Inquest into the deaths of Terrence Michael Malone and Garry Ronald Appleton

On 8 May 2019 State Coroner Terry Ryan delivered his findings into the deaths of Terrence Michael Malone and Garry Ronald Appleton. Mr Malone and Mr Appleton died in separate events from self-inflicted injuries caused by prison-issued razor blades at the Brisbane Correctional Centre. The state coroner examined the men's mental health assessment at the correctional centre and the availability of razor blades. The state coroner made identical recommendations at both inquests.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported.

The departments named in this response will provide implementation updates until the recommendation is delivered. Further information relating to the implementation of recommendations can be obtained from the responsible minister named in the response.

Recommendation 1

Queensland Corrective Services develop a policy in relation to the management of the risks associated with the provision of razor blades to prisoners within the first month of entry to prison, particularly where a prisoner has recently expressed suicidal ideation or has recently been discharged from a hospital emergency department following an emergency examination authority.

Response and action: the recommendation is agreed in part and implementation is complete.

Responsible agency: Queensland Corrective Services.

On 12 December 2019 the Minister for Police and Minister for Corrective Services responded:

Queensland Corrective Services is currently considering if and how such a policy regarding the provision of razor blades to prisoners could be managed. Factors requiring careful consideration include (but are not limited to):

- Queensland Corrective Services has implemented a process for identifying and managing prisoners identified as being an elevated risk of self-harm or suicide at any time during their custodial episode.
- Queensland Corrective Services already have a process of the removal of all property which may pose a risk inclusive of razor blades if a prisoner is under observation because of suicide ideation/self-harm.
- Assessment of the benefits or otherwise of such a requirement being imposed on a broader group of prisoners as recommended.
- Balancing the advantages and disadvantages of whether to continue with a focussed targeted approach with higher risk prisoners or develop a blanket approach with such prisoners considering the difficulties which would be associated with the management of this issue.
- The appropriateness of such a requirement being imposed on the prisoners, particularly given considerations under the Human Rights Act and also Optional Protocol to the Convention against Torture (OPCAT).

The recommendation will be considered by the Queensland Corrective Services suicide management and governance working group.

On 30 April 2020 the Minister for Police and Minister for Corrective Services responded:

Queensland Corrective Services acknowledges, in particular, that the access to razor blades whilst a prisoner is in a period of heightened risk of suicide/self-harm, or critical risk period, is an increased risk and should not be permissible.

Accordingly, Queensland Corrective Services manage their high risk areas where prisoners are accommodated during a period of critical risk of suicide or self-harm, as razor free areas. When certain situations arise and are appropriately assessed, this can include, under strict supervision, the provision of an alternative to razor blade shavers (e.g. a rechargeable Medline surgical clipper with safety blades) which ensures safety in such high risk circumstances.

An assessment is undertaken at the point of entry to custody to assess a prisoner's risk and prisoners undergo an induction during the first days in custody in each centre. This further focuses on the prisoner's transition and any presentation of risk. Additionally, Queensland Corrective Services implemented a process for identifying and managing prisoners as being an elevated base line risk of self-harm or suicide at any time or multiple times during their custodial episode.

On 17 September 2018, Queensland Corrective Services updated the *At-Risk* Custodial Operations Practice Directive (COPD), the *Safety Order* COPD and implemented the *Elevated Baseline Risk* COPD. These address the prompt identification of, and strategies to address, risk to prisoners, particularly those posing a chronic risk of suicide and/or self-harm.

The emphasis is on assessment of individual risk, needs and circumstances rather than a blanket approach being routinely imposed. Restricting a prisoner from access to sharps whilst in his/her first month in custody as a general rule is contrary to section 30(1) of the *Human Rights Act 2019* with specific reference to proportionality expressed within section 13(d). Prisoners are accommodated in general population units so as to not restrict their access and movement, and without unnecessarily restricting access to privileges. Queensland Corrective Services has balanced the prisoner's risk with proportionate access to basic rights.

Recommendation 2

Queensland Corrective Services, in partnership with Queensland Health, review its approach to suicide risk assessment and assertive responses to suicide risk in the context of best practice approaches.

Response and action: the recommendation is implemented.

