QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND
FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Vanelee Curtis Mitchell**
TITLE OF COURT:	Coroners Court
JURISDICTION:	TOWNSVILLE
FILE NO(s):	2020/1523
DELIVERED ON:	2 September 2022
DELIVERED AT:	BRISBANE
HEARING DATE:	17 June 2022
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, First Nations prisoner, death in custody, natural causes, health care, human rights, sudden death in epilepsy, provision of anticonvulsant medication to prisoners, reception triage, monitoring of medication.

REPRESENTATION:

Counsel Assisting:	Ms Josephine Villanueva
Queensland Corrective Services:	Ms Megan Lincez
ATSILS:	Ms Angela Taylor

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Introduction

1. Vanelee Mitchell was a First Nations man who was imprisoned at the Townsville Correctional Centre (TCC) when he passed away on 10 April 2020. He had been found unresponsive in his cell during the morning muster. Resuscitation efforts were unsuccessful, and he was declared deceased at 8:07am. He was aged 30 years.

The investigation

2. Detective Sergeant Ramsay from the Townsville CIB carried out the investigation into the circumstances surrounding Mr Mitchell's passing. A Coronial Report was provided dated 15 October 2021 with various annexures, including witness statements and incident logs.[1]

3. On 10 April 2020 investigators from the Townsville CIB, Scenes of Crime personnel and officers from Stuart Police Station went to the TCC after being notified of the death. A targeted direction for investigation was issued by the State Coroner. Mr Mitchell's correctional records and his medical files from TCC were obtained.

4. The investigation was informed by statements from the relevant custodial correctional officers, medical and nursing staff, and fellow prisoners at TCC. These statements were tendered at the inquest. I was provided with annexures including witness statements, recordings, Corrective Services Records and photographs.

5. Dr Natalie MacCormick from the Clinical Forensic Medicine Unit (CFMU) also examined Mr Mitchell's medical records and reported on them for the Coroners Court.

6. The investigation concluded that Mr Mitchell passed away from natural causes, and that he was provided with adequate medical care in prison. It also found that there were no suspicious circumstances associated with the death. I am satisfied that all relevant material was accessed.

The inquest

7. At the time of his death, Mr Mitchell was a prisoner in custody under the *Corrective Services Act 2006*. Mr Mitchell's death was a 'death in custody' and an inquest was required by the *Coroners Act 2003*. The inquest was held on 17 June 2022.

8. In addition to counsel assisting, leave was granted to Queensland Corrective Services and to ATSILS under s36(1)(c) of the *Coroners Act 2003.*

[1] Exhibit A7

The evidence

Personal and medical history

9. Mr Mitchell was born on 3 May 1989 in Mount Isa. He grew up with his father's sister, who he considered to be his mother. As a boy, Mr Mitchell moved between Doomadgee and Mornington Island and had family in both communities. He is survived by his daughter. I extend my condolences to his family and friends.

10. Mr Mitchell had a criminal history with entries for property related offences, offences of violence, drug related offences and contravention of domestic violence orders. On 10 January 2018, Mr Mitchell was imprisoned for a period of nine months for an offence of threatening violence. He was released on 4 October 2018.

11. On 25 September 2019, Mr Mitchell was remanded in custody in relation to a charge of grievous bodily harm. The offending involved Mr Mitchell hitting a 15 year old boy with a baseball bat, resulting in a serious injury. On 3 April 2020, Mr Mitchell was sentenced in the District Court at Mt Isa to 5 years imprisonment for that offence. His parole eligibility date was 25 December 2020, with 190 days of pre-sentence custody declared.

12. Mr Mitchell suffered a number of medical conditions, including epilepsy, acquired brain injury with mild cognitive impairment and gastro-oesophageal reflux disease.

13. Mr Mitchell's epilepsy and brain injury were a result of being 'king hit' and falling to the ground in January 2014. He subsequently underwent a craniotomy. After that surgery, Mr Mitchell started experiencing seizures and blackouts. Mr Mitchell was started on Sodium Valproate and Levetiracetam to manage seizures. He presented to hospitals on a number of occasions while in the community as a result of seizures after he did not take his medication.

14. While in custody, Mr Mitchell was prescribed 500mg of Valproate and Levetiracetam once in the morning and once in the afternoon. These doses had to be adjusted on occasions when concentration levels of the medications in his blood were found to be too high or low.

