The Queensland Government's response to coronial recommendations 2008

Published August 2009

Hon Cameron Dick MP
Member for Greenslopes

Queensland Government

Attorney-General
and Minister for Industrial Relations

Dear Premier

In accordance with Cabinet's request, I present to you a whole-of-government report detailing responses prepared by the various Queensland Government departments responsible for considering and/or implementing coronial recommendations which were directed to the government in 2008.

Yours faithfully

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and Minister for Industrial Relations

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The Queensland Government's response to coronial recommendations 2008

Includes the Queensland Government's response to coronial recommendations handed down between 1 January 2008 and 31 December 2008.

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Inquest into the death of Alan Thomas Wigg

Mr Wigg died on 3 December 2004 whilst employed as a farm worker. The elevated working platform from which he was working failed and he was ejected from the platform and sustained fatal crush injuries due to the forward movement of the machine.

Coroner Brassington handed down findings on 16 January 2008.

Recommendation 1

Workplace Health and Safety facilitate the development and usage of a harness in banana bagging machines in Queensland.

Response and action

Agreed in part and partially completed

Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland already recommends and enforces harnesses be worn during the operation of all elevating work platforms used in horticulture where there is a risk of injury to a worker from impacting the ground after the failure of the basket levelling system.

The Rural Industry Action Plan 2008–2010 is the second phase of implementing the Queensland Workplace Health and Safety Strategy 2004–2012. This plan identifies Workplace Health and Safety Queensland's key areas of focus for the rural industry from 2008–2010. The initiatives outlined in this plan aim to reduce work-related injuries and fatalities in the rural industry.

Two initiatives from the Rural Industry Action Plan address the coroner's Recommendations.

1. A safer system of field work (supported by audits) will be developed, piloted and trialled in five horticultural industries in the fruit growing sector, to reduce the high injury numbers associated with farm vehicles including elevating work platforms.

   This will be achieved by:

   - promoting and implementing horticultural field pilots and trials in the banana sector
   - disseminating information and education about compliance outcomes for safer systems of field work through Farmsafe Queensland and/or other industry associations and grower groups.

2. A safety improvement program for manufacture and supply issues of high risk plant will be introduced to reduce injuries relating to high risk plant, and improve Queensland's rural industry compliance with national standards. The high risk plant will include elevating work platforms. High risk plant safety improvements will be achieved by:

   - implementing manufacturer and supplier audits
   - undertaking compliance inspections of plant design at agricultural field days
   - contacting importers, suppliers or manufacturers to rectify non-compliance.

The audits, inspections, and follow up contact with importers, suppliers and manufacturers, have commenced and will continue until September 2010.

Recommendation 2

There is an urgent need for inspection of current machinery or an alert issued to ensure all banana bagging machines are checked by a competent person and modifications, particularly to the joints securing of the working platform, checked.

Response and action

Agreed and completed

Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland's Code of Practice for Rural Plant (2004) outlines the requirements for the inspection and maintenance of all farm machinery.

Following the incident in 2004, Workplace Health and Safety Queensland conducted safety audits on rural mobile plant in 2004 and 2005. Banana bagging machines were specifically targeted in these audits. Based on the findings of the audits, Workplace Health and Safety Queensland conducted a series of information seminars in 2005 to provide information on safe design to manufacturers, suppliers and maintainers of this type of equipment.

In consultation with the industry, Workplace Health and Safety Queensland has produced three factsheets to support the new design registration process. Factsheets cover the requirements for:

- maintenance, inspection and repair of banana and orchard industry elevating work platforms
- design registration of banana and orchard industry elevating work platforms
- safe operation of banana and orchard industry elevating work platforms.

The factsheets are available on the department's website www.justice.qld.gov.au.

Recommendation 4

Workplace Health and Safety consider the development of a system to include systematic, regular inspection of high risk farm machinery to ensure compliance with the Australian Standards.

Response and action

Agreed and completed

Responsible agency: Department of Justice and Attorney-General

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Workplace Health and Safety Queensland has produced with industry three factsheets to support the new design registration process. These factsheets cover the requirements for:

- Maintenance, inspection and repair of banana and orchard industry elevating work platforms;
- Design registration of banana and orchard industry elevating work platforms; and
- Safe operation of banana and orchard industry elevating work platforms.

These factsheets are in the process of being published and will be available on the Department's website by the end of July 2009.

Recommendation 5

Workplace Health and Safety consider an alert noting both the security and integrity of levelling rods for elevating work platform is most critical to the safety of the operator and they should be designed and maintained in a professional manner.

Response and action

Agreed in part and completed

Responsible agency: Department of Justice and Attorney-General

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- Design registration of banana and orchard industry elevating work platforms; and
- Safe operation of banana and orchard industry elevating work platforms.

These factsheets are in the process of being published and will be available on the Department's website by the end of July 2009.

Recommendation 6

Workplace Health and safety ensure that investigators have access to, and coroners are routinely supplied with, information as to the statistical frequency of similar incidents to those being investigated.

Response and action

Agreed and completed

Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland obtains incident information from workers' compensation data and incidents required to be reported to it under the *Workplace Health and Safety Regulation 2008*. Any such relevant information is made available to investigators and will be made available to coroners. Investigation reports are also being amended to require assessment of the remoteness of the issue being investigated to assist with the identification of appropriate responses to investigation findings.

Recommendation 7

Workplace Health and Safety investigators adopt a similar process to the Queensland Police Service whereby an application is made to the coroner for an indication that an exhibit is not longer required before returning the exhibit.

Response and action

Agreed and completed

Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland inspector training manuals and procedures have been amended to ensure that where an investigation relates to a fatality, the inspector must apply to the coroner for an indication of whether the property is no longer required.

Inquest into the death of Janet Louise Young

Mrs Young died from multiple injuries as a result of a traffic accident in 10 May 2006. A semi-trailer, loaded with bricks, rolled over as it turned through a 90 degree bend in the road and collided with Ms Young's vehicle.

Coroner Lock handed down findings on 23 January 2008.

Recommendation 1

Queensland Transport incorporates information about driver responsibility for loads generally; and the risks of rollover at low speed for high centre of mass loads in any information and training it provides in relation to the new 'Chain of Responsibility' concepts to be introduced through legislation this year.

The Machinery of Government administrative arrangements in March 2009 saw Queensland Transport transition to the Department of Transport and Main Roads.

Response and action

Agreed in part and completed with ongoing implications

Responsible agency: Department of Transport and Main Roads

The Department of Transport and Main Roads has undertaken two rounds of industry education in relation to the introduction of new mass laws and the impact of the Chain of Responsibility in March and August 2008. In addition, the Department of Transport and Main Roads produced and distributed 2,500 information kits on the new mass laws, which included the requirements for drivers to ensure that loads are secured and not shifting.

The Department of Transport and Main Roads will participate in forums and conferences on mass requirements. For example, Port of Brisbane Chain of Responsibility Forum.

Recommendation 2

Queensland Transport investigates the Electronic Stability Program systems and if it is regarded as suitable and viable take up with the industry and the National Transport Commission its more widespread use.

The Machinery of Government administrative arrangements in March 2009 saw Queensland Transport transition to the Department of Transport and Main Roads.

Response and action

Agreed in part and implementation is under consideration

Responsible agency: Department of Transport and Main Roads

To date, the technology involved in electronic stability control of heavy vehicle loads is still in the developmental phase. The Department of Transport and Main Roads is monitoring the development of this technology.

Recommendation 4

The Department of Main Roads issues a directive to relevant staff to review the Webcrash database to identify locations where there has been a 'cluster' of accidents and then assess those locations (when they are within the Department of Main Roads jurisdiction) for possible safety improvements.

The Machinery of Government administrative arrangements in March 2009 saw the Department of Min Roads transition to the Department of Transport and Main Roads.

Response and action

Agreed and completed

Responsible agency: Department of Transport and Main Roads

The former Department of Main Roads issued a directive to relevant staff to review the Webcrash database in accordance with this Recommendation. Districts were requested to conduct safety audits of those crash locations involving two or more truck roll overs between 1979 and 2006. The assessment resulted in safety improvements either being implemented or considered for programming.

Coronial investigation into the death of Adam Wade Foks

On 25 January 2006, Mr Foks was seen to collapse after alighting from a bus and was unable to be resuscitated. Mr Foks had a history of asthma since childhood: his ventolin inhaler was found nearby, he was taking medication and had previously been hospitalised

Coroner Halsted handed down findings on 7 March 2008.

Recommendation 1

Staffing levels at emergency service communication centres be immediately reviewed with an emphasis on ensuring there are sufficient numbers of appropriately trained staff to accept ooo calls. There should be sufficient staff to accept ooo calls so that, if required by the situation, a staff member should be able to maintain telephone contact with a caller without having to field other ooo calls.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Department of Community Safety

The Queensland Ambulance Service has undertaken a comprehensive review of workload and staffing requirements for communication centres over the past three years which has delivered increased staffing numbers across the state. The staff establishment has increased from 74.5 to 99.5 in December 2008 for the Brisbane Region Communications Centre (AFcom). AFcom also undertook a roster review to better match the available human resources to service delivery requirements in May 2008. These changes involved moving from 10 hour rosters to a new 12 hour format. These changes have increased the availability of triple zero call takers. The process of reviewing demands for service and performance in meeting this demand is ongoing and part of normal workforce management in the Queensland Ambulance Service.

Recommendation 2

An investigation should be conducted into the current state of the sophistication of computer software to see whether it is feasible for a caller's responses to specific questions posed by a communications officer can be directly accepted by the computer system, as opposed to having to be input by a human operator, and thus minimise the potential for human error or bias.

Response and action

Not agreed and not being implemented

Responsible agency: Department of Community Safety

The Queensland Ambulance Service introduced the new state-of-the-art computer aided dispatch system (VisiCAD) in 2008. The Department of Community Safety is unaware of any use of the type of system described for computer aided dispatch of emergency response vehicles by any other emergency services organisation. The complexity and diversity of the emergency calls made to a triple zero communications facility means that these emergency calls are best handled by highly trained personnel. The successful replacement of these personnel with an automated voice activated system would be unlikely.

Recommendation 3

The procedures to be undertaken where the computer system does not accept a nominated address for an incident should be reviewed. The review should focus on back up manual procedures, including the potential supply to each officer at each communication office the most recently published street and locality directory regardless of publisher.

Response and action

Agreed and completed

Responsible agency: Department of Community Safety

In preparation for the introduction of VisiCAD (the new computer aided dispatch program implemented during 2008) all Queensland Ambulance Service standard operating procedures (SOPs) were reviewed for currency and relevancy. Specifically SOP024 Difficulties Locating an Address has been updated to deal with situations where there is some degree of difficulty in determining the address of an incident. Maps such as street directories, regional maps, local shire maps and developers' maps are made available to communications centre staff in all centres.

Recommendation 4

The process of 'clearing' and 'freeing' of incidents or jobs to be urgently reviewed. Consideration should be given to a procedure that would see a job 'cleared' or noted as completed or finished only by a specific order at a specific location, and only then after specific benchmarks had been reached. The process of 'freeing' a job or releasing a particular ambulance crew from any other further involvement in an incident should be undertaken by an officer at a designated level within each communication centre. Consideration should be given to allowing only the office that has initiated a job to 'free' that job.

Response and action

Agreed and completed

Responsible agency: Department of Community Safety

Cases are freed/cleared for many reasons and there are multiple reasons for freeing/clearing units from a specific case including the case being cancelled, other responding units having already arrived, the case being found to be less severe than originally reported and therefore additional units are no longer required. The emergency medical dispatcher in the communications room is the only person with the authority to free/clear a responding unit. If an emergency medical dispatcher in a different region wishes to free/clear a responding unit from the first region he/she is required to call the communications centre supervisor to discuss the matter and determine appropriate action.