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

On 11 December 2019 Minister for Police and Minister for Corrective Services and the Minister for Health and Ambulance Services responded:

Queensland Corrective Services will commence scoping a project to undertake this work in consultation with Queensland Health.

On 30 April 2020 the Deputy Premier and Minister for Health and Minister for Ambulance Services, and the Minister for Police and Minister for Corrective Services responded:

Queensland Corrective Services is currently developing a series of training products focused on suicide risk processes for a broader staffing group to build capability in safe, holistic suicide risk assessment (as a factor noted by the coroner in the findings of Mr Appleton's and Mr Malone's deaths). Queensland Corrective Services' oversight of suicide and at-risk procedures sits within the Suicide Management and Governance Working Group to ensure evidence-based and holistic approaches to procedural management in this area. This working group contributes to the broader

strategy of improved information sharing between Queensland Corrective Services and Queensland Health.

Queensland Corrective Services will invite Queensland Health representatives to participate in this working group to ensure their input in any future procedural changes and to have input into any new training and capability building strategy.

On 24 September 2020 the Deputy Premier and Minister for Health and Minister for Ambulance Services, and the Minister for Police and Minister for Corrective Services responded:

A number of training products for Queensland Corrective Services staff that promote a holistic and assertive response to suicide risk have been developed by Queensland Corrective Services with Queensland Health input.

These modules have been endorsed by the Queensland Corrective Services Suicide Prevention working group and provided to staff to trial at Arthur Gorrie Correctional Centre, the correctional centre for remanded men in South East Queensland.

Queensland Corrective Services will now gather feedback to refine these modules, engage with Queensland Health for formal endorsement and seek internal approval for inclusion within mandatory training requirements.

On 8 July 2021 the Minister for Police and Corrective Services, and Minister for Fire and Emergency Services, and the Minister for Health and Ambulance Services responded:

Queensland Corrective Services has experienced some delay in gathering feedback from staff to refine the training modules due to the COVID-19 pandemic. However, the feedback received on the modules to date has been positive and has enabled staff at Arthur Gorrie Correctional Centre to demonstrate an increased understanding of suicide risk management. The psychology team at Capricornia Correctional Centre are also in the process of completing this training.

Queensland Corrective Services are now in the process of embedding minor changes based on the feedback received, seeking internal approval for the mandatory training to roll out state-wide and seeking formal endorsement from Queensland Health.

On 31 May 2022 the Minister for Police and Corrective Services, and Minister for Fire and Emergency Services, and the Minister for Health and Ambulance Services responded:

Following the trial at Arthur Gorrie Correctional Centre and Capricornia Correctional Centre and the inclusion of feedback received, this specific training package designed for the Risk Assessment Team members and after-hours custodial supervisors has been completed. This training package was developed in consultation with Queensland Health. Psychological Services and Queensland Corrective Services Academy are preparing to formally rollout this training across correctional centres in early 2022.

An additional training package on clinical assessment is being developed. This training package will be developed for centre-based psychologists and will support specialised staff to conduct suicide and self-harm risk assessments and ensure evidence based, contemporary responses and management strategies are in place. Once this package is completed in draft, it will be provided to Queensland Health for consultation and endorsement.

On 7 July 2022 the Minister for Health and Ambulance Services and Leader of the House, and the Minister for Police and Corrective Services responded:

Queensland Corrective Services have updated the specific training package designed for the Risk Assessment Team members and after-hours Custodial Supervisors to increase understanding of suicide risk management. This training package has now been endorsed as mandatory training for

these staff members. Currently the Queensland Corrective Services Academy are working on the logistics of a state-wide roll-out, commencing early 2022.

A further training product, that will focus on clinical assessment of suicide and self-harm risk will be developed. Queensland Health will be invited to contribute to the development of the training package and provide endorsement of the package once complete.

On 23 September 2024 the Minister for Health, Mental Health and Ambulance Services and Minister for Women, and the Commissioner for Queensland Corrective Services responded:

Queensland Corrective Services, in partnership with Queensland Health, have completed a review in its approach to suicide risk assessment and assertive responses. A Memorandum of Understanding for a training partnership and training plan to enable delivery of mandatory training for QCS psychological services staff focusing on engagement, assessment, response, and support to prisoners presenting at risk of suicide has been finalised.