15. Mr Mitchell experienced three medical episodes during his last period in custody:

    - 16 October 2019 – difficulty breathing and chest tightness;
    - 5 January 2020 – seizure lasting two minutes not requiring further treatment;
    - 20 February 2020 – seizure involving loss of consciousness which was followed by some testing. He told medical staff he had not taken his morning medication.

Circumstances surrounding the death

16. Mr Mitchell was housed in Cell 3 of Unit R05B - also known as the McCann Complex at TCC. There are six cells in the McCann Complex with each prisoner having a key to their cell. Prisoners can lock the door to their cell. There is a communal kitchen, lounge, and laundry area. At night, the main door to the complex is locked and secured.

17. On 9 April 2020, at around 5:00pm, Mr Mitchell refused dinner and did not take his afternoon medications. Sometime after this, Mr Mitchell lifted weights and 'trained' in his room with another prisoner, Mr Jupiter. Mr Jupiter observed that Mr Mitchell 'trained well' and appeared healthy despite not taking his medications.

18. At around 7:30pm, Mr Mitchell played cards with another inmate, Mr Broomhall. Mr Broomhall had known Mr Mitchell for four or five days. At around 8:00 or 9:00pm, Mr Jupiter saw Mr Mitchell return to his cell after having a shower.

19. At around 11:00pm, another prisoner, Mr King, went into Mr Mitchell's cell to return a CD he had borrowed.

20. At around 12:00am on 10 April 2020, inmate Walsh saw Mr Mitchell in the kitchen. Mr Walsh observed Mr Mitchell to be happy. Mr Walsh asked Mr Mitchell for some milk to put in his coffee.

21. After midnight, Mr Jupiter, who was housed in the lounge room, saw Mr Mitchell go to the bathroom. This was the last time Mr Mitchell was seen alive.

22. At around 7:10am, Corrective Services Officer (CSO) Martin Dunn was in charge of conducting the morning head count. He noticed that Mr Mitchell did not present for the head count. Mr Jupiter was asked to open Mr Mitchell's cell door, but it was locked.

23. At around 7:15am, CSO Dunn called for backup and as another CSO was arriving, CSO Dunn used his own key to open Mr Mitchell's cell door. CSO Dunn saw Mr Mitchell lying in bed on his stomach. Mr Mitchell did not respond to his name being called or to his right ankle being shaken. CSO Dunn observed liquid near Mr Mitchell's mouth and called a Code Blue.

24. Mr Mitchell was lifted off the bed and onto the floor. CSO Dunn performed chest compressions while CSO Anderson performed mouth to mouth resuscitation with the aid of a disposable mask. Staff from the medical centre arrived and provided treatment using a defibrillator without success and 25ml of fluid was suctioned from Mr Mitchell's upper airway.

25. Paramedics arrived and continued CPR. Despite continued efforts, Mr Mitchell was not able to be revived and was pronounced deceased at 8:07am on 10 April 2020.

26. Ms Roxanne Deere, Nurse Unit Manager, Prison Health Service in the Townsville Hospital and Health Service (THHS) reviewed Mr Mitchell's medical records.[2] He underwent a medical intake on 11 October 2019 where he was given a full health screening, pathology and provided information about how to access health services in prison. He was listed as Category 3 on the visiting medical officer's waiting list. The visiting medical officer charted his medication on the same date.

27. Mr Mitchell remained as Category 3 on the waiting list. During this time, Prison Health had a waiting time of 6-7 months. Mr Mitchell saw a nurse on medication parade twice a day and was provided information should he have any health requests. No health request was received from Mr Mitchell.

[2] Exhibit B6

28. Ms Deere said that medications in prison are provided by a registered nurse in the morning and the afternoon. In Mr Mitchell's case, his medication was provided at a medical line, which means the CSO will call out to prisoners to advise them a nurse has arrived for the medication parade. The onus is on the prisoners to attend the medication parade to receive their medications. The prisoners also have the right to refuse to take their medication and/or not present to the medication line.

29. Ms Deere said that if a prisoner does not present to the medication line three times in a row, the nurse will speak to the prisoner to discuss the reason for missing the medication rounds and provide education on the importance of taking medications. Mr Mitchell presented to the medication line for the most part while in custody. He sporadically missed his medications on seven occasions prior to 20 February 2020 but he would only miss either the morning or the afternoon medications, never both.

