Chief Inspector's investigations 9
Response to criticism of Chief Inspector's Report and Root Cause Analysis 13
  Report of Dr Jill Reddan 13
  Statement of Dr Andrew Aboud 16
  Statement of Dr John Reilly 18
  Response from the Inspectors 19
Conclusions on the Issues 19
  How Zach died 20
  Whether there is information held by Offender Health Services, Metro North Hospital and Health Service and/or any of its staff who provided health services to Mr Holstein whilst he was a prisoner at the Woodford Correctional Centre that would further add to or amend the findings and recommendations made by the Office of the Chief Inspector arising from Mr Holstein's death. 20
  Response of QCS to recommendations made in Chief Inspector's Report 23
  Response of Queensland Health to the Recommendations made in the Chief Inspector's Report 24
  Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003. 24
Findings required by s. 45 28
    Identity of the deceased 28
    How he died 28
    Place of death 28
    Date of death 28
    Cause of death 28
.... **Error! Bookmark not defined.**
Comments and recommendations 28

Introduction

1. On 8 February 2016, during the 2.30 pm muster within the residential compound at Woodford Correctional Centre (WfdCC), prisoner Mr Zachary James David Holstein (Zach) was found hanging from a bed sheet behind the door of his cell.

2. A 'Code Blue' (medical emergency) was called, and responding staff lifted Zach down, removed the makeshift noose and commenced CPR. The first responders and Centre medical staff continued with the administration of first-aid and an ambulance was called. Queensland Ambulance Service (QAS) officers transported Zach to Caboolture Hospital. He was later transferred to Redcliffe Hospital where he was placed on life support.

3. On 12 February 2016 in the presence of his family, Zach's life support was discontinued and his life was declared extinct. Zach was only 23 years old at the time of his death.

4. At autopsy, Zach's cause of death was determined as '*Hypoxic-ischaemic encephalopathy, due to, or as a consequence of hanging*'. Toxicology tests were 'unremarkable', with non-quantifiable levels of mirtazapine (an anti-depressant he had been prescribed) and propofol (a drug that had been administered during resuscitation and treatment).

Issues for inquest

5. As Zach's death occurred whilst he was in custody, section 27 (1) of the *Coroners Act 2003* requires that an inquest must be held. At a pre-inquest hearing held on 1 March 2018 the following issues for the inquest were determined:

   i. The findings required by s. 45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death.

   ii. Whether there is information held by Offender Health Services, Metro North Hospital and Health Service and/or any of its staff who provided health services to Zach whilst he was a prisoner at the Woodford Correctional Centre that would further add to or amend the findings and recommendations made by the Office of the Chief Inspector arising from Mr Holstein's death.

iii. The response of Queensland Corrective Services and Queensland Health to the recommendations made by the Office of the Chief Inspector.

iv. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act 2003*.

Background evidence

Health Services provided at Woodford Correctional Centre

6. Dr Andrew Aboud, Clinical Director of Prison Mental Health Service, provided information concerning the health services provided at WfdCC. General health care is provided by nursing staff and visiting medical officers (VMO) employed by Metro North HHS as part of the Offender Health Service (OHS).

7. General mental health care, equivalent to that provided by primary health care services in the broader community such as GPs, can be provided by nursing staff and VMOs of the OHS. Psychologists employed by QCS may also have a role in identifying and supporting prisoners who have mental health difficulties, and this may involve referral to the general health service or to the specialist mental health service, depending on the level of mental health acuity.

8. Specialist mental health care is provided by psychiatrists and clinicians employed by West Moreton Hospital and Health Service as part of the Prison Mental Health Service (PMHS). Referrals to the PMHS can occur through the nurses and VMOs of the OHS; QCS staff including psychologist, counsellors and custodial staff; or by the consumer's self-referral amongst others. The PMHS provides specialist mental health care to prisoners who have been referred, and this can involve identification, assessment and treatment of mental disorder. Treatment can include management with medication, by psychological intervention, by the diversion to psychiatric hospitals when required, and by ensuring continuity of care at release.

9. Clinical Nurse Unit Manager Martha Pitt advised that OHS employs only Clinical Nurses (as distinct from Registered Nurses)to attend WdfCC. Clinical Nurses generally have more experience and can provide care more autonomously. A Visiting Medical Officer (VMO) attends three days a week, one other VMO attends on a Wednesday and a Nurse Practitioner attends five days a week and two Saturdays a month. PMHS also attends a few days a week.

Personal circumstances and correctional history

10. At the time of his death Zach was aged 23. He was a single man with no children. His family stated he was intelligent, honest, loyal to his family and had a great sense of humour. As was noted by one witness Zach, unlike many others in custody, had the support of his mother and other family and it is clear he was well loved. Unfortunately, like many people, the scourge of illicit drugs impacted greatly on Zach, who had a history of substance abuse, which had been exacerbated by the death of his partner on 23 November 2013. Investigations have revealed that she died as a result of a drug overdose of methadone, which had been prescribed to Zach.

11. Zach's criminal history commenced in October 2009 for drug related offences. He also had a history of fraud related offences involving the use of fraudulent medical prescriptions.

12. On 11 April 2014 he was convicted and sentenced to three years imprisonment for one charge of Grievous Bodily Harm. He was released on Court Ordered Parole on 9 January 2015.

13. After his release he contravened the conditions of his Parole Order on a number of occasions resulting in him being returned to custody on 4 May 2015 until 22 May 2015. There had been reports that he had presented with unstable mental health and an unwillingness to attend intervention programs. He had tested positive to various drugs on a urine test. After he failed to report he was returned to custody on 2 June 2015 until he was released on 16 September 2015.

14. On 22 September 2015 Zach's parole officer received advice he had been charged with resisting arrest when police located him attempting to break into a dwelling on 19 September 2015. As a result his parole was suspended. He was returned to custody on 27 September 2015 and spent some time in the Brisbane Watch House and Brisbane Correctional Centre until he was transferred to WdfCC on 20 October 2015, where he remained until he was found hanging in his cell.

15. At the time of his death Zach was a resident in the Residential Accommodation having moved from Secure Accommodation in December 2015.