Recommendation 5

If not already part of the screen that a computer operator views, once a job is received, and a level of priority is set by the system, a timing mechanism should be visible to an operator that should prompt the operator to confirm that specified procedures have been undertaken. Or prompt the operator to undertake procedures relevant to the particular incident having regard to the level of emergency.

Response and action

Agreed and completed

Responsible agency: Department of Community Safety

VisiCAD (the new computer aided dispatch program implemented during 2008) provides a visible and audible timing prompt for all urgent and potentially urgent incidents (Code 2A and above). This mechanism prompts the emergency medical dispatcher to confirm that required procedures have been undertaken or, if not taken, to undertake such procedures.

Recommendation 6

Consideration should be given to the annual re-testing of communication operators to ensure that they remain aware of approved emergency procedures.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Department of Community Safety

All Queensland Ambulance Service communications staff across Queensland are required to undertake specific vocational education and to maintain certificates of currency of practice, which incorporates annual validation of skills.

Recommendation 7

The supplier of geographical information for the computer aided dispatch system be approached to see whether it is both economically and technically feasible for uploads of information into the relevant communications systems to occur an a monthly basis as opposed to a quarterly basis.

Response and action

Agreed and completed

Responsible agency: Department of Community Safety

Department of Community Safety has confirmed with the supplier of geographical information for the computer aided dispatch system that the supplier only provides updates to this information on a quarterly basis.

Recommendation 8

The Department of Emergency Services approach the Department of Local Government, Planning, Sport and Recreation with a view to establishing a working party concerning the timelier gathering of accurate street and road addresses.

The working party might consider such initiatives as:

- local authorities making it a condition of granting a sub development permit that the details of all new road works be provided to a local authority within 14 days of completion
- officers of local authorities be required to certify that a developer has complied with a requirement to identify all new road works within a subdivision
- that it be an offence under local laws for failing to provide details of all new road works within14 days of completion
- local authorities be required to carry out an independent annual audit of all streets and roads within their shire. Such audit may take the form of the local authority being required to adequately identify all streets and roads appearing on satellite images and to ensure that annual street and road audits are carried out by local authorities, consideration be given to withholding some government funding until the audit is completed.

The Machinery of Government administrative arrangements in March 2009 saw the Department of Emergency Services transition to the Department of Community Safety and the area of Local Government transition from the Department of Local Government, Sport and Recreation to the Department of Infrastructure and Planning.

Response and action

Agreed and partially completed

Responsible agency: Department Infrastructure and Planning

In response to this incident, the then Premier established the Addressing Taskforce in May 2006, chaired by the then Department of Local Government, Planning, Sport and Recreation.

The Addressing Taskforce was formed in response to public safety risks primarily associated with private roads in gated communities. The then Premier announced the formation of this taskforce following the incident. The Taskforce was expanded to include wider issues with addressing practices in Queensland.

The Recommendations of the Taskforce are consistent with the coroner's Recommendations.

The outcome of the work of the Taskforce resulted in legislative proposals to improve the addressing system. It was proposed to change the *Local Government Act 1993* to provide local governments with a head of power to approve naming and numbering of private roads.

The then Minister for Main Roads and Local Government agreed to the Recommendations of the Addressing Taskforce and to implement the proposed legislative amendments relevant to the *Local Government Act 1993*. The *Local Government Act 1993* provides for local governments to keep an up-to-date register of all roads in their area.

On 22 April 2009 the then Minister for Infrastructure and Planning introduced the *Local Government Bill 2009* into Parliament. The Bill contains provisions which address the coroner's Recommendations relevant to the local government portfolio. Once the Bill is debated and passed, the Recommendation will be complete and will, in fact, exceed the Recommendations made by the coroner in relation to improving the accuracy of capturing street and road addresses.

Regarding the coroner's suggestion about auditing all streets and roads within a local government area, the *Local Government Act 1993* already requires local governments to prepare and keep up-to-date maps and registers of roads in their areas.

The Department of Infrastructure and Planning is progressing Recommendations from the Taskforce to amend the *Sanctuary Cove Act 1985*, *Integrated Resort Development Act 1987*, *Mixed Use Development Act 1993*. Amendments to these Acts were introduced into Parliament on 19 May 2009 as part of the *Resorts and Other Legislation Amendment Bill 2009*. The proposed amendments will require address plans to be lodged with the relevant local government for new developments. It is anticipated that this Bill will be debated in the first half of 2009. This partially supports the intent of the recommended working group.

The then Department of Infrastructure and Planning wrote to the then Department of Local Government, Sport and Recreation to advise that it has not progressed the address plan amendment to the *Integrated Planning Act 1997*, citing that it may be more appropriate for the amendment to be made in the *Land Act 1994*. However, the Addressing Taskforce met on 20 February 2009 and identified a possible alternative administrative solution which would involve amending development application forms to require address plans be submitted as part of an application. The Department of Infrastructure and Planning is considering this alternative solution.

The Department of Infrastructure and Planning will investigate this amendment as a matter of urgency with the Department of Environment and Resource Management.

Response and action

Not applicable to the Department of Community Safety and not being implemented.

This Recommendation relates to matters within the portfolio of the Department of Infrastructure and Planning therefore the Department of Community Safety is unable to progress the implementation of this Recommendation.

Recommendation 9

If necessary, legislation be passed to allow local authority officers to enter on to private land to undertake an audit of compliance with the conditions of a sub-development permit or to complete the compulsory annual street and road audit.

Response and action

Agreed and partially completed
Responsible agency: Department of Infrastructure and Planning

The then Minister for Main Roads and Local Government agreed to the Recommendations of the Addressing Taskforce.

This Recommendation is being addressed through Clause 132 of the *Local Government Bill 2009*, which provides for authorised persons to enter private land to inspect the property in order to process an application made under any Local Government Act.

The Recommendations made by the Addressing Taskforce that are relevant to the *Local Government Act 1993* have been included in the Bill which was introduced to Parliament on 22 April 2009.

Parliament will debate the proposed legislation with a view to pass the new provisions during the first half of 2009.

Inquest into the death of Dion Waite, Mieng Huynh, James Jacobs and James Gear

Between October 2003 and February 2006, officers of the Queensland Police Service acting in the course of their duty, shot and killed four men in separate incidents in South East Queensland. Each of them was a long term sufferer of mental illness and was experiencing serious symptoms of that illness at the time they were killed. Their mental illness caused them to come into contact with the police and directly led to their death.

State Coroner Barnes handed down findings on 17 March 2008.

Recommendation 1

The Director of Mental Health develop standardised processes and assessment tools that do not seek to replace clinical judgment but which do introduce more objectivity into mental health assessments and which address the tendency of mental health workers to give insufficient weight to relevant information other than that gathered from the patient during the assessment.

Response and action

Agreed and completed

Responsible agency: Queensland Health

A suite of standardised clinical documentation which includes a range of assessment and treatment tools for adult Mental Health Services has been developed, piloted and evaluated in eight Mental Health Services. The documentation was endorsed by the Steering Committee for Achieving Balance: Implementation of the Report of the Queensland Review of Fatal Mental Health Sentinel Events in April 2008. Implementation of this suite of documentation complements clinical judgement, supports clinicians to demonstrate evidence-based practice and promotes clinical process review at the service level.

The statewide rollout of this suite of clinical documentation commenced on 12 May 2008. A user guide and training participant's handbook has been developed as part of the suite of documents which, as part of the statewide rollout, formed the basis of a training program in 2008. A statewide forum for Older Persons Mental Health Services was held on 13 May 2008 to consult with stakeholders regarding the suite of clinical documentation and its application to older persons. The forum was attended by 60 health professionals.

In addition, the Department of Mental Health is committed to implementing targeted training to improve clinician processes when making mental health assessments. Similar standardisation activity regarding clinical processes and supporting documentation is underway for Child and Youth Mental Health Services and for Older Persons Mental Health Services.

A draft suite of standardised clinical documentation was developed for Child and Youth Mental Health Services after eight sites participated in a four week trial of the documents. Following feedback from the trial, a final suite of documentation was completed with statewide training and endorsed by the Achieving Balance Steering Committee in 2008.

Training material to support the new documentation will be developed and made available to Child and Youth Mental Health Services statewide. The feedback provided from the statewide forum for Older Persons Mental Health Services that was held on 13 May 2008, was analysed and will be used to develop a draft suite of forms, a proposal for statewide training and to select future pilot sites to trial the documents.

Recommendation 2

Mental health practitioners be required to complete and retain the standardised documentation used to undertake mental health assessments and that compliance with these processes be audited as a quality measure.

Response and action

Agreed and completed

Responsible agency: Queensland Health

All clinical documentation is retained and becomes part of the patient's clinical record. A chart audit tool is included in the standardised suite of clinical documentation discussed in the response to Recommendation one. Chart audits were conducted at three and six months of the pilot program for the adult suite of clinical documentation and were used as a component of the evaluation methodology.

The chart audit tool will be available to services for the measurement of compliance with use of the suite of clinical documentation. Chart audits are recommended to be conducted at three and six month intervals as a continuous quality improvement mechanism.

Recommendation 3

The processes include mechanisms for supervision or overview so that whenever someone other than a psychiatrist decides:

- not to order a psychiatric assessment following an examination pursuant to a Justices Examination Order
- not to admit as an inpatient following an examination pursuant to an Emergency Assessment Order
- to discharge a patient previously assessed as suffering from mental illness warranting involuntary treatment; that decision be reviewed by a psychiatrist as soon as possible.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

The Mental Health Act Resource Guide (the Resource Guide), updated in April 2008, clearly outlines clinicians' responsibilities pertaining to the various orders under the *Mental Health Act 2000 (the Act)*.

Examinations pursuant to a Justices Examination Order commonly occur in the person's home and can be undertaken by a doctor or authorised mental health practitioner. There are processes in place to ensure that decisions made and actions taken are reviewed by clinical peers.

The Resource Guide (chapter three) clearly states that if a Recommendation for assessment is not made, the doctor or authorised mental health practitioner must provide reasons on the back of the Justices Examination Order form. At a minimum, the doctor or practitioner should document:

- the reasons the examination did not result in the making of assessment documents
- the management plan, in particular, referral or follow up plans made for the person
- consultation with senior staff where this has occurred
- results of communication with the applicant where this communication is appropriate;
- if the examination was not conducted, the doctor or practitioner should document appropriate details (e.g. if the person could not be located, action taken to locate the person in the seven day period).

With regard to Emergency Examination Orders, the Resource Guide clearly outlines the responsibility of doctors or authorised mental health practitioners. Where a doctor or practitioner considers that the criteria for assessment are not met, they must discuss the assessment with an authorised psychiatrist prior to making a final determination on the matter. In rural or remote services where an authorised psychiatrist is not available, advice may be sought from a senior registrar in psychiatry or a senior medical officer who is an authorised doctor.

If it is determined that a Recommendation for assessment should not be made, at a minimum, the doctor or practitioner should document (in the relevant section of the Emergency Examination Orders form):

- the reasons the examination did not result in the making of assessment documents (i.e. with reference to the assessment criteria)
- the management plan, in particular, referral or follow arrangements made for the person
- consultation undertaken with the consultant psychiatrist (or authorised doctor).

The doctor or practitioner should also document this information in the person's clinical file.

It should also be noted that a copy of the Emergency Examination Orders and Justices Examination Order is forwarded to the Department of Mental Health by the administrator of the authorised mental health service. The purpose of notification to the Department of Mental Health is to provide a layer of oversight where detention and examination under an Emergency Examination Orders and Justices Examination Order does not result in involuntary assessment. In order for the Director of Mental Health to be satisfied that the provisions have been appropriately applied, a full explanation of the results of the examination (detailed above) must be provided by the doctor or practitioner on the back of the relevant form.