30. On 25 January 2020, Mr Mitchell was found to have critically high Valproate levels at 139 (40-100 normal range). As a result, Mr Mitchell's medication was withheld for three days. Mr Mitchell's Valproate dosage was reduced to 400mg from 28 January 2020.

31. Following his seizure on 20 February 2020, Mr Mitchell's pathology result on 24 February 2020 indicated Valproate levels just below normal range (39). His Valproate dosage was increased to 500mg in the afternoon only.

Autopsy Results

32. An external and full internal post-mortem examination was conducted by Dr Paull Botterill on 15 April 2020. A neuropathology report was also provided by Dr K Iyengar.

33. The post-mortem examination revealed changes consistent with past skull surgery, excess fluid in the lungs and changes attributed to resuscitative efforts. There were microscopic changes of focal myocardial scarring in Mr Mitchell's heart but no features of active rheumatic carditis. Microscopic changes of hepatic congestion were also observed in the liver.

34. The toxicology test from femoral blood detected 0.68mg/L of Levetiracetam and 6.2 mg/L Valproic acid. No alcohol was detected.

35. At the time of the examination, Dr Botterill was of the opinion that the cause of death was unclear. However, he ruled out overt drug toxicity and recent injury. He stated that *"the relatively low anticonvulsant blood levels present combined with the history of seizures means that an uncontrolled seizure could not be completely excluded. Nevertheless, as no recent seizures were observed, in my opinion the death is best regarded as a sudden death in epilepsy"*.

36. Dr Botterill stated that although the dosage of anticonvulsant medication is usually titrated, both medications were detected at blood levels below the reported therapeutic ranges.

37. Dr Botterill concluded the cause of death was "sudden and unexpected death in epilepsy".[3]

[3] Exhibit A5

Clinical Forensic Medicine Unit Review

38. Given the circumstances of Mr Mitchell's death and his associated medical conditions, a review of his health care was obtained from Dr Natalie MacCormick, Forensic Physician from the Clinical Forensic Medicine Unit.[4]

39. Dr MacCormick noted that Valproate and Levetiracetam are anti-convulsant medications. The concentration of both medications detected in Mr Mitchell's blood were well below the suggested therapeutic range. This was likely due to Mr Mitchell missing his afternoon medications the day before his death, on the background of recent low blood levels.

40. Dr MacCormick considered low anticonvulsant levels likely precipitated a seizure in Mr Mitchell who had poorly controlled epilepsy and a long history of seizures when he missed his medications. It was likely that Mr Mitchell's seizure was complicated by aspiration.

41. Dr MacCormick said that the findings of hypoglycaemia during Mr Mitchell's resuscitation raised the possibility of valproate induced hypoglycaemia, a rare and poorly understood phenomena associated with valproate therapy. The significance of hypoglycaemia was less clear than low anticonvulsant blood levels. Valproate induced hypoglycaemia might precipitate a seizure or cardiac arrest. However, the cause of death described as "sudden death in epilepsy" captured both possible scenarios.

42. Dr MacCormick expressed no concerns about the medical care provided to Mr Mitchell while in prison. All attempts were made to monitor Mr Mitchell's Valproate levels and the titrations of his medications were done appropriately. Dr MacCormick was of the opinion that Mr Mitchell's death was sudden and unexpected and there were no missed opportunities that could have changed the outcome.

Systemic issues raised by ATSILS

43. While accepting that Mr Mitchell's death was from natural causes, ATSILS identified several issues in relation to his death:

- Whether Mr Mitchell receive culturally appropriate support and engagement with his medical treatment and medication compliance;
- Whether the medical treatment Mr Mitchell received for his brain injury subsequent and subsequent epilepsy satisfied s37 of the *Human Rights Act* (Qld);
- Whether the Queensland Corrective Services (QCS) Custodial Operations Practice Directives (COPD) provide for culturally sensitive support and engagement with prisoner's medical treatment; and
- Whether there should be therapeutic intervention with a prisoner earlier than three consecutive missed doses of medication.

[4] Exhibit H

44. Queensland Corrective Services was asked to respond to ATSILS' concerns. QCS confirmed that it was aware Mr Mitchell was prone to seizures and of the seizures he suffered while in custody. QCS submitted that Queensland Health was the agency responsible in providing medication and treatment to prisoners. However, there were occasions when Mr Mitchell suffered seizures where QCS staff provided first aid.