Medical and mental health history

16. Zach had a history of mental illness, self-harm and substance abuse. The QPS investigation noted that when his girlfriend passed away in 2013 and whilst QAS were attempting to resuscitate her, Zach was seen punching walls and injected himself with a syringe. He then burned his arm with a cigarette. Police detained him and took him to Princess Alexandra Hospital under an Emergency Examination Order.

17. When he first came to WdfCC in April 2014 he was placed under medical observations as he was suffering severe drug withdrawal. He had reported he was using Ice, heroin and Xanax. He reported that he had self-harmed two weeks previously by cutting his arm with a knife. He was assessed by the QCS psychologist as being a moderate risk of self-harm or suicide and was placed on 60 minute observations.

18. When he returned to prison on 4 May 2015 Zach was observed to have enlarged pupils consistent with recent drug use and he told the authorities he was using drugs during the time since his release from custody.

19. On 1 October 2015 he was assessed by the QCS psychologist to again be at a high risk of self-harm and suicide. He disclosed he had engaged in self-harming behaviours during periods of grief. He was placed on 15 minute observations. On 7 October 2015 his observations schedule was extended to 120 minute observations and this remained the case until it was discontinued on 23 October 2015.

20. The QCS facility case notes did not indicate any real concerns or issues and staff noted he mixed well with other members of his unit, and his cell and personal hygiene was of an acceptable standard. An At-Risk Assessment report completed by a QCS psychologist on 23 October 2015 noted Zach denied any current feelings of self-harm, depression or anxiety and it was considered this was congruent with his presentation. It was further recorded he reported undisturbed sleep and that his mental health status appeared unremarkable. It was also recorded that he denied a current medication regime but wanted to see medical staff to obtain medication. When questioned about this he again denied any mental health history and stated he just wanted medication.

21. Throughout his last period in prison he denied any suicidal ideation but on a number of occasions reported to QCS and medical staff that intended to seek a medication review with the VMO. This was first recorded in the medical records at Brisbane Correction Centre on 13 October 2015 and was also reported to QCS staff during risk assessments the same day.

22. On 15 October 2013 whilst still at Brisbane Corrections Centre there is a nursing note stating Zach had put in a Medical Request Form stating he was suffering from depression and anxiety with no thoughts of suicide or self-harm.

23. Zach was medically assessed by nursing staff on his arrival at WdfCC on 20 October 2015, and he completed a Medical Request Form stating he was not sleeping and was anxious and was seeking to be given Avanza.

24. Further Medical Request Forms were completed on 29 October 2015 and 3 November 2015 in largely identical terms. These forms are completed by prisoners at their residential compound and are provided to visiting nursing staff who attend to provide medications. NUM Pitt stated that these forms were very common requests amongst the prison population. She said prisons are not happy places and a huge percentage of prisoners were on some form of antidepressant.

25. Of some concern is that Zach was only first seen by the VMO Dr Prakash on 5 November 2015. Dr Prakash described the process after such forms are completed in that the Clinical Nurse at the medical centre would triage each case. Urgent cases would be addressed the same day but non-urgent cases are placed on the doctor's waiting list.

26. Dr Prakash stated the time frame from 20 October 2015 to 5 November 2015 was a prolonged delay likely due to the increasing prison population and hence growing patient list, high work load, long lists and not enough resources. As well there are limitations in the physical capacity to take more patients as it is a small medical centre with only two consultation rooms.

27. Dr Prakash did not set out a detailed note as to this first presentation and has no recollection of the appointment, but stated he would have utilised his normal mandatory set of questions for someone mentioning anxiety. The patient did not disclose suicidal ideation. If he had this would have been recorded and other

action taken. The patient was requesting Avanza (mirtazapine), a drug Zach had been provided before. Dr Prakash prescribed 30 mg. Dr Prakash stated in evidence that Avanza is a sought after drug among prisoners as it has a sedative effect.

28. Dr Prakash next saw Zach on 10 November where he requested an increase in the medication and Dr Prakash increased this to 45 mg to commence on 18 November 2015.

29. There is no other record of Zach attending on the medical centre until his death on 8 February 2015. Zach would have been seen each day by the Clinical Nurses during medication rounds and there is no recording of any other concerns in that period.

Events leading up to death

30. On Monday, 8 February 2016 at about 2:44 pm during the afternoon muster, CCOs Gregory Bowman and Richard Lavis were conducting a head count in unit 3 of QO1 block. This housed six prisoners each in separate lockable rooms. CCO Bowman then conducted a welfare check on the prisoners that were in attendance and checked the faces matched the photograph in the muster book. There were five prisoners in attendance at the muster.

31. CCO Bowman then noticed a blue towel covering the observation window of cell 5 which was occupied by Zach. This was not unusual as prisoners often covered the observation window with towels for privacy. CCO Lavis then approached cell 5 and knocked on the door to gain Zach's attention and to advise him of the muster. He tried to open the door, however it was locked. In this particular unit prisoners have a key to their cell enabling them to lock the cell when they are in the cell or out of the cell. CCO Lavis then used a second key to unlock cell door 5 and noticed a sheet tied around the outside door handle. Upon entry they noticed Zach was not in his bed and looked around the door and saw him hanging from the other end of the white sheet. He was unconscious at the time.

32. A CODE BLUE was called. CCO Lavis lifted Zach to take the weight off the sheet and was assisted by CCO Bowman and Zach was lowered to the floor. The sheet was removed from around his neck and after checking his airway and looking for a pulse, which was not detected, CCO Lavis immediately started chest

compressions. He was assisted by CCO Bowman until medical staff members CN Michael Doyle and CN Tony Gibson attended.

33. Whilst CPR continued medical staff added an oxygen mask and AMBU bag and commenced manual ventilation. An automatic defibrillator was connected to the chest and this advised to continue with chest compressions. Visiting Medical Officer Raff then arrived and he applied an intravenous catheter to the left hand of Zach.

34. Queensland Ambulance Service paramedic Anthony Cowen arrived and administered adrenaline, sodium bicarbonate, magnesium sulphate and defibrillated and intubated Zach. A pulse was then obtained.

35. Zach was taken by ambulance to the Caboolture Hospital and was administered adrenaline to maintain a pulse and blood pressure enroute. He was later transferred to Redcliffe Hospital where he was placed on life support.