Regarding the third element of this Recommendation (to discharge a patient previously assessed as suffering from mental illness warranting involuntary treatment), all involuntary patients are under the care of an authorised psychiatrist (part of the treating team) within an authorised Mental Health Service. Therefore, any decisions made by doctors who are not psychiatrists are made in consultation with the relevant authorised psychiatrist.

The Resource Guide (chapter four) states that an authorised doctor must revoke an involuntary treatment order if the doctor is satisfied that the involuntary treatment criteria no longer apply to the patient. A revocation of involuntary treatment order form must be completed, outlining how the treatment criteria no longer apply. If the authorised doctor is not a psychiatrist, consultation with a psychiatrist should occur before the order is revoked.

The Mental Health Branch will explore the practicality of making a policy change which will ensure that all Justices Examination Orders that do not result in a Recommendation for assessment are reviewed by an authorised psychiatrist as soon as possible. This matter will be referred to the statewide Mental Health Network for consideration. The Mental Health Branch is in the process of recruiting for two full time positions which will be responsible for monitoring and auditing services' compliance with the requirements of the Act in relation to Emergency Examination Orders and Justices Examination Order as well as other Department of Mental Health issued policies.

Recommendation 4

Consideration be given to removing the risk of imminent harm criterion from the 'treatment criteria' contained in the Mental Health Act so that an involuntary treatment order can be made whenever a person has a mental illness that requires immediate treatment and the illness has deprived the person of the capacity to consent to the treatment or the person has unreasonably refused treatment.

Response and action

Agreed in part and partially completed

Responsible agency: Queensland Health

This Recommendation is supported in principle. Queensland Health agrees that the criteria for involuntary treatment should not focus solely on imminent risk of harm and has developed policy, guidelines and training (rolled out in 2008) for clinicians on applying treatment criteria which places greater attention on requirements for immediate treatment and whether the person has the capacity to consent to treatment or has unreasonably refused treatment. With reference to the coroner's Recommendation that consideration be given to removing the risk of imminent harm criterion from the treatment criteria contained in the *Mental Health Act*, it is noted that the criterion of imminent risk of harm for making an involuntary treatment order is consistent with the United Nations Principles for the Protection of Rights of People with Mental Illness and for the Improvement of Mental Health Care and the Report to the Australian Health Ministers' Advisory Council National Working Group on Mental Health Policy on Model Mental Health Legislation, 1994.

In a letter to the then Acting Director-General, Queensland Health, dated 30 May 2008, the coroner refers to the lack of reliable base for assessing imminent risk. Queensland Health acknowledges and agrees that imminent risk is difficult to establish, assess and quantify. In this regard the suite of standardised clinical documentation mentioned in the response to Recommendation one and rolled out in 2008, this includes comprehensive assessment tools which prompt clinicians to thoroughly consider and document risk screening. The Consumer Assessment form includes a section on assessment of risk of suicide/self harm and violence. This part of the form lists the dynamic and static factors which clinicians must consider in order to accurately assess the level of risk. Interpretation of assessment and treatment criteria has been raised as an issue of concern in a number of instances which raises the need to develop greater understanding by clinicians in interpreting the full provisions of assessment and treatment criteria in the legislation.

Queensland Health is committed to providing the required training to ensure that all mental health clinicians have an adequate understanding of the Act and its application. Currently, all authorised mental health practitioners approved under the Act must complete the *Mental Health Act 2000* Online Training. The online learning modules provide in-depth education on the application of various provisions of the Act. One of the modules is titled *Involuntary Assessment and Treatment* and deals specifically with the Act's provisions and processes relating to involuntary assessment and treatment. The Queensland Centre for Mental Health Learning has also been involved in providing ongoing training on conducting mental state examinations and suicide risk assessment and management.

Queensland Health agrees to develop policy and education for clinicians which places greater focus on the consequences of their illness. Queensland Health will also explore the possibility of addressing this concern through processes for monitoring compliance. Queensland Health undertakes to research other relevant legislation, the literature and consult with stakeholders for the purposes of reviewing the provisions of the Act in relation to involuntary treatment and considering any legislative amendments that may be required. The need for further training and educational requirements on the interpretation of the Act and in particular section 14 of the Act (criteria for involuntary treatment) will be explored.

Recommendation 5

As a matter of priority and on a regular and continuing basis, the Director of Mental Health cause to be undertaken an evaluation of the impact of policies designed to more effectively respond to the needs of Community Mental Health Service patients with a dual diagnosis. This evaluation should clearly demonstrate whether the alcohol and drug abuse problem of Community Mental Health Service consumers is being appropriately managed.

Response and action

Agreed in part and partially completed

Responsible agency: Queensland Health

Queensland Health is nearing finalisation of the policy: *Service Delivery for People with Dual Diagnosis* (co-occurring mental health and alcohol and other drug problems). This policy articulates the following principles (among others) in relation to the coroner's Recommendations:

Principle 1: Effective collaborative partnerships between mental health and alcohol and other drug services, and with professionals in primary care, social services, housing, criminal justice, education and related fields are required to meet the complex needs of people with dual diagnosis and to sustain recovery. This includes service providers across the government, non-government and private sectors.

Principle 2: Individuals with dual diagnosis are the expectation not the exception in our health care system.

Principle 3: An integrated care approach that ensures continuity and quality between mental health and alcohol and other drug services, and across other service sectors, is used in the provision of treatment for individuals with a dual diagnosis;

Principle 4: A 'no wrong door' approach is used that provides people with, or links them to, appropriate services regardless of where they enter the system of care. Services must be accessible from multiple points of entry and be perceived as caring and accepting by the consumer. This principle commits all services to respond to the individual's stated and assessed needs through either direct service or linkage to appropriate programs, as opposed to sending a person from one agency to another; and Principle 5: within the treatment context, both mental health and alcohol and other drug problems are considered primary. This policy has been endorsed by the DMH, the Senior Director of Alcohol, Tobacco and Other Drug Services and the Statewide Mental Health Network.

The Queensland Health Mental Health Branch is currently reviewing relevant district structures and processes and progress towards a district plan to strengthen coordination and collaboration between Mental Health Services and Alcohol, Tobacco and Other Drug Services, with a focus on improving consumer access to comprehensive, coordinated care. The two statewide Dual Diagnosis Principal Project Officers will be undertaking a post-implementation survey of all District Mental Health Services and Alcohol, Tobacco and Other Drug Services to identify service processes and structures to respond to the needs of people with a dual diagnosis in the second half of 2008. This will occur approximately 18 months after the service mapping exercise undertaken in March-April 2007. A comparison of data regarding the implementation of processes and structures to improve service provision will be undertaken to ascertain district progress towards improving service provision for this client group. The Rotary Research Fund, Queensland Health and Queensland University of Technology partnership Dual Diagnosis Research project is currently underway.

The purpose of the project is to evaluate strategies to promote the dissemination of programs for people with serious mental disorders and co-morbid substance use disorders.

All Dual Diagnosis Coordinators (approximately 20) working in both Mental Health Services and Alcohol, Tobacco and Other Drug Services across the state meet on a quarterly basis with colleagues in the non-government sector. Meetings include voluntary regular reports by participants against district progress towards structural and process integration between Mental Health Services and Alcohol, Tobacco and Other Drug Services. Meetings also provide an opportunity to discuss district dual diagnosis initiatives, district progress toward integration, training and education strategies, engagement with the non-government sector and progress toward mandatory alcohol and drug screening of all clients implemented through the statewide standardisation of mental health assessment forms. A pilot intervention has commenced in six sites across Queensland

to increase integration between Mental Health Services and Alcohol, Tobacco and Other Drug Services..The model adopted will guide improved integration between Mental Health Services and Alcohol, Tobacco and Other Drug Services. It will also assist in directing policy and protocol development of the pilot sites. Mental Health Services and Alcohol, Tobacco and Other Drug Services staff will receive training as to their role in the pilot intervention.

This research project is exploring the effectiveness of the Dual Diagnosis Coordinator in supporting district clinicians to provide screening, assessment, treatment planning and interventions to this client group. An evaluation of the adopted integrated treatment model within Mental Health Services will report on district progress toward improving clinical practice outcomes. The completion date for this project is September 2009. An evaluation of progress toward increased integration across mental health and alcohol and other drug services in pilot sites will ascertain progress towards the implementation of the requirements specified by the forthcoming dual diagnosis policy, development of district protocols, partnership agreements, inter-service steering committees and local collaboration strategies. Self reported survey data will be evaluated and presented along with the collation of formal structural and process outcomes achieved during this intervention.

The Statewide Mental Health Network will establish a dual diagnosis subgroup within the next three months which will oversee and advise the ongoing development of dual diagnosis service models in Queensland. This subgroup will have a role in regular evaluation of the impact of policies designed to more effectively respond to the needs of consumers with a dual diagnosis.

Recommendation 6

As a matter of priority and on a regular and continuing basis, the Director of Mental Health cause to be undertaken an evaluation of the impact of policies designed to more effectively link prisoners suffering from mental illness with Community Mental Health Service after their release from prison.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

The inquest findings outline recent enhancements to the Prison Mental Health Service. The current process of release planning for people requiring Community Mental Health Services care usually involves the treating psychiatrist and clinical co-ordinator (there are two Prison Mental Health Service clinical co-ordinator positions funded in Southern and Central areas with a third to be allocated in July 2008) collaborating to liaise with the relevant Department of Mental Health Services and establish suitable mental health care follow up arrangements. The network of District Forensic Liaison Officers and at times the Community Forensic Outreach Service may also collaborate in this process.

Recent additional funding has enabled the establishment of the Transitional Care Co-ordination Program, now in the early stages of implementation, with seven transitional coordinator positions to cover the southern and central areas. The program provides intense mental health services for people with severe mental illness and collaborates with specifically funded non-government organisation services at the time of a person's transition back to the community. The program helps to establish continuity of care with Department of Mental Health Services.

The Department of Mental Health will undertake an evaluation and review of the mechanisms, needs, challenges and current processes by which people with mental illness open to the Prison Mental Health Service are linked to the Department of Mental Health Services following release. It should also be noted that a variety of factors influence this process. Factors include:

- the large number of people open to this service; the heterogenous nature of the clients varying from those with a major mental illness on involuntary treatment orders, to those who could be adequately managed in the primary care setting
- the voluntary nature of individuals' involvement in participation in the referral process (where concerns arise regarding the safety of the person or others as a result of mental illness, the involuntary assessment provisions of the Act may be invoked, but only in an authorised mental health service, not in custody)
- the frequent lack of certainty about accommodation that is critical to establishing the appropriate Department of Mental Health Services for referral.

Recommendation 7

The Director of Mental Health engage the toxicologists at Queensland Forensic and Scientific Services to develop blood and urine tests for the drugs commonly prescribed for the management of schizophrenia.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

The Queensland Health Mental Health Branch and Queensland Forensic and Scientific Services staff have commenced discussions to progress this Recommendation. Queensland Forensic and Scientific Services has the technology to conduct blood assays for psychotropic medications commonly prescribed for the management of schizophrenia, consistent with the trials being conducted in Europe (by Pierre Baumann and others). There is substantial evidence to support the use of this emerging technology in relation to several medications commonly used for the management of schizophrenia. The technology can be used for both for the purposes of therapeutic drug monitoring and measuring medication compliance.

Queensland Forensic and Scientific Services has advised that it can provide blood assays of antipsychotic medications correlated with dosage, with a reasonable degree of accuracy for the purposes of assessing medication compliance. Blood analysis is more reliable than urine analysis, as the results of urine testing can vary considerably according to factors such as time of day of taking the sample, fluid intake and presence of other drugs.

The Queensland Health Mental Health Branch will engage the toxicologists at Queensland Forensic and Scientific Services to develop blood assays in the context of monitoring medication compliance. Protocols and guidelines will be developed for clinicians in using blood testing for measuring medication compliance as a part of the systematic response to addressing issues of medication compliance.