The training package has been developed by Queensland Centre for Mental Health Learning staff based on current research and best practice. The initial training delivery plan has been executed with training delivered to Psychological Services staff across the state.

A total of 125 staff completed the training package between November 2023 and April 2024. Training sessions for new staff will be scheduled on an as-needs basis.

Recommendation 3
These findings be provided to the Queensland Mental Health Commission and the strategic leadership group overseeing the implementation of the Mental Health, Alcohol and Other Drugs Strategic Plan with a view to informing the enhancement of responses to persons with co-occurring mental illness and substance use disorders who are at risk of entering or have entered the criminal justice system.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Health.

On 11 December 2019 the Minister for Health and Minister for Ambulance Services responded:

The Queensland mental health commissioner met with the state coroner to discuss the findings, following this the findings were tabled by the Queensland Mental Health Commission at the *Shifting minds* strategic leadership group meeting on 29 May 2019 for noting.

The *Shifting minds* strategic leadership group is a cross-agency group which consists of senior level officers from state government agencies and is responsible for the collective implementation of *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*. This strategic plan includes a priority action to expand responses to people involved in the criminal justice system through better coordination across mental health, alcohol and other drugs, justice, housing, disability, employment and psychosocial supports.

The findings will continue to be considered by the *Shifting minds* strategic leadership group through the development, implementation and evaluation of the *Shifting minds* implementation roadmap which includes this priority action. The *Queensland Mental Health Commission Act 2013* also requires the commission to report to the Minister for Health and the Minister for Ambulance Services on the implementation of the strategic plan.

Recommendation 4

The Queensland Government consider an increase in funding to enable Queensland Corrective Services (QCS) to enhance the integrated offender management system (IOMS) to support the

recommendations of the Office of the Chief Inspector to enable risk assessment information to be displayed and accessible for QCS staff within a drop down menu.

Response and action: the recommendation is agreed in part and implementation is complete.

Responsible agency: Queensland Corrective Services.

On 12 December 2019 the Minister for Police and Minister for Corrective Services responded:

Queensland Corrective Services intend to modernise the IOMS system and include this recommendation in an updated or replacement system. A business case for government consideration is due early in 2020. Until then Queensland Corrective Services is assessing short term options that may fulfil the coroner's recommendation.

On 30 April 2020 the Minister for Police and Minister for Corrective Services responded:

Following the recommendation from the coroner to enable risk assessment information to be displayed and accessible to Queensland Corrective Services staff within a drop down menu, Queensland Corrective Services has implemented procedures and processes that supersede this recommendation.

Modifications to the at-risk management process have been implemented including the introduction of the Elevated Baseline Risk (EBLR) procedure and an EBLR warning flag.

The EBLR procedure ensures prisoners with chronic or an elevated baseline risk of suicide and/or self-harm are managed in accordance with their presenting risks and needs. Prisoners can be identified as being at an elevated baseline risk at any point within a custodial period.

If a prisoner presents with an elevated risk of self-harm/and or suicide, the prisoner may be referred to a multidisciplinary team for consideration for management under the EBLR procedure. The multidisciplinary team will review the referral and determine the prisoner's suitability to be managed under the EBLR procedure.

An EBLR plan must be developed within four weeks of the prisoner being placed on EBLR and is to include identified clinical needs, risk mitigation strategies, specialised services or supports, review date/s, frequency of contact with case manager, summary of progress including any changes in risk or protective factors and reasons/rationale for exit from EBLR (if applicable).

The EBLR procedure requires that any staff member involved in the management of the prisoner be made aware of the prisoner's EBLR status, reasons for EBLR, triggers, warning signs, risks, protective factors and plan. The correctional supervisor and/or psychologist must also brief staff responsible for the supervision, case management and intervention in relation to the contents and purpose of the EBLR plan. The EBLR plan is electronically saved and attached to the Integrated Offender Management System (IOMS) in addition to being placed on the offender file. The EBLR plan is readily accessible to all staff involved in the management of the prisoner.