36. Whilst at Redcliffe Hospital it was the medical opinion that he would not regain consciousness and the ICU specialist Dr Warhurst turned off life support in the presence of his family at about 12:10 PM on 12 February 2016.

Autopsy results

37. A full internal and external autopsy examination was conducted by forensic pathologist Dr Beng Ong.

38. The main findings were the presence of a healing ligature mark in keeping with death being caused by hanging. There was hypoxic-ischaemic encephalopathy of the brain in keeping with the clinical diagnosis of brain death. Additional injuries were observed including a subcutaneous bruise to the back of the left hand and contusion affecting muscle on the back of the neck. Histology of the injuries showed no reactive change and therefore, it was the opinion of the pathologist that this was caused after the episode of hanging and likely to be therapeutic related. There were no suspicious injuries.

39. Toxicology testing of blood obtained a few hours after admission to hospital showed non-quantifiable levels of mirtazapine and propofol. The latter had been administered during resuscitation and treatment.

40. The cause of death was considered to be hypoxic ischaemic encephalopathy due to hanging.

The investigations

41. The Corrective Services Investigation Unit of the Queensland Police Service (QPS) undertook an investigation into the death in custody of Zach.

42. The circumstances of the death were also investigated pursuant to s 294 of the *Corrective Services Act 2006* by two inspectors appointed by the Office of the Chief Inspector of Queensland Corrective Services, whose role is to independently inspect and review correctional facilities to ensure they are operated safely and in accordance with international benchmarks established by the World Health Organisation.

Queensland Police Service

43. Plain Clothes Senior Constable Tongiatama of the Corrective Services Investigation Unit of the Queensland Police Service prepared an investigation report, which is included within the brief of evidence together with relevant investigative material including statements, interview transcripts and audio recordings of those interviews, Queensland Corrective Services (QCS) documentation relevant to Zach's periods of incarceration, QAS records, and photographs of Zach's cell and neighbouring cells. QCS documentation were provided to CSIU in a timely manner.

44. The death was notified to Police by QCS staff in a timely manner. A crime scene was established by QCS in the cell where Zach was found and all prisoners were separated and taken to the detention unit where they were spoken to by CSIU. No prisoners provided any information that would suggest the death in custody was suspicious of third party involvement. All the prisoners within his residential unit stated they got along with Zach and had no issues with him. They all stated that they were surprised that he took his own life.

45. QPS scenes of crime attended and processed the scene and took photographs. The prison cell occupied by Zach was searched the next morning and the prison issued key to his cell was located by Corrective Intel Officer Woolwray in the

middle section of a shelf underneath some clothing. The key being located is evidence supporting there was no third party involvement in his death.

46. The QPS investigation was thorough and professional and it appears all relevant material has been accessed.

Office of the Chief Inspector

47. The Chief Inspector's report explores a number of issues including not just the response to the incident on 8 February 2016, but also the adequacy of health services provided to Zach whilst he was in prison. The Inspectors noted that when Zach was transferred to WfdCC on 20 October 2015, which was approximately three months prior to his death, he had been on 120 minute observations due to risk of self-harm and suicide.

48. Zach's risk of self-harm was related to both his own self-reporting and QPS reporting of instances outside of custody, where Zach had engaged in self-harming behaviours during periods of grief and poor coping over the loss of his girlfriend. She passed away in traumatic circumstances in 2013 when Zach was 21 years old. He also had a history of addiction/abuse of prescription medications and his conviction for forgery was in relation to obtaining a prescription pad and attempting to obtain prescription-only medications.

49. At the time of the hanging incident in February 2016, Zach was being medicated with an anti-depressant after self-reporting anxiety and depression to Queensland Health (QH) medical staff at WfdCC. The Inspectors therefore considered Zach's management as an at-risk prisoner, and the medical treatment he received whilst in prison, particularly in relation to his mental health, were important matters relevant to a proper consideration of the circumstances of Zach's death.

Key findings of Chief Inspector's investigations

50. With regards to the events of 8 February 2016 when Zach was found hanging in his cell, the Inspectors found the response by QCS staff was immediate, efficient and effective with no significant issues identified. QCS staff performed CPR immediately and obtain emergency medical assistance, including a defibrillator, within a very short period of time. Having obtained a pulse, QCS staff were

hopeful Zach might survive the incident. Sadly that was not the eventual outcome.

51. With regards to Zach's management as an at-risk prisoner, the Inspectors did identify some minor deficiencies in relation to compliance with QCS' *At-Risk Management Practice Directive* and *Elevated Baseline Risk* (EBLR) processes and practices, but nothing that had any significant impact in terms of how Zach was managed. Zach's history of self-harm and being on observations automatically classified him as an EBLR prisoner, and he was appropriately accommodated in a modern suicide resistant cell with his case notes appropriately monitored by QCS supervisors. The Inspectors reviewed those case notes and considered there was nothing within those notes that ought to have alerted staff to any concerns.

52. With regards to the health care Zach received whilst in WfdCC particularly in relation to his mental health, it should be noted the Inspectors did not have the benefit of speaking with Metro North HHS Offender Health Service (OHS) staff as they apparently elected not to be interviewed. The findings of the Inspectors' report as to the involvement of OHS in Zach's care is therefore limited to what information could be obtained from medical and QCS records and from speaking with QCS staff.

53. A matter of concern identified by the Inspectors following their review of those records, was evidence that Zach had informed OHS staff on a number of occasions in late 2015 (via Medical Request Forms) that he felt anxious and depressed and was having trouble sleeping. The Inspectors stated that it appears from the records that OHS did not inform QCS of this fact.

54. The Inspectors made an assessment that this had an impact on QCS' ability to manage Zach's risk of self-harm and suicide, stating:

It is evident that once the decision was made to remove prisoner Zach from observations, there was no further follow up or review (by Psychological Services/Offender Development staff), with his case notes indicated that there was no interaction with a QCS psychologist or counsellor at all after 23 October 2015. The prisoner was informing medical staff however that he was anxious, depressed and not sleeping. This information was not passed on by nursing staff

to any QCS staff. In the circumstances, if prisoner Zach was not requesting to meet with QCS Offender Development staff and was not displaying any overt concerning behaviours in the presence of unit officers (which case notes indicated that he was not), there was no reason for prisoner Zach to have come to the attention of psychological or counselling staff at the centre to re-activate the At Risk Management process.