Issues in relation to efficacy and costs will need to be explored and resolved. The frequency of the testing required to measure medication compliance raises concerns regarding access to and involvement of the target group (presumably community mental health patients as in-patients are more likely to comply with medication regimes), issues of consent and compliance regarding rigorous testing by a patient group who have already been identified as non-compliant with medication, and the financial and human resources required to administer and process the tests. The Act enables blood samples to be taken from involuntary patients in the absence of consent, but it is anticipated that the frequency of the testing required would present difficulties for these people if they were not willing participants and for the staff involved. This matter has been referred to the Statewide Mental Health Network and is currently under consideration.

Recommendation 8

The Director of Mental Health cause to be developed a standardised protocol to assist case managers more systemically address the issue of medication compliance. It should reflect the extensive literature on the issues involved. The protocol should have regard to the risks posed by a patients failing to take medication and in appropriate cases provide for blood or urine testing.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

The Department of Mental Health supports the coroner's Recommendation to use the relevant literature to develop a statewide protocol and guidelines to assist case managers to more systematically address the issues of medication compliance, including the use of blood assays as discussed in the response to Recommendation seven above. This matter has been referred to the Statewide Mental Health Network and is under consideration. Some Mental Health Services in Queensland have received specific training from Medication Alliance, a training program for health professionals that enables them to better understand individual reasons for patients' non-adherence to medication. It shapes interactions between staff and patients in such a way that they develop a therapeutic relationship which helps the patient overcome not only problems with adhering to medication, but also other treatment regimes. The program has been delivered in a number of sites across Australia. To date, however, the delivery of the program has been predominantly associated with research.

Preliminary results indicate that patients of staff trained in Medication Alliance adhere more to their medication and as a result have an improvement in mental health outcomes. Mitchell Byrne from the Illawarra Institute for Mental Health developed this program and is planning to roll out an online version and sell licences to potential providers in 2009.

In 2008 the suite of standardised clinical documentation discussed in the response to the coroner's Recommendation one includes sections dedicated to identifying risk related to non compliance. An evaluation of these risks forms the basis for the development of care planning.

The Resource Guide that was updated in April 2008 (chapter 4) outlines protocols to ensure consistent management of non compliance. Section 3.4 of the Resource Guide titled *Non Compliance with Involuntary Treatment Order (community)* outlines processes to be followed where clinicians have concerns that patients are not complying with their treatment plan, including attendance at appointments for medical review or depot medication.

The Resource Guide refers to the policy on taking pathology specimens. This policy states that the Act provides authority for clinicians to provide treatment under a treatment plan. If the treating doctor is of a view that taking a blood sample is necessary to promote and maintain mental health and wellbeing of a patient under a forensic order or involuntary treatment order, the blood sample may be taken in the absence of consent. If taking blood samples is considered necessary to promote and maintain the patient's mental health and well being, it should be documented in the treatment plan.

Additionally, in February 2008, the Department of Mental Health Services issued the Forensic Patient Management Policy and Procedures which provide clinicians with a decision tree for the management of a patient's non-compliance with one or more of their limited community treatment conditions (e.g. medication regime).

It should be acknowledged that non-compliance or lack of adherence to medication therapy is not restricted to psychiatry, as the coroner points out. The ability to form a therapeutic alliance based on trust, engagement and understanding is significant in achieving adherence to treatment therapies that may have distressing side effects. Review of the literature clearly supports the therapeutic relationship as the catalyst for adherence to occur. Other issues of concern for clinicians and carers in managing compliance

with medication are denial, forgetfulness, influential friends and the often underestimated power play between the patient and carer or patient and treating team. The development of this delicate balance of empowerment of the patient and the need to protect the patient from harm is the basis for long term adherence and understanding.

Queensland Health will assess the suitability of this specific training from Medication Alliance for all mental health clinicians once the Medication Alliance training program becomes available.

Recommendation 9

Pending the development of a central data base able to provide access to information from all health services statewide, the statutory restrictions on the provision of information to the Queensland Police Service by Queensland Health concerning mental health patients in crisis be reviewed with the aim of enabling local Community Mental Health Services to provide to police information relevant to police interaction with such patients.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

The Government supports the release of information where the public interest balance between disclosure and patient confidentiality permits it.

There are a number of ways under existing law that appropriate release of information can take place. There are already relevant and appropriate exceptions to the statutory duty of confidentiality with respect to patient identifying information contained in the *Health Services Act 1991* to enable relevant information to be communicated to the Queensland Police Service by Queensland Health. There was a comprehensive public review of the relevant statutory duty of confidentiality as it then existed in 2003. Following the review, significant amendments were made to the *Health Services Act 1991*. Amendments took effect in April 2005. One of the new exceptions to the duty does permit disclosure of patient information if it will assist in averting a serious risk to life, health or safety (of any individual) or to public safety.

The mental health crisis situations that culminated in the tragic deaths of the four men investigated by the coroner would be considered examples of situations where Queensland Health may have disclosed relevant patient information to the Queensland Police Service. Furthermore, information sharing to assist in averting a serious risk to life, health or safety, or public safety, has now been incorporated in the Memorandum of Understanding between Queensland Health and the Queensland Police Service. The Memorandum of Understanding constitutes an agreement for the purposes of section 62N of the *Health Services Act 1991*, and it is expressly recognised in the *Health Services Regulation 2002*. The Memorandum of Understanding therefore establishes exceptions to the statutory duty of confidentiality for cases that are captured within its terms.

Relevantly, guidelines titled *Preventing and Responding to Mental Health Crisis Situations and Information Sharing Guidelines*, were also developed to underpin the operation of the Memorandum of Understanding, to assist officers of both Queensland Health and the Queensland Police Service in determining when information may be shared. Regrettably the Memorandum of Understanding and associated guidelines did not take effect until 3 April 2006, which postdates the deaths investigated by the coroner.

While a statutory review is not supported, it is acknowledged that both the Memorandum of Understanding and the information sharing guidelines should be reviewed and, if necessary, rewritten to ensure that advice to officers of both Queensland Health and the Queensland Police Service is clear and unambiguous.

In March 2006, Queensland Health developed the part seven Confidentiality Guidelines to assist health professionals understand and apply the new provisions of the *Health Services Act 1991*. These guidelines explain the duty of confidentiality and the circumstances when confidential information may be disclosed.

The guidelines state that where confidential information is disclosed, only information that is relevant in the particular circumstances should be disclosed i.e. the minimum necessary to satisfy the particular requirement. For example, if a request for confidential information relates to a particular condition or episode of care then only information relevant to that condition or episode should be disclosed.

The Queensland Health Mental Health Branch has developed a draft document titled Confidentiality – a quick guide for mental health professionals.

The restrictions on the dissemination of information about mental health patients to police officers are a requirement of section 62A of the *Health Services Act 1991*. Amendments to this Act, if considered necessary, would be progressed by Queensland Health. However, within the bounds of current legislation and information technology infrastructure, it is considered by the Queensland Police Service that suitable information sharing protocols are in place.

The Queensland Police Service signed a Memorandum of Understanding with Queensland Health in April 2006, which provides protocols and guidelines for the sharing of information. The Memorandum of Understanding is a prescribed agreement under section 35 of the *Health Services Regulation 2002*. This enables the disclosure of confidential information under s. 62N(1)(b) of the *Health Services Act 1991* and provides an adequate legislative basis for the sharing of information in mental health crisis situations.

In addition, the Queensland Police Service has prepared a draft policy (a Commissioner's Circular titled *Mental Health Interventions*) which outlines the roles and responsibilities of Queensland Police Service officers involved in mental health crisis situations and related information sharing arrangements. The draft policy provides for the exchange of information between the Queensland Police Service, Queensland Health and/or the Queensland Ambulance Service in accordance with the relevant Memorandum of Understanding and Information Sharing Guidelines to which these agencies are parties.

Queensland Health will consult with the Queensland Police Service regarding review of the Memorandum of Understanding and the guidelines in the context of a broad review of information sharing protocols between Queensland Health and the Queensland Police Service and the operational requirements of police officers responding to people with mental illness. A project officer is completing the final product, which it is envisaged will be a self-explanatory document (format to be decided), which will be available to mental health services across the state together with the Confidentiality Guidelines. Any need for associated training will be explored. The draft policy, a Commissioner's Circular titled Mental Health Interventions is currently in consultation with Regional Assistant Commissioners.

Recommendation 10

Queensland Police Service district mental health intervention coordinators collaborate with local Community Mental Health Service officers and Queensland Ambulance Service officers to make greater use of pre-crisis planning, and in particular that consumers on forensic orders and involuntary treatment orders who are not undertaking in-patient treatment be encouraged to participate in such planning.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The Mental Health Intervention Project is a tri-agency partnership between Queensland Health, Queensland Police Service and the Queensland Ambulance Service in which the three agencies share expertise and resources to respond effectively to mental health crisis situations. The Mental Health Intervention Project commenced in 2005 and is being established in 17 Health Service districts and related Police and Ambulance districts across the state. The project aims to prevent and/or safely resolve incidents involving persons experiencing a mental health

emergency. Training delivered through the Mental Health Intervention Project provides staff of the three agencies with opportunities to enhance their knowledge and skills to be better equipped to respond to mental health emergencies.

Queensland Health is establishing Mental Health Intervention Coordinators in each health district. Fifteen of a possible 17 Mental Health Intervention Coordinators have been appointed with the roll out this year to include a further two positions in Mount Isa and Mackay. The Mental Health Intervention Coordinators liaise between police, ambulance, mental health staff and other relevant stakeholders to ensure that a timely and appropriate response and relevant information is being shared between parties in a time of crisis. The principal police officer involved in pre-crisis planning is the Queensland Police Service District Mental Health Intervention Coordinator.

The Mental Health Intervention Project has developed the concept of a Crisis Intervention Plan, which enables a mental health consumer to give informed consent for information to be shared in the event of a crisis incident. The Crisis Intervention Plan is prepared by the treating clinician with input from the patient, and contains information about relevant aspects of the person's illness, behaviour, disability, culture, history and treatment that will help police to better understand any incident that may occur. The Mental Health Intervention Project supports strongly the need for increased use of the pre-crisis planning for clients who are on forensic orders and for clients who have histories that indicate there are enhanced safety risks for police, health or ambulance officers. Clearly it does not preclude any client requesting that a crisis plan be developed on a voluntary basis.

The role and status of the Queensland Health and Queensland Police Service District Mental Health Intervention Coordinators and ways to better integrate service delivery and information resources is being considered by the Mental Health Intervention Project. By working together at the health service district level, Queensland Health, Queensland Police Service and the Queensland Ambulance Service are designing customised intervention strategies to deal with individual mental health crisis situations. A draft Commissioner's Circular, *Mental Health Interventions*, has been prepared as a result of the Mental Health Intervention Project and is likely to be published in the near future.

Together with the training provided as part of the Mental Health Intervention Project, this circular will facilitate greater use of pre-crisis planning. The working party will comprise police representatives from a number of police regions as well as Operations Support Command and Information Management Division. Monthly progress reports will be forwarded for the advice of the Queensland Police Service senior executive.

Response and action

Agreed and completed with ongoing implications
Responsible agency: Queensland Police Service

The Queensland Police Service established a working group to consider this issue. The working group included representatives from the Queensland Police Service, the Crime and Misconduct Commission, Queensland Health and the Queensland Ambulance Service.

The working group was closely aligned with the Mental Health Intervention Project, a joint project between the Queensland Police Service, Queensland Health and the Queensland Ambulance Service. The Mental Health Intervention Project was responsible for the introduction of District Mental Health Intervention Coordinators. There are currently 17 police officers assigned to these roles on a part-time basis across Queensland. The Mental Health Intervention Project has trained a total of 60 police officers to perform the role of District Mental Health Intervention Coordinator.