Upon a prisoner being identified as being at an elevated baseline risk, the EBLR warning flag within IOMS is activated. The EBLR warning flag is displayed on the IOMS home screen and alerts staff that the prisoner has been assessed to be at an elevated risk of self-harm/suicide and that further information is available in IOMS. When raising the EBLR warning flag, the staff member is to ensure that sufficient comments are recorded in the warning on IOMS to describe the EBLR information obtained.

The EBLR procedure and warning flag are considered to be of significant benefit in mitigating the risk of prisoners and facilitating identification by staff of at-risk prisoners.

Recommendation 5

The Queensland Government consider an increase in funding to enable Queensland Corrective Services to be a competitive employer to attract and retain experienced psychologists and senior psychologists within custodial settings.

Response and action: the recommendation is agreed to in part and implementation is complete.

Responsible agency: Queensland Corrective Services.

On 12 December 2019 the Minister for Police and Minister for Corrective Services responded:

Queensland Corrective Services develop a workforce strategy which will examine the role of psychologists within custodial settings.

On 30 April 2020 the Minister for Police and Minister for Corrective Services responded:

The workforce strategy is anticipated for completion by midyear however a number of components are progressing separately. In addition to reclassification of base level psychologists in 2017 to remuneration equivalent to other government employers of psychologists, the approval for the reclassification of senior psychologists currently employed in correctional centres to align their remuneration to that received in other government departments was approved by the commissioner in January 2020.

On 24 September 2020 the Minister for Police and Minister for Corrective Services responded:

Queensland Corrective Services undertook a significant recruitment process to recruit trained psychologists. In addition, an extensive review has been undertaken to reclassify a number of positions to recruit and/or retain experienced staff.

Recommendation 6

The Queensland Government consider a trial program for 'front end services' of intake, health assessment and mental health assessment at the Brisbane City Watchhouse that involves collaboration between relevant stakeholders, including Queensland Corrective Services, Queensland Health, the Queensland Police Service and the Prison Mental Health Service.

Response and action: the recommendation is implemented.

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

On 26 November 2019 the Minister for Police and Minister for Corrective Services and the Minister for Health and Minister for Ambulance Services responded:

Queensland Corrective Services, Queensland Police Service and Queensland Health will work together in considering the implementation of this recommendation.

In 2018, prior to the completion of the coroner's findings into Mr Appleton's and Mr Malone's deaths, QCS conducted a brief trial program of Queensland Corrective Services front end services at the Brisbane Watchhouse.

The findings of the trial program are still being considered by Queensland Corrective Services and will inform how Queensland Police Service, Queensland Corrective Services and Queensland Health progress implementation of this recommendation.

On 30 April 2020 the Minister for Police and Minister for Corrective Services, and the Deputy Premier and Minister for Health and Minister for Ambulance Services responded:

In February 2020, representatives from the Queensland Police Service, Queensland Corrective Services and Queensland Health met to review and discuss the trial outcomes.

All agencies will continue to collaborate to determine the next steps for this recommendation.

On 24 September 2020 the Minister for Police and Minister for Corrective Services, and the Deputy Premier and Minister for Health and Minister for Ambulance Services responded:

Queensland Police Service, Queensland Corrective Services and Queensland Health will continue to collaborate in determining the next steps forward for this recommendation. Responding to the COVID-19 pandemic has seen a delay in the progression of this recommendation.

Queensland Police Service, Queensland Corrective Services and Queensland Health will meet to consider options to best meet the intent of this recommendation.

On 8 July 2021 the Minister for Police and Corrective Services, and Minister for Fire and Emergency Services, and the Minister for Health and Ambulance Services responded:

On 23 September 2020, the Commissioner, Queensland Police Service directed an Inquiry into custody arrangements in Queensland Police Service watchhouses. Recommendation 6 was considered as part of the inquiry. A report has been provided to the commissioner for approval.

The inquiry provided a series of suggested actions which will require the establishment of a series of work packages involving a number of government agencies, including Queensland Corrective Services and Queensland Health.

The report, once approved by the commissioner, will be shared with Queensland Corrective Services and Queensland Health for discussion.