55. The Inspectors also noted that based on their limited review of OHS records, it appears that there was a delay of 16 days from when Zach first requested help for anxiety and depression and when he was reviewed by OHS' Visiting Medical Officer (VMO). At this review, Zach was prescribed an anti-depressant, Avanza, which contains the active ingredient mirtazapine, traces of which were found in his system at autopsy. After being on this medication for five days, Zach requested an increased dose, and this appears to have been arranged five days later on 10 November 2015 following another review by the VMO. The Inspectors noted there was no further record of any review or follow up regarding the effectiveness of the medication and no record of any further medical requests by Zach. The next entry within his medical records was the incident on 8 February 2016 when he was found hanging.

56. The Inspectors noted evidence that Zach had earlier disclosed to a psychologist that he was reluctant to self-report thoughts of suicide or self-harm due to fear of being placed on observations. This would also mean that he could not be accommodated within Residential (if on observations). The Inspectors considered this was a likely explanation for why he was telling the WfdCC psychologists on admission to that Centre that he did not feel depressed or anxious but at the same time was seeking medication from OHS practitioners due to feeling anxious and depressed.

57. Given the apparent lack of information sharing between OHS and QCS staff in relation to Zach's requests for help with anxiety and depression, the Inspectors considered the information sharing legislative and policy requirements and restrictions in place at that time.

58. In brief the Inspectors found there was no policy restriction on the release of relevant information by OHS staff to other health professionals, including QCS psychologists, who are participating in the care and treatment of a prisoner.

Further, the new *Hospital and Health Boards Act* introduced in 2011 allowed for disclosure of confidential health information to any person, not just to a health professional, if it was for the care and treatment of the person to whom the information related. As such, it appears there was no legislative or policy impediment for OHS staff to provide information about Zach's help-seeking in relation to anxiety and depression to relevant QCS staff.

59. The Inspectors acknowledged the importance of patient confidentiality. However, they also noted that correctional centres are uniquely intense, volatile, dynamic and sometimes dangerous environments, which means different protocols may need to apply. It can be unsafe and harmful to prisoners themselves and other individuals in a centre if information about the negative mood of prisoners and histories of self-harm and conditions involving anxiety, depression and anger, are not readily and sometimes even automatically passed on in a timely way to corrections staff.

60. The Inspectors found that while there was no direct indication that Zach would take his own life, OHS had information regarding his emotional and psychological state in the lead up to, and at the time of the incident, that, had it been shared appropriately with QCS staff, would have been used in the assessment of his risk of self-harm/suicidal and may have resulted in different management strategies to address any assessed elevated risk.

61. The Inspectors also stated that while there was no information in existence prior to the incident that might have indicated Zach intentions, they considered his admitted reluctance to self-report should perhaps have been given more weight in terms of his suitability for some further monitoring or follow-up process. The Inspectors have also considered the telephone calls made recently by Zach and a review of these and the content of the investigation interviews indicates that there was no further information in existence prior to the incident, which might have indicated that the incident was likely to have occurred.

62. The Inspectors also noted that findings from other death in custody investigations highlighted a pattern of inadequate sharing of information relating to prisoner health and care and, in particular, deficiencies in the arrangements then existing for communication between QH and QCS in regards to mental health diagnosis and treatment. The Inspectors did note that since Zach's death, QCS and QH

have entered into a Memorandum of Understanding (MOU) regarding the exchange of information, including medical information, between them. The Inspectors acknowledged this may now allow for a better understanding of when such information can be shared.

63. The Root Cause Analysis attached to the report made a number of general assertions and findings in respect to OHS and QH, the most critical of which was there was a lack of a prisoner-centric healthcare model and there is a lack of information sharing from QH that results in vital information, critical to the safe management of prisoners, not being available to QCS staff.

Response to criticism of Chief Inspector's Report and Root Cause Analysis

64. This issue arose in the course of the inquest because of the stringent criticism of a number of findings of the Inspectors about OHS/QH and published in the Chief Inspector's Report. NUM Pitt and Dr Prakash both gave evidence disagreeing with the assumptions made in the report. They both said a request for mirtazapine is not on its own a concern for suicide risk. It is apparent NUM Pitt was approached to be interviewed however this request was referred to Metro North HHS legal advisors and she did not hear anything further. Dr Prakash was not approached at all.

65. Dr Prakash did not agree with the assertion made in the report that OHS staff do not understand the legislative and procedural requirements to share relevant information with QCS. He stated there is interaction with QCS officers and psychologists and there is information sharing. He is well aware that a significant event can be shared with anyone and he would do so immediately. There are also a number of other weekly meetings between OHS/PMHS and QCS and other avenues for sharing of information.

Report of Dr Jill Reddan

66. Dr Jill Reddan is a consultant psychiatrist with very significant experience in the provision of public, prisoner and forensic mental health services. Dr Reddan was requested by Metro North HHS to comment on the Chief Inspector's report. It is fair to say she is highly critical of aspects of that report, particularly where opinion is expressed about clinical matters and that there appeared to be a set of assumptions and beliefs underlying the Inspectors' conclusions.

67. She noted the Inspectors placed considerable emphasis on OHS staff not informing QCS staff of the fact that Zach was asking to be prescribed Avanza (mirtazapine). She also noted that they referred to Zach telling a QCS psychologist, Ms Anna Howlett, that he was reluctant to self-report due to fear of being placed on observations. She noted that they jumped to the conclusion that this was a likely explanation for why he was telling the psychologist that he did not feel depressed or anxious but at the same time was seeking medication for depression and anxiety from OHS practitioners. Dr Reddan stated this was one possible conclusion but there were several other possible conclusions that the Inspectors had not considered.

68. Dr Reddan also noted that the Inspectors went on to say that although Zach had a history in relation to abuse of prescription medication, *"the antidepressant sought was not the type of medication a drug seeker would be requesting. It is not an opiate and has no euphoric effect".* Dr Reddan stated this was an incorrect conclusion and she queried whether the Inspectors had the necessary qualifications and experience to be making recommendations about clinical practice.