Queensland Police Service District Mental Health Intervention Coordinators are collaborating with their counterparts from Queensland Health and the Queensland Ambulance Service on a regular basis to pre-crisis plan and to manage difficult and recurring cases. There is a significant number of persons for whom crisis intervention plans may be appropriate and the development of plans is

ongoing. To support this process, the Queensland Police Service published a Commissioner's Circular (an internal policy document) titled 'Mental Health Interventions' in September 2008 to establish a procedural basis that facilitates greater use of pre-crisis planning.

The Queensland Police Service, in partnership with Queensland Health and the Queensland Ambulance Service, has ensured that structures, processes and resources are in place to maximise the use of pre-crisis planning. The process of developing Crisis Intervention Plans will be ongoing.

Recommendation 11

Queensland Police Service review the training it provides to officers regarding their obligation to warn before using firearms.

Response and action

Agreed and completed

Responsible agency: Queensland Police Service

The Queensland Police Service Police Shootings Inquest Steering Committee established a working group consisting of representatives from the Queensland Police Service and the Crime and Misconduct Commission to examine tactical communications training options to ensure appropriate use of warnings. The working group made inquiries with international and other national law enforcement agencies to identify what training police receive from those agencies regarding warning offenders when police present a firearm in response to an incident. Responses were received from a number of Australian and international agencies. The responses revealed little standardisation of warnings. There is a general consensus of practice among Australian jurisdictions that police officers identify themselves and give verbal commands specific to the situation to attempt to peacefully resolve incidents.

The Queensland Police Service has since adopted some communication terminology used by police in the United Kingdom and incorporated it into Queensland Police Service training. From 2009 the 'dynamic interactive scenario training' undertaken as part of the Operational Skills and Tactics syllabus has emphasised that Queensland Police Service officers are to identify that they are armed and negotiate (verbally/non-verbally) in order to achieve control of a policing incident.

The current Queensland Police Service training on 'warning to shoot' has been reviewed and is compliant with Queensland legislation and is consistent with national and international practice.

Recommendation 12

The *Police Service Administration Act 1990* be amended to create a requirement for police officers involved in critical incidents resulting in death to provide a specimen of blood for analysis as soon as reasonably practicable after the incident.

Response and action

Not agreed and not being implemented

Responsible agency: Queensland Police Service

The issue of mandatory blood testing post-critical event has previously been considered by the Queensland Police Service Drug and Alcohol Steering Committee and Testing Sub-Committee during the development of current policy. It was determined based on National Standards (Australian Standards 4308) to adopt the current policy of breath testing for alcohol and urine testing for other drugs. Among the reasons for not adopting mandatory blood testing are logistical issues surrounding the taking of blood samples, the availability of health professionals able to take blood samples, the fact that blood sampling is more invasive than urine and breath testing and that urine and breath testing provide a comprehensive nationally recognised scheme for testing for the presence of alcohol and other drugs.

Recommendation 13

Queensland Police Service review the operational skills training provided to officers to ensure that tactical withdrawal is more likely to be used in appropriate cases.

Response and action

Agreed and completed

Responsible agency: Queensland Police Service

The Queensland Police Service Police Shootings Inquest Steering Committee formed a working group including representatives from the Queensland Police Service and Crime and Misconduct Commission to examine Operational Skills and Tactics training to ensure adequate emphasis on tactical withdrawal within the training syllabus. The working group made inquiries with other law enforcements from Australia and overseas to identify what training police from those other agencies receive on tactical withdrawal and situational containment. The Queensland Police Service identified that tactical withdrawal has been a component of the Queensland Police Service's operational skills training since 1997 and that it is one of the few agencies to provide training on this aspect. Threat Assessment and Situational Awareness are core components of mandatory operational skills training and this training places significant emphasis on the need for officers to have situational awareness and for them to consider all their options, including tactical withdrawal and situational containment.

To enhance the Queensland Police Service training, the working group developed definitions of the concepts of tactical withdrawal and situational containment for incorporation into the syllabus. Definitions are designed to accurately describe the actions that a police officer should undertake should they tactically withdraw from or contain a policing incident. Practical knowledge and application of these techniques is exercised in the dynamic interactive scenario training component of Operational Skills and Tactics training. From semester one 2009, tactical withdrawal has been a key element of dynamic interactive scenario training.

Recommendation 14

Queensland Police Service develop a procedure for reviewing critical incidents whereby the appropriateness of the actions of its officers and its policies and procedures can be expeditiously considered and remedial action taken if necessary.

Response and action

Agreed and completed

Responsible agency: Queensland Police Service

The Queensland Police Service has developed a critical incident review model which will ensure that regionally established Significant Event Review Panels conduct prompt and thorough reviews of the actions of officers and the appropriateness of policies and procedures after a wide range of critical and significant incidents.

The policy introducing Significant Event Review Panels was published on 23 December 2008 and became effective on 1 January 2009.

Recommendation 15

Queensland Police Service develops a process by which, whenever an officer is involved in an incident in which someone is shot, it can assess any resulting impairment of the officer's operational decision making capacity.

Response and action

Agreed in part and partially completed

Responsible agency: Queensland Police Service

The Queensland Police Service agrees that officers involved in critical incidents should be provided with appropriate support to minimise any negative impacts on their operational decision making capacity. To achieve this, the Queensland Police Service currently provides a Critical Incident Stress Debriefing process to reduce the impact of traumatic events on members of the Service. During this process impairment of an officer's operational decision making capacity may be identified.

It is not necessarily agreed that a further formal assessment of operational decision making capacity is feasible, however further consideration is being given to this issue.

The Queensland Police Service formed a working group, including representatives from the Crime and Misconduct Commission, to examine this issue. The working group has developed a draft policy document and information technology solution in response to this issue. The policy and associated IT system intends to introduce a scheme within the Queensland Police Service to ensure an officer's exposure to potentially traumatic events is recorded. A police shooting incident is one type of incident which would be recorded as a potentially traumatic event under the scheme. The system aims to enhance the Service's ability to identify officers who are at risk and ensure that the well being of these officers is monitored and that appropriate intervention strategies are implemented when non-coping behaviours are identified. The draft policy has been distributed to key stakeholders within the Service for consideration and comment and the consultation process is nearing completion.

The working group is currently undertaking a literature review and inquiries with other Australian law enforcement agencies with a view of developing an appropriate welfare assessment tool for police who are involved in police shootings. An education program for all Queensland Police Service employees to support the proposed Potentially Traumatic Events policy is also being developed.

Recommendation 16

Critical incident command training be extended to all operational police with particular emphasis given to general duty officers in operational positions.

Response and action

Agreed in part and completed

Responsible agency: Queensland Police Service

The Queensland Police Service currently provides training to police personnel of varying ranks in the components of incident management.

It is not necessarily agreed that all ranks would undertake the current critical incident command course. Nevertheless, in response to this Recommendation, a working party was established within the Queensland Police Service to progress a gap analysis concerning the different critical incident command training provided for the different levels (e.g. recruit, first year constables, constables, senior constables, etc).

The Queensland Police Service Police Shootings Inquest Steering Committee formed a working group including Queensland Police Service and Crime and Misconduct Commission representatives to review and consider current training and the potential for improvement. The working group undertook a gap analysis of critical incident command training delivered at various levels to identify potential improvements. It was identified that the Queensland Police Service provides extensive incident command training to address the needs of all levels of the Service.

Incident management training begins in the First Year Constable Program and is offered to officers in their first 12 months of service. This training is an information session facilitated during the First Year Constable Workshop. The information session deals with the role of a first year constable in responding to significant incidents. During the session constables discuss issues relating to isolation, containment and evacuation.

The Constable Development Program also provides incident command training in the third year workshop. This is a one day training session involving both theory and practical exercise in incident management. While this program is not compulsory, it captures 96 per cent of Constables. Since early 2008, the curriculum of Level One of the Management Development Program Legal Studies Unit has concentrated on the topics of Incident Management and Crime Scene Management. This unit is completed by all Senior Constables who wish to be considered for promotion to the rank of Sergeant.

In 2005, the curriculum of Level 3 of the Management Development Program Legal Studies Unit was changed to focus on the topic of Incident Command. This unit is completed by all Senior Sergeants who wish to be considered for promotion to the rank of Inspector.

The Incident Command Course for Inspectors has been conducted since 2002 and has trained approximately 90 per cent of all substantive Inspectors. Additionally the Queensland Police Service provides a two day Incident Command Workshop which is delivered in each region to officers from the rank of Senior Constable to Senior Sergeant. Finally, all operational officers receive training in operational risk assessment and situational awareness, the critical elements of incident command training, in their compulsory Operational Skills and Tactics training.

Recommendation 17

The trial of tasers continues and the evaluation by the Crime and Misconduct Commission have regard to international experience in the use of these implements. When the results of the trial and the Crime and Misconduct Commission's evaluation are made known the Queensland Police Service should review its policy in relation to the use of tasers.

Response and action

Agreed and partially completed

Responsible agency: Queensland Police Service

The taser trial concluded on 30 June 2008. The report of the Review of the Queensland Police Service Taser Trial was publicly released on 2 July 2009 and set out amendments made to Queensland Police Service policy, procedures and training on taser use made as a result of the review's findings. As the Government recently announced a further review of tasers to be conducted by the Crime and Misconduct Commission and the Queensland Police Service, the Government's response to this Recommendation will remain under consideration until this further review is completed. The further review will look at taser training and operational policy and commenced on Monday 15 June 2009. The Queensland Police Service will report to Cabinet in August 2009 on the results of this review.

Inquest into the death of an infant who died at Deception Bay

Shortly before midnight in mid 2006, the child's father fell asleep in a lounge chair whilst nursing his infant son. When he awoke the child was face down in his lap and not breathing.

The identity of the child has been de-identified pursuant to the confidentiality provisions of the *Child Protection Act 1999* (Chapter 6 Part 6).

State Coroner Barnes handed down findings on 10 April 2008.

Recommendation 1

The Department of Child Safety review the information put before this inquest when deciding what action if any should be taken by it in relation to any children of either parent.

The Machinery of Government administrative arrangements in March 2009 saw the Department of Child Safety transition to the Department of Communities.

Response and action

Agreed and completed

Responsible agency: Department of Communities

Action taken is the subject of confidentiality pursuant to relevant provisions of the *Child Protection Act 1999* (section 187).

Inquest into the death of John Malcolm Schibrowski

Mr Schibrowski died on 23 November 2003 as a result of injuries sustained in a single vehicle incident on the Burnett Highway near Bouldercombe.

Coroner Hennessey handed down findings on 24 April 2008.

Recommendation 1

Queensland Police Service consider dedicating traffic accident investigators in regional areas on a full time basis and that those officers are resourced in an appropriate way to enable them to fulfil their duties. Further, Traffic Accident Investigation Squad officers have their skills and competencies upgraded and refreshed on a regular basis to ensure the quality of investigations being conducted around the State.

Response and action

Agreed in part and partially completed

Responsible agency: Queensland Police Service

The Queensland Police Service agrees that its forensic crash investigators should be as well trained and resourced as possible. It is not necessarily agreed that those officers should be placed in full-time positions in regional areas.

The Queensland Police Service has investigated the current staffing, training and equipment situation of its forensic crash investigation units in light of this Recommendation. As a result of this investigation a range of options to address this Recommendation has been developed and given preliminary consideration by the Queensland Police Service senior executive at the Assistant Commissioners' Conference in November 2008.

The Queensland Police Service has implemented a range of measures, including a trial appointment of a part time forensic crash coordinator in the Northern Region, to ensure the high quality of forensic crash investigations is maintained without incurring significant additional costs. A report on the impact of the measures and trial will be produced in late 2009. After the report is completed, further consideration will be given to the implications and viability of the various options by the Queensland Police Service senior executive.