45. QCS staff and Queensland Health staff may case manage a prisoner with complex needs or mental health conditions if the prisoner is refusing medication. However, in the absence of an involuntary treatment authority or forensic order, the decision to comply with taking medications remains with the prisoner. As I noted in the Inquest into the death of Ashley Gavenor:

> *"As in the wider community, a prisoner cannot be forced to take prescribed medications in the absence of an involuntary treatment order or a forensic order. While* encouragement *and counselling can be provided by nursing staff and medical staff, the decision to take medication ultimately rests with the prisoner'.*

46. QCS submitted there is no evidence to suggest Mr Mitchell was not afforded his recognised and protected human rights pursuant to the *Human Rights Act 2019.*

47. A response to ATSILS' submission was also provided by Ms Marina Daly, Executive Director, Clinical Governance, THHS. In relation to culturally appropriate support and engagement, Ms Daly indicated that the organisation engages with and provides support to persons accessing health services while in prison. However, THHS recognises that there is scope to improve the cultural appropriateness of this support. The Townsville Prison Health Service (TPHS) does not have Indigenous Liaison Officers (ILO) or Indigenous Health Workers (IHW). While the TCC has Cultural Liaison Officers, they do not provide support in health-related matters.

48. It was confirmed that work is underway to improve this situation and embed culturally appropriate support and engagement strategies to deliver health services to prisoners and in the community. There are three strategies currently underway to improve the situation.

49. The first strategy is the implementation of the THHS Health Equity Strategy 2022-2025 which aims to reduce inequalities between Indigenous and non-Indigenous health outcomes in line with the Closing The Gap initiative. This strategy has been codesigned with Aboriginal and/or Torres Strait Islander people, communities, and organisations. There is continuing consultation to shape, inform and adapt the strategy and its implementation.

50. This strategy has five following priority areas:

    i) *Actively eliminating racial discrimination and institutional racism within the health service;*
    ii) *Increasing access to health care service;*
    iii) *Influencing the social, cultural, and economic determinants of health; and*
    iv) *Working with First Nations people, communities, and organisations to design, deliver, monitor, and review health services*.

51. In relation to healthcare provision in custodial settings the strategy will:

    a) *identify ways through continued community consultation to include traditional knowledge and cultural healing practice into hospital and healthcare to treat and support Aboriginal and Torres Strait Islander people.*
    b) *Update clinical practice guidelines and quality and safety standards to embed cultural safety and responsivity in practice.*
    c) *Partner with regional and remote Aboriginal and Torres Strait Islander Health organisations to embed culturally safe models or care and incorporate these learnings across services and boundaries*.

52. The Health Equity Strategy will include key performance indicators to measure and understand progress in achieving its outcomes. It will be reviewed within three years with the review findings to be published. It will also be evaluated as part of a state-wide First Nations Health Equity monitoring and evaluation framework being developed by Queensland Health. This strategy is currently in its final stages and is expected to be released in the second half of 2022.

53. The second strategy involves improvement in employing ILO or IHW within TPHS. TPHS has included an ILO in its future service plan and work is continuing to implement this change. The role of an ILO is considered to flexibly adapt to the need and support of First Nations people in TPHS, including for an ILO to provide a service delivery model to achieve better and more culturally appropriate engagement with patients.

54. The third strategy is to improve information sharing protocols between Queensland Health and QCS. A working group has been established to discuss information sharing and operational practice between Queensland Health and QCS. The focus of the group is to improve the working relationships between QCS and Queensland Health (including Hospitals and Health Services) by strengthening the current memorandum of understanding (MOU) for confidential information disclosure. The current operational guideline is to be updated to provide a better guidance about sharing relevant confidential information between the agencies.

55. While it is the preference of Queensland Health to obtain patient consent in relation to disclosure of confidential information, the updated MOU and operating guidelines will refine the sharing of relevant information to allow both Queensland Health and QCS to perform their respective roles and responsibilities and to allow Queensland Health to deliver services.

56. In addressing ATSILS' submission regarding human rights issues, Ms Daly submitted that the healthcare provided to Mr Mitchell satisfied s 27 of the *Human* Rights *Act 2019*. Mr Mitchell had access to health services without discrimination and was not refused medical treatment when he needed it urgently. He was comprehensively screened upon arrival and provided information on how to access medical services.