69. Dr Reddan noted there is a cohort of prisoners who use threats of self-harm and suicide to gain drugs in prison and/or to gain advantages in prison and/or to express frustration and anger. Prisoners also occasionally did not report thoughts of self-harm or suicide because the observation process is, in itself, depending upon the prison, demoralising, and it often means the prisoner will be housed in circumstances or accommodation which is very stressful and/or very uncomfortable and/or very intrusive.

70. Dr Reddan stated that mirtazapine is a widely sought drug in prisons because of its sedative effect. Many prisoners report suffering from depression and anxiety in order to obtain a variety of drugs, of which mirtazapine is one.

71. Dr Reddan noted the evidence from the observations recorded in QCS records and telephone calls with Zach from family strongly suggest that Zach was not suffering from a melancholic depression. It is common for individuals, whether in prison or not, to state they suffer from depression, but that does not necessarily mean they suffer from a melancholic depression. Dr Reddan stated there is very little evidence that antidepressants are particularly useful in non-melancholic

depressions. The assumption that somehow prescribing an antidepressant will fix misery and prevent suicide is very flawed.

72. Dr Reddan stated that what happened between 4 February 2016 when Zach last spoke with his mother and the hanging incident on 8 February 2016 will never be known. Further there was nothing in the material that indicated that Zach was suffering from a major mental illness and that he was at an imminent risk of suicide. Dr Reddan stated it was important to acknowledge that a significant proportion of those who suicide do not suffer from major mental illness and they may not give significant clues about their actions. Because an individual states he or she has no intention or plan to suicide, does not mean he or she cannot change their mind.

73. Dr Reddan was critical of the Chief Inspector's report where it was suggested there was a lack of a prisoner-centric healthcare model and there is a lack of information sharing from OHS/QH that results in vital information, critical to the safe management of prisoners, not being available to QCS staff.

74. Dr Reddan stated this was a very sweeping accusation and it is by no means an easy matter to decide what information should be provided to QCS staff in any individual case.

75. Dr Reddan stated that in view of the observations of Zach and his behaviour, there was no indication for OHS staff to inform QCS staff that he was seeking mirtazapine. She stated it is a leap of logic and a reflection of hindsight bias to suggest that because a prisoner states he has depression and/or wants to be prescribed a named drug, QCS should be informed.

76. Dr Reddan stated that if a failure to prescribe medication was a factor in his suicide, then he would have suicided much earlier. There were no indications evident that Zach needed to be referred for specialised mental health treatment, and if he had been referred, he would probably have been triaged as a non-urgent case. Dr Reddan stated it is always tempting after a suicide, to engage in hindsight forgetting that risk assessment is not risk prediction and that unfortunately, mental health treatment is no guarantee of anything.

77. Dr Reddan also commented on the statement of Dr Rajendra Prakash who stated that as medication is dispensed daily by clinical nurses, Zach had the opportunity to discuss any further concerns with the nurse and he also had the opportunity to see Dr Prakash again. She stated Dr Prakash is quite correct when he states that seeking drugs such as mirtazapine is common and does not necessarily indicate that a prisoner is at a greater suicide risk even in a prison, and mirtazapine is a frequently requested or demanded drug.

Statement of Dr Andrew Aboud

78. Dr Andrew Aboud is currently the Clinical Director of the Prison Mental Health Service. Dr Aboud was asked to respond to the issues raised by the Chief Inspector's report. He stated from a clinical perspective it is not clear from the information available whether the patient was suffering from clinically diagnosable anxiety or depression at any time during the custodial period. There are many reasons why prisoners might request a sedating medication, such as mirtazapine. Dr Aboud noted that the citing of anxiety and depression may have been genuine, or it may have been an instrumental attempt to procure the medication for its sedative or other effect. In any event, once prescribed the medication, the patient did not subsequently make further requests to see an OHS clinician. In his view there is no strong evidence that the issues of anxiety, depression or psychotropic medication were related to Zach's subsequent death.

79. Dr Aboud stated the decision by OHS to not share this information with QCS was appropriate and in keeping with the Memorandum of Understanding. The issues that the patient were raising were not, in themselves, obviously or directly related to potential risk. Whether or not a prisoner is prescribed psychotropic medication should not, in itself, automatically or routinely be considered relevant to QCS decision making as regards risk management. Prisoners' actual presentation and reports to OHS or QCS assessments, together with observed or collateral information in respect to stability, is far more relevant.

80. Dr Aboud stated there may be times when a prisoner's decision to request mental health assistance might be considered relevant information sharing for QCS, but this decision would be made on a case-by case basis, and would relate to other information about the prisoner and his/her presentation.

81. Dr Aboud stated he would be concerned if QCS made decisions to manage prisoners differently based on whether or not he/she was taking or not taking certain medications, or if he/she had requested to see a health professional for a reported mental health problem. Such issues in requests are extremely common place in the prison setting, and at any given time significant portions of the custodial population make such requests.

82. The decision by OHS/QH staff to share such information with QCS staff is a matter for routine discussion among attending OHS/QH clinicians and the threshold for sharing information is in his view crossed when more obvious or direct risk-related information is reported or elicited in the course of patient contact or assessment. It is important to recognise that if OHS/QH staff shared such a low threshold and non-specific health information with QCS, and QCS use that information to impact management practices (perhaps by employing restrictive measures), it would quickly come to pass that prisoners would be reluctant to engage in healthcare assessment.

83. In respect to the assertion made in the Chief Inspector's Report "that there are generally inadequate levels of mental health care and general health care provided", Dr Aboud stated there has been increased funding for both PMHS and primary health services since 2015, although he accepts there is still a greater demand for such services in prisons than current health service resources can provide in full. He notes that a key impediment to health service provision has been, and is, the inadequate prison health care centre infrastructure that exists in many of the prisons. Many of the health care centres are too small, and lack sufficient examination rooms, to facilitate an adequate working environment for the health care professionals who work in them.

84. In respect to the assertion made in the Chief Inspector's Report that "*appropriate information sharing between QCS and QH was unnecessarily impeded*", Dr Aboud does not believe that the information sharing in this case was impeded. Importantly, the clinical information available to OHS was not considered to be relevant information for the purpose of risk management.