Inquest into the death of Robert Lee Brown

Mr Brown died on 25 December 2006 when the motor cycle he was driving collided with a vehicle attempting a u-turn.

Coroner McLaughlin handed down findings on 1 May 2008.

Recommendation 1

Queensland Police need to urgently address the situation of having a senior collision analyst employed, or at least available, to vet reports.

Response and action

Agreed in part and completed with ongoing implications

Responsible agency: Queensland Police Service

The Queensland Police Service agrees there is a need to initiate action that will enable the Service to appoint a qualified and experienced senior collision analyst who can vet crash reports for the coroner.

The Queensland Police Service is not able to rectify this situation in the short term due to the relatively lengthy training involved. In recent years the Service has lost the services of its previously trained senior collision analysts at a rate greater than succession planning could replace and is in the process of rebuilding its capacity in this area.

The Queensland Police Service is currently implementing a comprehensive advanced training program for forensic crash investigators to enable them to acquire the knowledge and skills required of a senior collision analyst. Before a police officer can be appointed as a senior collision analyst, the officer must have successfully completed six advanced training courses and must also have several years experience applying speed and crash reconstruction formulas. The Queensland Police Service is working with external training providers to ensure that the full range of appropriate and accredited training is available through the Queensland Police Service Academy for the next three years commencing in 2009.

For the interim period the Queensland Police Service has adopted a practice of peer review to ensure that officers with advanced qualifications review the work of other forensic crash investigators to maintain quality. Additionally, the Queensland Police Service will continue to source external expert assistance in investigations where the collision analysis requirements are beyond the capability of officers within the Service.

Relevant training courses have been made available and it is anticipated that senior collision analysts will be trained within 18 months to three years.

Inquest into the death of Ricky Glenn Blinco and Michael Wayne Last

Messrs Blinco and Last were killed in separate incidents at Black Duck Valley Four Wheel Drive and Motorbike Park at East Halidon near Gatton. Mr Last died when he came off his motorcycle on 25 June 2005, and Mr Blinco died on 16 January 2007 when he lost control of his vehicle.

State Coroner Barnes handed down findings on 2 May 2008.

Recommendation 1

The Integrated Planning Act and/or Integrated Planning Regulation be amended so that local authorities dealing with development applications concerning out door recreation facilities be required to refer the application for assessment by the Department of Local Government, Sport and Recreation.

The Machinery of Government administrative arrangements in March 2009 saw the area of Sport and Recreation transition from the Department of Local Government, Sport and Recreation to the Department of Communities.

Response and action

Not agreed and not being implemented

Responsible agency: Department of Communities

This amendment has not been progressed because:

- it would have no impact on the operation of existing facilities
- there is no existing legislation or Code upon which to base referral jurisdiction
- assuming a concurrence agency role for all development applications concerning outdoor recreation activities would have a significant resource impact on the Department of Communities given the number of outdoor recreation related applications considered by councils across Queensland each year with very little beneficial impact for development applications for outdoor recreation activities.

However, since this Recommendation was made, Sport and Recreation Services of the department has progressed a number of actions that support the spirit of the Recommendation including releasing the following guidelines to provide assistance to those seeking to establish and/or manage trail bike riding facilities:

- So you want to set up a private trail bike park? Guidelines for establishing and managing trail bike riding facilities
- So you want development approval to set up a private trail bike park? A guide to the development application process for trail bike site developers

The department has also published a third guideline targeted primarily at local governments titled *Guidelines for facilitating provision for trail bike riding in local government planning schemes.*

In addition, the department has developed and commenced delivery of community education workshops to promote awareness and understanding of these guidelines.

The department will continue to deliver workshops to assist private landowners establishing and managing trail bike and 4WD facilities to understand and use the above mentioned guidelines.

Response and action

Not applicable and not being implemented

Responsible agency: Department of Infrastructure and Planning

The Department of Infrastructure and Planning does not oblige other departments to become advice or concurrence agencies. The implementation of this Recommendation cannot be instigated by the Department of Infrastructure and Planning.

In his Recommendation, the state coroner stated that the former Department of Local Government, Sport and Recreation should become an advice agency/concurrence agency for development applications for outdoor recreations facilities.

The Department of Infrastructure and Planning advised the former Department of Local Government, Sport and Recreation that should it wish to become an advice /concurrence agency, the Department of Infrastructure and Planning will act as the facilitator by amending the *Integrated Planning Act 1997*.

If the former Department of Local Government, Sport and Recreation wished to become an advice/concurrence agency, the Department of Infrastructure and Planning would have facilitated that role by amending the *Integrated Planning Act 1997* to provide a head of power for this to occur. The *Integrated Planning Regulation 1997* would have also required amendment to accommodate the former Department of Local Government, Sport and Recreation as a concurrence/ advice agency.

The Interdepartmental Trail Bike Riding Working Group has formed a sub-committee to examine the state coroner's Recommendations. The Department of Infrastructure and Planning is a member of the sub-committee and provided the former Department of Local Government, Sport and Recreation advice about the role of an advice/ concurrence agency.

The former Department of Local Government, Sport and Recreation advised that it did not wish to take on the role of an advice/concurrence agency. The now Department of Communities is proceeding on that basis.

However, since this Recommendation was made, the former Department of Local Government, Sport and Recreation released a number of guidelines to provide assistance to local governments and those seeking to establish and/ or manage trail bike riding facilities.

The former Department of Local Government, Sport and Recreation also developed and commenced delivery of community education workshops to promote awareness and understanding of these guidelines. The Department of Infrastructure and Planning understands that the now Department of Communities will continue to facilitate workshops to assist private landowners establishing and managing trail bike and 4WD facilities to understand and apply the guidelines.

Recommendation 2

The Department of Local Government, Sport and Recreation stipulate continuing membership of the appropriate outdoor sports or recreation body as a condition of the application's approval. Alternatively, the department could stipulate compliance with the relevant Adventure Activity Standard as a pre-condition to approval of the application.

The Machinery of Government administrative arrangements in March 2009 saw the area of Sport and Recreation transition from the Department of Local Government, Sport and Recreation to the Department of Communities.

Response and action

Agreed in part and partially completed

Responsible agency: Department of Communities

Continuing membership of the appropriate outdoor sports or recreation body as a condition of the application's approval

The department will require that an applicant organisation for funding become a member of the appropriate sport or recreation peak body as a condition of any funding which it provides for trail bike related purposes. The peak body in this case, Motorcycling Queensland, has developed guidelines for the establishment and management of motorcycle facilities which complement those issued by the Department.

However, in other instances (e.g. four wheel driving), membership of the industry association is not open to commercial enterprises and/or membership would not necessarily ensure access to similar guidelines and advice.

The department's guideline targeted at local government is being amended to strongly recommend that Councils seek to have operators of private parks affiliated with either Motorcycling Queensland or another appropriate body as part of the development approval process.

The criteria within the South East Queensland Trail Bikes and Off Road Vehicles Program (which provides funding of up to $25 000 to private land owners seeking to develop new or expand existing trail bike and 4WD facilities), requires the landowner/lessee to have affiliation with, or support of, the relevant state body. It is a term of any funding agreement that the approved applicant agrees to be an affiliated member of either Motorcycling Queensland or another body deemed acceptable to the Department.

Compliance with the relevant Adventure Activity Standard as a pre-condition to approval of the application

The department has contracted the Queensland Outdoor Recreation Federation to develop Adventure Activity Standards in 15 activity areas, including recreational trail bike riding. The Recreational Trail Bike Riding Adventure Activity Standards will provide a minimum, voluntary benchmark for the conduct of these activities.

The Adventure Activity Standard has been drafted and is currently the subject of final consultation with industry stakeholders. It is expected to be completed by August 2009.

Recommendation 3

The Division of Workplace Health and Safety review its determination that the injury to members of the public at worksites such as Black Duck Valley are beyond its investigative jurisdiction. In the event that it is determined that the division does have authority to intervene, as a matter of urgency they undertake a full risk audit of Black Duck Valley and take appropriate action in relation to the findings of such an audit as provided for in the Act.

Response and action

Agreed and completed

Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland has sought the legal advice of Crown Law and Senior Counsel and has confirmed the activities and operation such as Black Duck Valley is a business or undertaking for the purpose of Queensland Workplace Health and Safety Legislation. As such, Workplace Health and Safety Queensland does have jurisdiction over an inquiry or illness to a person caused by the operation of such a facility.

In response to the deaths of Mr Last and Mr Blinco, an enforcement note on public safety was developed. The enforcement note requires inspectors to make appropriate enquiries into incidents occurring at such facilities to determine if the incident was due to factors within the scope of the employer's obligations. This includes inquiring into the provision and maintenance of a safe plant, means of ensuring safe systems of work, provision of information, instruction, training and supervision as opposed to enquiring

simply into an injury caused by the poor handling and landing of a motorcycle off a jump. In cases where the incident was due to factors within the scope of the employer's obligations, an investigation would usually ensue.

To enhance risk management at the park, Workplace Health and Safety Queensland insisted Black Duck Valley:

- demonstrate an understanding of risk management to an industry accredited standard, or in the absence of an industry standard for an activity, a standard acceptable to a independent risk management assessment
- demonstrate the application of risk management to its operations and facilities that satisfies an accredited industry standard, or in the absence of such an industry standard, a standard acceptable to an independent risk management assessment
- ensure that the participants' skills and experience have been assessed (i.e. ensure a participant holds a qualification to undertake the activity)
- provide sufficient information to participants to enable them to make an informed decision over risks.

A workplace health and safety audit of Black Duck Valley was completed in June 2008 and a follow up audit was conducted in September 2008.

Workplace Health and Safety Queensland is advised that Black Duck Valley has ceased operation.

Recommendation 4

The Chief Forensic Pathologist develop a guideline to assist pathologists undertaking coronial autopsies identify those cases in which vitreous humour should be collected for toxicological analysis.

Response and action

Agreed and completed

Responsible agency: Queensland Health

In December 2008 the Chief Forensic Pathologist distributed a memo to all pathologists performing coronial autopsies directing the implementation of this Recommendation.

Specifically, pathologists performing coronial autopsies note that aside from blood, the best material to analyse for alcohol is vitreous, and to also note that the vitreous is an isolated location and affords a method for looking back in time.

The Chief Forensic Pathologist also noted the suggestion that a corrective ratio to estimate the blood alcohol level from that measured in the vitreous be used by the pathologists performing coronial autopsies.

Inquest into the death of Phillemon Edward Mosby

On 27 October 2004 Mr Mosby, a deckhand on the pilot vessel *Alert*, was involved in the transportation of a marine pilot to a merchant vessel. The transfer was achieved without incident. However, during the process of transferring the pilot's luggage onto the ship via a heaving line, Mr Mosby disappeared. A search failed to locate any trace of him.

State Coroner Barnes handed down findings on 23 May 2008.

Recommendation 1

The General Manager, Maritime Safety Queensland, establish why no action was taken in relation to Mr Richie's (former master of the *Alert*) complaint about the condition of the *Alert* with a view to ensuring there is no repeat of such failings.

Response and action

Agreed and completed

Responsible agency: Department of Transport and Main Roads

At the time of the complaint made by Mr Richie, Maritime Safety Queensland did not have a permanent staff member based in the Torres Strait. Staff from Cairns were tasked to attend the Torres Strait to investigate the complaint, however the vessel to transport them became unavailable and did not become available again until after the incident involving Mr Mosby. Maritime Safety Queensland has since employed personnel within the Torres Strait who are able to respond to issues and complaints immediately as they arise.