57. Mr Mitchell was triaged as a Category 3 when he arrived at TCC. At that time, TPHS did not have a formalised triage process. The process relied upon the RNs applying their experience and judgement to make the triage assessment. There is now a 'Reception Triage', which is a prison triage process introduced in June 2021.

58. Waiting lists have been audited since the introduction of the Reception Triage. The list is now more manageable and persons not needing to see a doctor (Category 5 patients) are no longer included in the waiting list. More time is spent with patients in higher categories. Feedback from TPHS staff is positive and the changes have been entrenched in TPHS processes.

59. Where a patient presents with a new health complaint or deteriorating health condition, TPHS nurses can review and update the triage category. A nurse can organise a medical practitioner to see the patient within 1-3 days, contact the on-call doctor to seek advice/intervention, or organise for the patient to be transferred to Townsville University Hospital (TUH). Mr Mitchell was transferred to Townsville University Hospital on 16 October 2019 when he presented with chest pain.

60. Pathology tests may be ordered at any time by a doctor or nurse after speaking to a doctor. Results are processed at TUH overnight and uploaded to the patient's medical record.

61. On 25 January 2020, Mr Mitchell's Valproate levels were tested after he suffered a seizure. The levels were found to be critically high, and this was communicated by the pathology lab at TUH to TPHS on the same day. As a result, Mr Mitchell was reviewed by Dr Milns, who ordered that Valproate be withheld from Mr Mitchell for three days and thereafter reduced.

62. In the following weeks pathology tests were repeated. On 6 February 2020, Mr Mitchell's levels were just below normal at 39 and no changes were made to his medications by Dr Milns. On 20 February 2020, Mr Mitchell's dose of Valproate was increased to 500mg (from 400mg) in the afternoon only after his levels were found to be just below normal. On 14 March 2020, Mr Mitchell's Valproate levels were within the normal range. No further changes were made.

63. ATSILS raised in submissions whether Mr Mitchell was advised of the change in Valproate dosage on 20 February 2020. Ms Daly has advised that while it is not always possible for patients to see a doctor in person, doctors regularly review charts and may order medications to be changed or request further pathology tests as a result of the reviews.

64. It is usual practice for the patient to be told of the change in medication by the nurse who gives the next dose of medication. Due to the time intensive nature of providing medications during a medication parade and the number of patients presenting during the parade, it is not feasible to record such discussions have occurred in each patient's medical record.

65. In 2021, THHS employed a permanent Nurse Practitioner, who manages patients with chronic diseases (including epilepsy) and is also responsible for triaging Category 4 patients. This has allowed doctors to attend to more complex and higher acuity patients. Audits of the waiting list have shown improvement, partly due to the introduction of the Nurse Practitioner.

66. Ms Daly reiterated that the current process is that an intervention with a patient will occur after the patient has missed their medications three days in a row ('3-day rule'). The nurse will discuss with the patient their reasons for not presenting at the medication parade and provide support to the patient about taking their medication and what time they should present at the parade.

67. Ms Daly advised ‘anecdotally’ a patient is spoken to by a nurse about missing urgent medication (including medication to treat epilepsy) before three days has passed.

68. Ms Daly advised that there are a number of factors to consider when deciding the most appropriate timeframe to speak to a patient who has missed a medication parade. The first factor for patients with capacity to make their own health care decisions is to respect their choice. It is the responsibility of each patient to present to the medication parade. The patient make this decision based on their personal circumstances, beliefs and priorities in the same way as people in the community. Mr Mitchell retained capacity during his term of imprisonment.

69. The second factor is the ratio of prisoner to medical staff. It is not feasible to ensure that every prisoner attends the medication parade. In June 2021, there were 1179 prisoners across the four TCC sites of whom around 50% required medication, with 31 FTE nurses responsible in running the daily medication parade.

70. The third factor is the amount of work required to prepare the administration of medication during the parade. It takes up a significant portion of the health centre’s day. Each nurse spends four hours per day packing medications and a further two hours administering medications in the different prison units. It is planned to replace this process with a packaging system that will package medications in Webster packs.