Statement of Dr John Reilly

85. Dr John Reilly is the Chief Psychiatrist of Queensland Health. He also was asked to respond to the findings and recommendations made in the Chief Inspector's Report.

86. Dr Reilly noted a recommendation that "*consideration be given to review of the Memorandum of Understanding between QCS and QH to ensure adequacy of protocols for timely information sharing and accountability*."

87. Dr Reilly noted a Memorandum of Understanding was in place at the time that Zach died. Legislation was also in force, which provided for a number of exceptions to the duty of confidentiality including disclosure to an entity of the State if the disclosure was allowed under an agreement such as an MOU; was prescribed under a regulation; and was considered to be in the public interest.

88. Dr Reilly stated the MOU has been updated with the commencement of the *Hospital and Health Boards Act 2011* and has been updated with the commencement of the *Mental Health Act 2016.* A set of Operating Guidelines were also put in place to assist OHS/PMHS/QH staff through the process of sharing confidential information as required in accordance with the latest MOU.

89. The Operating Guidelines are currently undergoing review with a working group being established with key stakeholders from Queensland Health and QCS, focusing on practical issues associated with information sharing and producing operating guidelines that better set out the process of sharing confidential information.

90. Dr Reilly does not agree with the assertion made in the Chief Inspector's Report that where the MOU says that obtaining a prisoner's consent is the preferred option, and that this potentially introduces uncertainty and undermines the process. Dr Reilly stated that the MOU provides QH's position on the sharing of confidential information. The position broadly is that disclosing information with the consent of the person concerned is the most common and preferred mechanism for disclosure of confidential information. In addition to that, where confidential information is disclosed it is also important that the information that is relevant to the particular circumstance is disclosed.

91. Dr Reilly also advised that in addition to previous ongoing funding arrangements, new investment of $15 million was allocated as part of the government response to *Queensland Parole System Revie*w recommendations to immediately enhance resourcing within the PMHS.

92. Dr Reilly is also aware of a review currently being undertaken by Queensland Health into Offender Health Services. That project has commenced and Phase 1 includes conducting a review of Offender Health Services and to develop a plan to improve the government arrangements for publicly provided offender health services. The review is to be wide ranging and is expect to be completed in 2018.

Response from the Inspectors

93. In general the inspectors who compiled the report were not prepared to change their opinions after reading the responses from Dr Reddan, Dr Aboud and Dr Reilly. In simple terms their view is that the information that Zach was wanting to see a VMO to discuss medication for depression and anxiety and where there had been a history of self-harm, and he had been on observations, is information that would have assisted QCS staff and they would have done an assessment. Their evidence was that the RCA findings and recommendations are reasonable and they would make no changes.

Conclusions on the issues

94. In reaching my conclusions it should be kept in mind the *Coroners Act 2003* provides that a coroner must not include in the findings or any comments or recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths.

95. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw* sliding scale is applicable. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

96. In matters involving health care, when determining the significance and interpretation of the evidence the impact of hindsight bias and affected bias must also be considered, where after an event has occurred, particularly where the outcome is serious, there is an inclination to see the event as predictable, despite there being few objective facts to support its prediction.

How Zach died

97. On the balance of probability and having regard to the gravity of such a finding, I am satisfied there is sufficient evidence to find Zach died as a result of suicide. There is no evidence supporting a different explanation for the hanging, and the key found in Zach's locked room is evidence supporting a positive finding that there was no third party involvement in Zac's death.

98. It is no doubt confounding for Zach's family to understand what brought him to make this decision when he did. There is no evidence he was experiencing or expressing anything resembling suicidal ideation in the months or days leading to his death. As Dr Reddan stated he was not a prisoner on serious offences, he had external family support and his behaviour had not deteriorated. He had been prescribed an antidepressant, but it is likely this was for its sedative effects as much as anything else to assist him sleeping. It was a drug well sought after in prisons. The drug would have reached a therapeutic level well before he took his own life. The drug was administered daily by nursing staff since November 2015 and there had been no concerning behaviours or observations made by OHS or QCS staff in that period.

99. As Dr Reddan acknowledged, Zach was in an unusual category of prisoners who, despite having good external support from his family and appearing to have settled into a reasonably stable emotional state over those months at Woodford, appears to have made a decision on that day in February 2016 to end his life. As Dr Reddan said, what happened between 4 February 2016 when Zach had that last, positive telephone conversation with his mother, and 8 February 2016 when he was found unconscious in his cell, may never be known.

Whether there is information held by Offender Health Services, Metro North Hospital and Health Service and/or any of its staff who provided health services to Mr Holstein whilst he was a prisoner at the Woodford Correctional Centre that would further add to or amend the findings and

recommendations made by the Office of the Chief Inspector arising from Mr Holstein’s death.

100. This issue was identified on the basis of the significance attached by the Inspectors to the information contained with Zach's Medical Request Forms, and the findings and recommendations arising from the opinions they formed about that information and the fact it was not shared with Queensland Corrective Services staff. The Inspectors described this as a "*failure*" to share information that they say was "*indicating to QH staff that he was anxious and depressed and subsequently medicated for depression*". The Inspectors attributed this failure to a QCS procedural document that they considered "*unnecessarily impeded*" appropriate information sharing between QCS and QH, as well as a lack of understanding by QH staff that "*negative thoughts or emotions or medication non-compliance...can create a much higher risk of harm (including self-harm or suicide) in a prison environment.[due to] the extreme nature and impact of incarceration on prisoners*".

101. I have considered the evidence of CN Pitt the Nurse Unit Manager responsible for nursing services provided to prisoners at WdfCC, as well as from the Visiting Medical Officer Dr Prakash who consulted with Zach in relation to his requests made in those forms.