Maritime Safety Queensland has also conducted an internal review of its regulatory function, with effective notification management as a focus of the review. The review had a particular stress upon the ownership of marine safety complaints by Maritime Safety Queensland as the regulator of maritime safety. To reinforce this message throughout all regions a workshop on effective investigative practice has been delivered to all personnel involved in the investigation of marine safety complaints.

Recommendation 2

Having regard to the evidence put before this inquest there is, in the coroner's view, a sound basis to be concerned about the safety culture within Torres Pilots. The coroner therefore recommends this information and any future complaints be considered when Maritime Safety Queensland monitoring activities are being targeted.

Response and action

Agreed and completed

Responsible agency: Department of Transport and Main Roads

Maritime Safety Queensland has introduced a risk based monitoring system to target vessels that are deemed a high risk to marine safety and has also undertaken a vessel audit in the Torres Strait. A notification system has also been put in place by Maritime Safety Queensland. Under this system any safety related complaint now triggers an urgent monitoring response.

Any notifications are reported on hot lists which are monitored on a weekly basis to ensure that complaints are considered in Maritime Safety Queensland monitoring activities. This system captures all commercial vessels operating in Queensland waters including those operated by Torres Pilots. The new process has proven to work well in practice.

Recommendation 3

The coroner is aware that self regulation is now the philosophical underpinning of many regulatory schemes. However, in view of the critical nature of the annual declaration that a commercial vessel is seaworthy, in a context where the regulator is unlikely to be able to regularly inspect all craft, the coroner considers there is a basis for winding back this system with its inherent conflict of interest. The coroner therefore recommends the General Manger Maritime Safety Queensland review whether the Transport Operations (Marine Safety) Act should be amended to require an accredited

marine surveyor to complete the certificate of seaworthiness on annual applications for renewal of registration of all commercial vessels.

Response and action

Agreed and partially completed

Responsible agency: Department of Transport and Main Roads

Maritime Safety Queensland has reviewed its approach to self declaration. Maritime Safety Queensland policy regarding the requirement for survey is that it will implement the National Standard for the Administration of Marine Safety as part of the national framework proposal for marine safety.

The final consultation on the National Standard for the Administration of Marine Safety closed 7 November 2008. Maritime Safety Queensland participated in a national workshop on 12 November 2008 to reach agreement on the classes of vessels and level of prescriptions to be applied to all Australian commercial and fishing ships. Vessels such as pilot boats are to be subject to full initial and periodic survey requirements.

The implementation of the new National Standard for the Administration of Marine Safety, including the reintroduction of mandatory periodic survey requirements is to be undertaken across all states. Under this new regime, a risk-based assessment will determine the frequency and extent of periodic inspections. The final decision on the national system including the implementation date is expected in the middle of 2009. The legislation underpinning the new regime is not expected to be in place before 1 July 2011, with a transitional period of one to three years to full implementation. The new regime is currently the subject of a Regulatory Impact Statement which is available at www.amsa.gov.au.

Recommendation 5

The Director of the Division of Workplace Health and Safety and the General Manger Maritime Safety Queensland review the operation of the Memorandum of Understanding in this case to consider whether changes are needed to encourage more collaboration in responding to incidents that appear to enliven the jurisdiction of both agencies.

Response and action

Agreed and partially completed

Responsible agency: Department of Justice and Attorney-General

A review of the operation of the Memorandum of Understanding between Workplace Health and Safety Queensland and Maritime Safety Queensland has been undertaken in relation to this case and the Recommendations of the Service Delivery and Productivity Commission. An instruction has been issued to Workplace Health and Safety Queensland Inspectors in relation to conducting joint investigations with Maritime Safety Queensland in response to incidents over which both agencies have jurisdiction, as an interim measure until the Memorandum of Understanding is finalised.

Collaboration between Workplace Health and Safety Queensland and Maritime Safety Queensland to review and enhance the Memorandum of Understanding is ongoing. It is expected that the process will be completed by October 2009.

Response and action

Agreed and partially completed

Responsible agency: Department of Transport and Main Roads

Significant work has been undertaken on the draft Memorandum of Understanding which relies upon the development of detailed protocols on such matters as investigations, enforcement and compliance monitoring. The draft Memorandum of Understanding prepared by Maritime Safety Queensland has been developed in consultation with the Queensland Police Force. The consultation assisted in contextualising the document for police matters, in particular criminal code and coronial investigations.

This draft Memorandum of Understanding is currently with the Office of Workplace Health and Safety Queensland for their consideration and further development. Maritime Safety Queensland participates in regular meetings with the Office of Workplace Health and Safety Queensland, and the next such meeting is scheduled for Tuesday 19 June 2009.

Until the draft Memorandum of Understanding is finalised, interim arrangements have been implemented that cover fatal and serious incidents, so as to ensure that both Maritime Safety Queensland and Workplace Health and Safety Queensland investigate incidents on board commercial ships appropriately.

Recommendation 6

The General Manager, Maritime Safety Queensland, review the manner in which this marine incident was investigated to establish why no consideration seems to have been given to initiating prosecution action under the Transport Operations (Marine Safety) Act.

Response and action

Agreed and completed

Responsible agency: Department of Transport and Main Roads

As a result of this Recommendation, Maritime Safety Queensland engaged an officer from New South Wales Maritime's Investigations Unit to conduct an independent review of the investigation into this marine incident, including Maritime Safety Queensland's methodology when investigating fatal marine incidents. The investigator found that while this marine incident was partially investigated by Maritime Safety Queensland, due to the departure of a number of key personnel at a critical time in the investigation the formal process laid down in the Marine Incident Investigation Manual was not complied with and no investigators report was produced for senior Maritime Safety Queensland staff. As a result whilst regional Marine Safety Officers recommended that the owners be prosecuted Maritime Safety Queensland did not act on this Recommendation. Maritime Safety Queensland should have followed this line ofinvestigation separately from the Queensland Police Service investigation into the loss overboard of Mr Mosby.

Maritime Safety Queensland now recognises the importance of conducting a separate investigation to the Queensland Police Service and the utilisation of investigative expertise in the case management of fatal marine incidents. The Compliance Unit within Maritime

Safety Queensland now has overall responsibility for the conduct of investigations into fatal marine incidents on behalf of Maritime Safety Queensland and provides case management expertise by acting as an interface between the Queensland Police Service, regional staff of Maritime Safety Queensland and Workplace Health and Safety Queensland.

In addition Maritime Safety Queensland has conducted an audit of all fatal marine incidents since 2005 to ensure that an investigation has occurred and any Recommendations made are considered and proper action is determined.

Inquest into the death of Christine Chloe Rouse

Chloe Rouse, aged 2, drowned at the public swimming pool at Cloncurry on 12 March 2005.

Coroner Luxton handed down findings on 26 May 2008.

Recommendation 1

Through the collaboration of the Royal Life Saving Society Association (RLSSA), the Department of Workplace Health and Safety and the Local Government Association of Queensland:

- A register of all low-patronage pools (as defined by the RLSSA Guidelines) which are owned or operated by regional/shire councils be kept and maintained by the Department of Workplace Health and Safety.
- The RLSSA Guidelines be promoted to all regional/shire Councils listed on the register as 'best practice' and that compliance with the guidelines is to be encouraged and monitored. The promotion of the guidelines should stress the importance of appropriate supervision, the implementation of emergency procedures, the provision of appropriate emergency equipment and the provision of first-aid equipment.
- A self-audit tool, in the form of a checklist, be developed to encourage compliance with the RLSSA Guidelines. The checklist should be distributed to all regional/shire councils on the register and the lodgement of the checklist with the Department of Workplace Health and Safety be required annually.
- Pool-related incidents which come to the attention of the Department of Workplace Health and Safety should be reported to all of the regional/shire councils listed on the register. This should take the form of a safety alert advising of the details of the incident. After any prosecution or coroner's inquest has been completed a more formal safety report or Bulletin should be provided. The comments of any judicial officer or coroner should be included in this report where it is deemed appropriate.

Response and action

Agreed and partially completed

Responsible agency: Department of Justice and Attorney-General

Further to the Recommendations of the coroner, Workplace Health and Safety Queensland convened a meeting on 26 August 2008 with the Royal Life Saving Society Association (Queensland) and the Local Government Association of Queensland. The meeting agreed that:

- the Royal Life Saving Society Association Guidelines be used as a standard reference for all workplace assessments of and complaints about swimming centres
- Workplace Health and Safety Queensland amend the current enforcement note on public safety so that the Royal Life Saving Society Association Guidelines are used as the appropriate standard for inspectors during any investigations into incidents in public swimming centres from 1 July 2009
- Local Government Association of Queensland attempts to compile, before 1 January 2009, the recommended register of low-patronage pools that are owned or operated by regional or shire councils
- Workplace Health and Safety Queensland, the Royal Life Saving Society Association and Local Government Association of Queensland develop a safety alert reflecting the provisions of the enforcement note and the application of the guidelines
- the self-audit checklist contained in the Royal Life Saving Society Association Guidelines be promoted to regional and shire councils for the 1 July 2009 commencement of the enforcement note and safety alert
- Workplace Health and Safety Queensland would from 1 July 2009 include all regional and shire councils on a Safety Alert email list for all incidents at swimming centres
- Workplace Health and Safety Queensland would advise the then Department of Sport and Recreation and Office of Child Safety of these outcomes and seek their involvement from 1 July 2009 in promoting the safety alert relating to council pool drowning.

Recent discussions with the Local Government Association of Queensland have indicated some potential difficulties with remote and regional councils conforming to the Royal Life Saving Society Association Guidelines. This issue will be monitored following the release of the revised enforcement note that is currently being finalised.

The compilation of the register of pools has also encountered some challenges due to the leasing arrangements of a high number of the facilities. In light of this, existing data sources will be utilised to ensure that relevant information about pool safety is circulated to persons likely to be affected by its operation.

To date, the Royal Life Saving Society Association Guidelines have been promoted to all regional/shire councils together with a copy of the coroner's Recommendation. The Royal Life Saving Society Association guidelines include a checklist that is suitable for pool operators to use for self assessment. All councils have been requested to incorporate the guidelines into their operational procedures.

Workplace Health and Safety Queensland is yet to consider the full implications of requiring pool operators to provide a copy of their self assessment to Workplace Health and Safety Queensland each year. Consideration will include the impact of the proposed national model Occupational Health and Safety legislation currently being developed and the costs and benefits associated with the receipt of the self-assessments.

Workplace Health and Safety Queensland publishes a bi-monthly electronic newsletter, eSAFE, and will include references to safety alerts issued since the last edition. Over 500,000 Queensland businesses, including pool owners and operators, were invited to register to have the newsletter emailed to them each time it is published.

Safety alerts are established predominately for issues that are not likely to be foreseen by obligation holders. It is understood that the safety alert proposed by the coroner was to address more general advice about the management of drowning risks associated with council owned or operated swimming pools. An information sheet is considered to be a more suitable tool for addressing the use of the guidelines to pools beyond those owned and or operated by councils. It is anticipated that the information sheet will be available by the end of July.

Inquest into the death of Ross Frederick Irwin

In the early hours of 22 April 2006, Mr Irwin and two deckhands were trawling about 35 nautical miles east of Noosa Heads when their nets snagged an unidentified object. The men commenced to haul the nets aboard to free the obstruction but before they could complete this task the boat rolled over and soon sank. Mr Irwin has not been seen again.

State Coroner Barnes handed down findings on 6 June 2008.

Recommendation 1

Compliance with the National Standard for Commercial Vessels be made mandatory for all commercial fishing vessels to which it relates forthwith and that in particular, the elements concerning crew competencies and safety equipment be made operative immediately.