71. While the process change to medication dispensing will result in nurses having more time for clinical work, THHS submitted that the ‘3 day rule’ remains the most appropriate timeframe given the above factors. Despite this, patients are able to seek assistance from TPHS at any point in time, and chart and pathology reviews are also regularly performed.

Conclusions

72. Mr Mitchell was not subject to an involuntary order or a forensic order while incarcerated at TCC. He had epilepsy since 2014 and would have been aware of the importance of taking his medication as he had regular hospital admissions in the community following seizures. It was beyond the scope of this inquest to examine his health care in the community since 2014.

73. During his imprisonment he was seen by medical staff and treated when necessary. His anticonvulsant medications were charted, and he was provided information about how to access health services. Mr Mitchell was to take his anticonvulsant medications twice a day – morning and afternoon. Given he was in a low security area of TCC, it was up to him to present himself to the medication line and get his medications. He did not do this on the afternoon before his death.

74. Despite missing his medications that afternoon, he was observed by other prisoners to be ‘healthy’ and had managed to exercise by lifting weights with another prisoner. He was found unresponsive the next morning in his cell and was unable to be revived.

75. Mr Mitchell was not provided additional cultural support with respect to his medications and medical treatment as this was non-existent during his incarceration. However, current strategies are in the process of being introduced for an ILO or IHW to be present at TPHS. Regardless, it cannot be certain that such support would have changed Mr Mitchell's attitudes to the management of his medical conditions while incarcerated. He was entitled to make such decisions.

76. THHS is also in the process of reviewing whether the '3-day rule' can be shortened to 1 or 2 days by introducing a new dose-aid packaging system in the hope of providing a better safety mechanism for those patients missing medication parades.

77. I accept the opinion of Dr MacCormick that there were no concerns in relation to Mr Mitchell's medical care and treatment while in custody. His death was sudden and unexpected. I also accept that the strategies and other changes that are already underway or being considered by TPHS are sufficient to address the systemic issues identified by ATSILS.

Findings required by s. 45

Identity of the deceased – Vanelee Curtis Mitchell

How he died – Mr Mitchell was a First Nations man from the far northwest of Queensland. He had a history of frequent seizures following an assault that caused a head injury in 2014. He was treated in the community and in prison with anticonvulsant medication. His anticonvulsant blood levels were monitored but he occasionally missed medication rounds in prison. The anticonvulsant blood levels present at the time of death were low and had likely precipitated a seizure. His death was sudden and unexpected. There were no suspicious circumstances.

Place of death – Townsville Correctional Centre, STUART QLD 4811 AUSTRALIA

Date of death– 10 April 2020

Cause of death – Sudden unexpected death in epilepsy

Comments and recommendations

78. The *Coroners Act 2003* enables a coroner to comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

79. As noted above, the response provided by THHS identified the following strategies to embed culturally appropriate support and engagement into the delivery of prisoner and community health services:

- the THHS Health Equity Strategy; and
- Indigenous Health Liaison Officers in the TPHS; and
- improving information sharing protocols between Queensland Health and QCS.

80. ATSILS urged that I make recommendations in order to formalise those strategies and ensure that they are implemented. However, in my view given the measures already taken by THHS in response to Mr Mitchell's passing and more generally, there is no basis on which I could make any useful preventative recommendations. It is clear that THHS is committed to their implementation. I encourage them to continue to do so. Information sharing between QCS and Queensland Health has also been directly examined in a number of other inquests.[5]

81. ATSILS also submitted that I should recommend that the investigation of natural causes deaths include an investigation into the medical treatment before the death so that any deficiencies can be identified and subsequently rectified. However, the State Coroner's Guidelines[6] already provide that "*the primary investigative task in apparent 'natural cause' correctional centre deaths will relate to the medical treatment afforded to the deceased while in custody*".

82. Finally, ATSILS submitted that the reception triage program implemented by TPHS be expanded to include further exploration of illness, disease, and injuries for inmates coming from remote communities. It is clear the reception triage program offers an assessment by a reception nurse for all prisoners. Prisoners with chronic issues, and first nations prisoners aged 55-65, will be seen within 28 days. The submission from the THHS indicates that the triage program will enable a timelier response to be given to the health needs of prisoners once an assessment is undertaken.

83. I close the inquest.

Terry Ryan
State Coroner
BRISBANE

[5] For example, the Inquest into the death of Franky Houdini
[6] Chapter 7.3