102. On the basis of that evidence from those clinicians I am satisfied the circumstances of Zach's death were not indicative of issues with information sharing between OHS and QCS staff, as the information contained within those Medical Request Forms was not, in and of itself, indicative that Zach was in fact suffering from anxiety or depression. Nursing staff appropriately triaged that information and Zach was seen by a VMO for further clinical assessment on two occasions. Whilst that VMO, Dr Prakash, had only a very limited recollection of those two consultations, he was confident in his evidence that Zach did not present with any suicidal ideation or other clinical concerns at those times. Dr Prakash’s evidence was, and I accept, that if there was anything about Zach that he considered warranted a different approach to Zach’s care and management within the centre, he would (and regularly does) issue those instructions to the Nurse Unit Manager or her representative for those things to happen.

103. Dr Jill Reddan and Dr Andrew Aboud, two very experienced clinicians with particular expertise in forensic mental health, had no criticism of the actions taken by the relevant clinicians in response to those Medical Request Forms.

104. It is also noted that the OIC Inspectors did not consider the need to obtain clinical advice and opinion in relation to the matters they were making adverse findings about.

105. A psychologist with QCS, Ms Lourigan also acknowledged that there would be some clinical assessment of that information on those forms before there was a decision whether to pass that information on. The Inspectors' insistence that the sharing of that information would have "triggered" a "process" by which QCS Offender Development psychologists or counsellors would then have gone and spoken to Zach (which appears to be the basis for the Inspectors' finding that information sharing was an issue that may have impacted on the outcome in this case), is not supported by the evidence as given by Ms Lourigan. Ms Lourigan's evidence about that was limited to the scenario of Correctional Services Officers raising concerns about Zach with her team, which is a very different proposition.

106. Based on the opinions of Dr Reddan and Dr Aboud, I am satisfied that in relation to the Medical Request Forms submitted by Zach to Offender Health Services at WdfCC in October and November of 2015, there was no information to be shared with QCS on clinical or safety grounds, and therefore no "failure" to share information.

107. It is quite evident to me that there are considerable difficulties in accepting some of the findings of the OCI report. The difficulties are not in relation to the factual matters as set out in the report. These are largely accurate and based on the records. Based on the Inspectors' experience it is clear they have experience in investigating incidents within a corrections environment and have an understanding of QCS policies and procedures.

108. The difficulty lies with the findings and recommendations made in respect to health service issues where the Inspectors have little experience, and certainly no clinical experience. The OCI report made a number of wide ranging conclusions, and as Dr Reddan stated "sweeping accusations", based on little evidence about the efficacy of OHS/PMHS/QH services provided to prisons. The

OIC states that the findings were also based on findings made in previous reports and reviews. That may well be, but these other findings were not at all evident in the report itself.

109. That being said, there is no doubt some improvements to this internal review process can and should be made. OHS/PMHS/QH staff should be asked to provide information to Inspectors. There was clearly an initial problem in this instance arising from an OHS perspective, although the issue about not allowing staff to assist was not further followed up by the Inspectors

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110. As well, having information from OHS in this case would arguably have made little difference to the opinions expressed by the Inspectors. Their evidence at the inquest is, that after receiving the information from the NUM Pitt and Dr Prakash that they most likely would have obtained if interviewed, and after reading and hearing the evidence of Dr Reddan, Dr Aboud and Dr Reilly, they still would not change anything in their report.

111. Although the OCI reports are largely developed for internal use, they are documents that can be publically released, and in Deaths in Custody investigations are always released to other interested parties and referred to in inquests. Given there were clearly adverse comments made about OHS generally, the Rules of Natural Justice would clearly apply and OHS should have been provided with an opportunity to answer those adverse comments and present their own case. I will refer to this issue in my comments and recommendations.

Response of QCS to recommendations made in Chief Inspector's Report

112. Deputy Commissioner Peter Haddock of QCS also noted that the Chief Inspector's report also contained a number of recommendations for QCS that fell within the operational area of State Wide Operations. The findings and recommendations remain on the agenda for the Incident Oversight Committee.

113. The report recommended regular, collaborative training between QCS and QH staff who are responsible for the delivery of services to prisoners.

114. Mr Haddock noted a range of training programs offered at the QCS Academy that are available to the undertaken by QH staff, should they wish to attend.

115. A review of the Custodial Operations Practice Directive –Risk Management (COPD) resulted in amendments being made to the COPD to require certain paper forms to be attached electronically to IOMS, with a hard copy of the documents to be placed on the offender management file. The revised COPD was expected to be completely implemented by the end of May 2018.

116. Mr Shaddock also gave evidence regarding the process for working through those recommendations in consultation with the OCI, which includes opportunities for QCS to provide feedback to the OCI as to the evidentiary basis for, and viability of, recommendations made by Inspectors to QCS.

117. In so far as DCS it is apparent that the recommendations of the OCI report, on issues that the inspectors have appropriate qualifications to make comment about, have been appropriately considered and adopted.

Response of Queensland Health to the recommendations made in the Chief Inspector's Report

118. I accept the submission made by Counsel Assisting that given there are issues with respect to the evidentiary basis for the findings and recommendations made by the OCI as they relate to health services, and in light of the evidence now before the Court as to the significant initiatives currently underway to improve the delivery of both offender health and mental health services to prisoners throughout Queensland (both through improved governance and additional funding), there is little practical value in making particular findings about the adequacy of QH's and the relevant HHS' responses to the OCI's recommendations.

Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003.

119. With the new QH Offender Health Services governance project and the recent commitment to additional funding for mental health services as part of the *Queensland Parole System Review*, it appears some significant efforts are being made towards improving those services for prisoners in Queensland and no further specific recommendations need be made.

120. I also note the comments of State Coroner Ryan in a very recent decision[1] where he stated in relation to PMHS and QCS psychologists, that he was not persuaded the current legislative framework prohibits the appropriate sharing of relevant confidential information. The State Coroner also referred to the evidence of Dr John Allen, the previous Chief Psychiatrist, where he agreed that enhancing working relationships between the respective agencies to operationalise the MOU, rather than prescribing the requirements in legislation, it is likely to lead to improved information sharing.

121. State Coroner Ryan also considered the policy underpinning the current information sharing arrangements is sound. This requires that the wishes of a prisoner regarding the release of information about their mental health treatment be respected, unless there is a legal or clinical requirement for the information to be shared. I adopt those comments.

122. I understand that Zach's family accept there are privacy and confidentiality issues that must be respected for prisoners but believe the prison environment is different and health concerns should have primacy over privacy issues. They also raised the need for increased medical resources in prisons as well as more CCTV cameras in the residential units.