An interdepartmental committee will be established, with representatives from Queensland Corrective Services and Queensland Health, to drive continuous improvement on watchhouse custody management.

On 31 May 2022 the Minister for Police and Corrective Services, and Minister for Fire and Emergency Services, and the Minister for Health and Ambulance Services responded:

The Queensland Police Service commenced implementing recommendations from the State Custody Officer Watchhouse Inquiry. An Interdepartmental Working Group – State Custody, comprised of representatives from Queensland Corrective Services, Queensland Health and the Department of Children, Youth Justice and Multicultural Affairs, was established to enhance the human rights, health and wellbeing of persons in the Queensland custody system. The working group will examine the journey of adults and children entering the criminal justice system to minimise barriers that impact negatively on persons in custody.

The working group will progress several work packages, champion research and best practice models and implement coronial and inquiry recommendations.

On 7 July 2022 the Minister for Health and Ambulance Services and Leader of the House and the Minister for Police and Corrective Services responded:

The Queensland Police Service is continuing to implement the recommendations from the State Custody Officer Watchhouse Inquiry. Several meetings of the Interdepartmental Working Group – State Custody (IWGSC) have now occurred with representatives from the Queensland Police Service, Queensland Corrective Service, Department of Justice and Attorney General and Department of Youth Justice and Multicultural Affairs agreeing to overview several bodies of work that will provide an environment within police watchhouses that ensure the rights, dignity and welfare of those in custody is maintained to the highest possible standard.

As an interim measure, the Queensland Health (Clinical Forensic Medicine Unit) have assisted QPS by providing regular nursing support to the Brisbane Watchhouse, whilst also providing remote support to several other watchhouses around the state.

Furthermore, those persons in custody at the Brisbane Watchhouse will continue to have access to the Mental Health Court Liaison Service. This is an existing service that assists in identifying risks and clinical needs of prisoners daily.

The Queensland Police Service (State Custody Group) will continue to develop and implement initiatives directed at improving and maintaining the welfare of persons whilst they are in QPS custody. The IWGSC have supported a new initiative that will holistically look at the physical and psychological welfare of persons in custody.

On 23 September 2024 the Minister for Police and Community Safety, Minister for Health, Mental Health and Ambulance Services and Minister for Women, and the Commissioner for Queensland Corrective Services responded:

The Queensland Police Service, Queensland Health and Queensland Corrective Services have collectively given consideration to a trial of front end services at the Brisbane Watchhouse. Since the findings were handed down in 2019, all three agencies have, and will continue to, collaborate to deliver multiple bodies of work in support of this recommendation, including:

- delivering an Inquiry into custody arrangements in QPS watchhouses
- establishing an Interdepartmental Working Group – State Custody comprising representatives from Queensland Corrective Services, Queensland Health and the Department of Youth Justice to enhance the human rights, health and wellbeing of persons in the Queensland custody system
- since March 2023, a direct referral pathway to the Metro North Virtual Emergency Department (VED) for persons requiring an escalation of their medical care in the Brisbane, Townsville and Maroochydore Watchhouses has been developed and implemented, with QPS remaining responsible for general medical care within watchhouses as per usual practice. This only applies to nursing staff and QPS officers across the state that have access to the Queensland Ambulance Service (QAS)/VED process. For all other Queensland watchhouses, as well as after 1530 hrs when there is no nursing service available in the Brisbane City Watchhouse, QPS personnel can contact the QAS Clinical Hub (the Hub) for assistance. The Hub provides an adaptive model of service that ensures a timely, appropriate, and patient-centric ambulance response occurs. Staffed by a multi-disciplinary team consisting of senior paramedics, mental health clinicians and medical officers, the clinical hub coordinates the entry of the patient into the broader healthcare system after a Triple Zero (000) call is received.

In June 2024, representatives from all three agencies met to discuss the next steps for this recommendation and agreed to establish a tri-agency working group to continue to review and improve front end services at watchhouses.

Implementation of this recommendation is directly linked to, and continues to be actioned and reported on under recommendations 105 and 106 of Women's Safety and Justice Taskforce Report Two. Future implementation updates will be published in the Women's Safety and Justice Taskforce Annual Reports, published on the Department of Justice and Attorney-General's website.