123. The issue of privacy and confidentiality and when information can be shared is set out in the MOU between QH and QCS and which was referred to in evidence. It is noted there is a working group of QH and QCS examining the existing MOU and Operating Guidelines to the MOU. I noted the evidence of Dr Reddan that in her view the MOU does not need review and it is best to not constrain clinicians.

124. I also note the submission from Counsel for the family to the effect that the current QH policy on information sharing appears to be narrower in scope that the legislation.

125. Given that the MOU review is taking place and also noting the recommendations made by the State Coroner to the working group concerning the MOU to consider whether amendments to the legislation is necessary to supplement the release

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[1] *Findings of the inquest into the death of Franky Houdini*, delivered 16 May 2018

of information including documents, I consider I do not need to make any further comment and adopt the State Coroner's recommendation.[2]

126. I also adopt the recommendations suggested by Counsel Assisting to the effect that Metro North HHS urgently consider additional resourcing of Offender Health Services within Woodford Correctional Centre (both staffing and number of consultation rooms) to ensure prisoners are able to see a doctor:
    - within at least seven days after they have been triaged and identified as requiring a non-urgent medical consultation, and ideally within a few days
    - and/or within a timeframe that is commensurate with those timeframes experienced by members of the general public in the community.

127. I note that the respective Counsel for Metro North HHS and Queensland Health accepted the submissions of Ms Jarvis and her recommendation is well open on the evidence given there was a prolonged delay in Zach first being seen by a doctor. The recommendation is largely uncontroversial although there of course may be some resource implications.

128. On the issue of increased CCTV use in residential units, Zach's family understood there would not be enough guards on duty to view CCTV cameras constantly, and understood the importance of providing some privacy. Their main concern was that CCTV cameras outside the units may have shown how the sheet was tied to the door. I understand this information may have provided them with some comfort that a third party was not involved. I can only say there is no available evidence there was third party involvement and it is clear that no other prisoner had access to his room given the key was found in the locked room subsequently.

129. On the issue of the OCI's findings and recommendations made in relation to Zach's death Ms Jarvis made the following suggestions for recommendations:-
    - That OCI review the investigation and report prepared in relation to the death of Mr Holstein and identify any opportunities for improvement to OCI investigation policies, processes and training, particularly in relation to the use of Root Cause Analysis methodologies.

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[2] *Findings of the inquest into the death of Franky Houdini*, delivered 16 May 2018 at page 19

- That OCI, QH and all HHS who provide health services to prisoners jointly consider ways for ensuring that, where a prisoner dies and health services provided to that prisoner are relevant to the OCI's investigation into that death, there is a mechanism for gathering relevant QH and HSS information to inform that investigation, including through interviews with QH and HHS staff.
- That where reports prepared by the OCI make findings and recommendations about services provided by QH and HHS, those reports are provided in draft form to QH and HHS for comment prior to being finalised.

130. In response to these submissions the OCI has advised by way of a letter dated 28 May 2018, that it has been concluded, through its own internal review of the matter, that regardless of the fact that QH did not participate in the investigation process, system conclusions about QH matters identified during the root cause process should not have been finalised without consulting with QH. As a result, OCI business processes have been redistributed to all staff, highlighting the requirement to consult and engage with all affected agencies in any matter investigated by OCI.

131. In further internal review by the OCI, it has been acknowledged that there could be a clearer demarcation between overall system conclusions and relevant inspection findings specific to an individual incident. In particular the process of including root cause analysis that is reliant on evidence from other sources such as previous investigation, inspection and reviews, will be reviewed. It is a primary objective for the OCI that systemic issues are raised and addressed, however it is important that this is done in a cogent way taking into account the particular individual circumstances of a case and the broader systemic issues.

132. The OCI has also determined that OCI inspectors will be required, in addition to their specialist knowledge and experience, to obtain relevant qualifications in statutory government investigations.

133. The OCI has also recently implemented relevant practice updates to include:
    - Consideration to involving subject matter experts in the investigation process where it is deemed necessary;

- A review of the language utilised within reports to ensure content is consistent with relevant subject area standards and accepted practice.

134. In so doing the OCI's letter states the OCI does not indicate acceptance as to any unfavourable submissions made during the inquest, rather they provide an opportunity to advise on the advancements taken to ensure that high quality standards of the unit in investigations and report writing are maintained.

135. Accordingly, taking into account the OCI response, I will not make any further recommendation other than in respect to the issue of collaboration between QCS and QH, when the OIC is conducting an investigation.

Findings required by s. 45

Identity of the deceased – Zachary James David Holstein

How he died – Zach died from hanging himself with a sheet tied to his cell door. He did so with an intent to take his own life. There is no evidence to suggest there was any third party involvement in his death. The reasons why he made this decision at this time are uncertain and his actions were unexpected to both the prison authorities and his supportive family. Although he was taking a medication utilised for depression there is little evidence to suggest he was clinically depressed, or that his behaviour had changed in the months and days leading up to his death.

Place of death – Redcliffe Hospital REDCLIFFE QLD 4020 AUSTRALIA

Date of death– 12 February 2016

Cause of death – 1(a) Hypoxic-ischaemic encephalopathy
1(b) Hanging.

Comments and recommendations

Recommendation 1

That Metro North HHS urgently consider additional resourcing of Offender Health Services within Woodford Correctional Centre (both staffing and number of consultation rooms) to ensure prisoners are able to see a doctor:

- within at least seven days after they have been triaged and identified as requiring a non-urgent medical consultation, and ideally within a few days
- and/or within a timeframe that is commensurate with those timeframes experienced by members of the general public in the community.

Recommendation 2

That Office of Chief Inspector, Queensland Health and all Hospital and Health Services who provide health services to prisoners jointly consider ways for ensuring that, where a prisoner dies and health services provided to that prisoner are relevant to the Office of Chief Inspector's investigation into that death, there is a mechanism for gathering relevant Queensland Health and Hospital and Health Services information to inform that investigation, including through interviews with Queensland Health and Hospital and Health Service staff.

I close the inquest.

John Lock
Deputy State Coroner
BRISBANE
20 June 2018