Response and action

Agreed in part and completed with ongoing implications

Responsible agency: Department of Transport and Main Roads

Crew Competencies

All crew licences issued by Maritime Safety Queensland are compliant with current national crew competency requirements. Requirements for crew that are not currently required to be licensed were the subject of a review of the National Standard for Commercial Vessels (NSCV) Part D (Crew Competencies). The new standard proposes that General Purpose Hands must complete a training program organised by an approved Registered Training Organisation before joining a ship. However, this review has been put on hold, with consideration being given to superseding Part D with a Single National Jurisdiction proposal. This proposal is currently the subject of a Regulatory Impact Statement, which is available at: http://www.amsa.gov.au/namsr/documents/2ndRndConsultationRIS-2April 2009.pdf

NSCV C7A - Safety Equipment

Maritime Safety Queensland has mandated new national safety equipment standards for commercial fishing vessels that require compliance with the NSCV Part C7A. Amendments to the Transport Operations (Marine Safety) Regulation 2004 took effect on 1 June 2009. These amendments:

- require both new and existing registered commercial fishing ships to comply with the safety equipment requirements of the National Standard for

Commercial Vessels

- remove an obsolete 'grandfathering' clause that allows ships that were operating before 1996 to be equipped to standards in place prior to the implementation of the Uniform Shipping Laws Code.

Operational requirements

Queensland will also adopt from 1 October 2009 the part of the NSCV that specifically addresses operational practices. From 1 October 2009 a commercial or fishing ship connected with Queensland will have to comply with the NSCV operational requirements, emergency procedures, and essential elements of a safety management system. This part provides safety solutions for the major generic types of risks associated with operating a vessel. These solutions should only be considered as providing a minimum base standard of operational safety.

Recommendation 2

The Director of the Division of Workplace Health and Safety Queensland and the General Manager Maritime Safety Queensland review the operation of the Memoranda of Understanding in this case to consider whether changes are needed to encourage more collaboration in responding to incidents that appear to enliven the jurisdiction of both agencies.

Response and action

Agreed and partially completed

Responsible agency: Department of Justice and Attorney-General

A review of the operation of the Memorandum of Understanding between Workplace Health and Safety Queensland and Maritime Safety Queensland has been undertaken in relation to this case and the Recommendations of the Service Delivery and Productivity Commission. An instruction has been issued to Workplace Health and Safety Queensland Inspectors in relation to conducting joint investigations with Maritime Safety Queensland in response to incidents over which both agencies have jurisdiction, as an interim measure until the Memoranda of Understanding is finalised.

Collaboration between Workplace Health and Safety Queensland and Maritime Safety Queensland to review and enhance the Memorandum of Understanding is ongoing. It is expected that the process will be completed by October 2009. This is to be done in conjunction with the Recommendations from the inquests of Mr Mosby and Mr Trcka.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Department of Transport and Main Roads

Maritime Safety Queensland has taken lead responsibility for further developing awareness of workplace health and safety standards on board fishing vessels and has initiated meetings with Workplace Health and Safety Queensland to encourage a joint effort to develop improved safety standards from a workplace and marine safety perspective. It is expected that, with the involvement of Workplace Health and Safety Queensland, greater emphasis will be placed on safety awareness and education about injury prevention. A new draft memorandum of understanding between all regulators with a responsibility for safety on ships is expected to be finalised for industry consultation by 1 July 2009.

Until the draft Memorandum of Understanding is finalised, interim arrangements have been implemented that cover fatal and serious incidents, so as to ensure that both Maritime Safety Queensland and Workplace Health and Safety Queensland investigate incidents on board commercial ships appropriately.

Following consultation between Maritime Safety Queensland and Workplace Health and Safety Queensland in 2008 an instruction has been issued by Workplace Health and Safety Queensland that all marine incidents are to be jointly investigated and that the existing Memorandum of Understanding between Maritime Safety Queensland and Workplace Health and Safety Queensland have no effect on the ability of either organisation to investigate a marine incident.

Recommendation 3

The General Manager Maritime Safety Queensland review the policies governing the investigation of marine incidents to ensure that incidents involving serious injury and loss of life are properly investigated, and that issues arising from such investigations are responded to in the manner most likely to promote marine safety in Queensland.

Response and action

Agreed and completed

Responsible agency: Department of Transport and Main Roads

Maritime Safety Queensland has drafted a Marine Incident Management Policy and Procedure that was implemented in January 2009. The document establishes ownership of marine safety complaints by Maritime Safety Queensland in its role as the regulator of maritime safety in Queensland. The Policy and Procedure has been delivered as a workshop to all personnel involved in the investigation of marine safety complaints.

The Policy and Procedure outline a priority assessment of complaints and has built in accountability, within the organisation, for the investigation of complaints and reporting of outcomes.

Maritime Safety Queensland recognises the importance of conducting a separate investigation to the Queensland Police Service and the utilisation of investigative expertise in the case management of fatal marine incidents. Maritime Safety Queensland's Compliance Unit now has overall responsibility for the conduct of investigations into fatal marine incidents and provides case management expertise by acting as an interface between the Queensland Police Service, Maritime Safety Queensland regional staff and Workplace Health and Safety Queensland.

In addition, Maritime Safety Queensland has conducted an audit of all fatal marine incidents since 2005 to ensure that:

- an investigation has occurred
- any Recommendations following an investigation have been considered
- appropriate regulatory actions following an investigation have been taken.

Inquest into the death of Kenneth Maggable

Mr Maggable presented to the Cairns Base Hospital on two occasions on 8 August 2005. He was discharged at about 4.50 am on 9 August 2005. Shortly after his arrival home Mr Maggable collapsed and died.

Coroner Black handed down findings on 17 June 2008.

Recommendation 1

As a matter of urgency the Regional Health Authority in conjunction with Queensland Health review or (if appropriate) develop and implement procedures for the auditing of interns in their clinical record keeping practices and procedures.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Queensland Health

It is part of the role of the Health Information Managers within each Health Service District to conduct regular audits of medical records. These audits include the records produced by interns amongst those of all other health professionals who document in patients medical records. Regular chart audits are conducted by Health Information Managers for accreditation purposes. While the District Health Information Managers meet regularly with Corporate Office Clinical Information Management, they are accountable to their respective District Chief Executive Officer. Therefore, there is no statewide process for overseeing the role and function of the Health Information Managers.

In the Cairns and Hinterland Health Service District, where this incident occurred, an audit of clinical records occurred in February 2008 in conjunction with the Medical Education Unit. The Medical Education Unit is also in the process of implementing the competencies listed in the *Australian Curriculum Framework for Junior Doctors* throughout the Junior Doctor (interns and second years) education program in the District. There are 324 competencies listed in the *Australian Curriculum Framework for Junior Doctors*, including a number relating to clinical records.

Recommendation 2

Queensland Health undertake a feasibility study into the implementation of an integrated electronic/computerised patient information system, incorporating clinical notes, treatment plans and discharge summaries, allowing for access to patient data across the Cairns Health Service District, at least.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

An eHealth Program of Work has been developed using extensive business consultation, the focus of which has been to improve patient safety and the availability of accurate and integrated patient information at the point of care. Six priority areas have been determined. The priorities are electronic discharge summary, electronic clinical notes, medications management, order entry, statewide scheduling, and results reporting.

The infrastructure to support and maintain the various applications that will deliver this electronic capability will also be delivered as part of the eHealth strategy. Delivery will commence end of 2009 and this will be a four-year program of work.

Inquest into the death of Kristian Bock

Mr Bock died on 29 October 2002 from injuries sustained when his campervan collided with a prime mover which had crossed the double white line of the Palmerston Highway, pushing the campervan off the road over an embankment.

Coroner Brassington handed down findings on 17 June 2008.

Recommendation 1

Queensland Police Service hold vehicles involved in fatal collisions where serious criminal charges are to be brought which may involve the possibility of mechanical defect in the vehicle until criminal charges are resolved or the coroner determines under s.60 that the physical evidence is no longer necessary.

Response and action

Agreed in part and completed

Responsible agency: Queensland Police Service

The Queensland Police Service acknowledges and supports the coroner's Recommendation to the extent of requiring that evidence seized in respect of coronial investigations not be disposed of without an appropriate order from the coroner.

The Queensland Police Service does not support a requirement to retain possession of a seized motor vehicle until the conclusion of any court proceedings based solely on the possibility of a mechanical defect. However, the requirement to seek an order from the coroner prior to disposing of vehicles seized as a result of investigations into fatality crashes will generally resolve the issue.

It is current policy to retain property seized for coronial investigations until an order for disposal is obtained from the relevant Coroner. This course of action has been stated in the Operational Procedures Manual since 1 October 2007.

The Queensland Police Service has extensive policy on the retention of seized property, including evidence and exhibits, and using secondary evidence obtained from the examination of such property, which is considered to adequately address other situations.

Inquest into the death of Derek Batten, Peter Tunstead and James Tunstead

On Sunday 15 April 2007, the Kaz II, an ocean going sailing catamaran, steamed out of the Abel Point Marina at Airlie Beach. On board were its owner Derek Batten, his neighbour and close friend Peter Tunstead and Peter's brother James Tunstead. Their ultimate destination was Mandurah in Western Australia but they expected to next make port in Townsville after a two or three day passage. They have not been seen since. Three days after leaving Abel Point Marina the boat was found drifting and unoccupied approximately 88 miles north east of Townsville.

State Coroner Barnes handed down findings on 2 August 2008.

Recommendation 1

The Queensland Police Service and Volunteer Marine Rescue review the procedures governing their interface to ensure information gathered by Volunteer Marine Rescue volunteers is disseminated to police in a timely and consistent fashion.

Response and action

Agreed and completed

Responsible agency: Queensland Police Service

This matter was reviewed by the Queensland Police Service and Queensland Volunteer Marine Rescue Committee in September 2008. A protocol to ensure more timely and consistent passage of information from Volunteer Marine Rescue members to police was developed and has been disseminated to Volunteer Marine Rescue organisations.

Recommendation 2

The Queensland Police Service State Search and Rescue Coordinator liaise with commercial fishing bodies and other boating organisations to ascertain how 'all ships broadcasts' can be made most effective and that Queensland Police Service Search and Rescue protocols be amended accordingly if necessary.

Response and action

Agreed and completed

Responsible agency: Queensland Police Service

A review has been conducted by the Queensland Police Service State Search and Rescue Coordinator in consultation with fishing vessel operators' representative groups, particularly of radio watch procedures. The legislative requirements surrounding the monitoring of emergency radio channels and maintaining a radio watch are comprehensive and are considered to be as thorough as is practicable. The Queensland Police Service has directed its search and rescue coordinators to liaise with fishing and boating organisations in their area of responsibility to encourage the greatest practicable compliance with radio watch protocols.

Recommendation 3

Queensland Transport consider amending the registration marking requirements of all sea-going ships to ensure that such vessels can be readily identified from Coastwatch, surveillance and search aircraft.

The Machinery of Government administrative arrangements in March 2009 saw the Department of Transport transition to the Department of Transport and Main Roads.

Response and action

Agreed and partially completed

Responsible agency: Department of Transport and Main Roads

As this is an issue that will affect all jurisdictions across Australia, the most appropriate forum for the discussion of this issue is the National Marine Safety Committee, which has responsibility for implementing the Australian Transport Council's National Marine Strategy. This strategy is aimed at achieving consistent national maritime standards and facilitating the safe movement of vessels and personnel between Australian marine jurisdictions. At the first available opportunity, Maritime Safety Queensland facilitated discussion of this issue at the National Maritime Safety Committee meeting, held on 15 May 2009. The action summary of this meeting indicates that a reference group is to be convened to consider the issues raised in the agenda paper and provide Recommendations for consideration by National Maritime Safety Committee.

Maritime Safety Queensland is also seeking to advance this issue through the Australian Maritime Safety Authority, which has lead responsibility for search and rescue operations.

Inquest into the death of Colin Arthur Greaves

On 17 July 2005 Mr Greaves was hydroblasting a settler tank as part of regular maintenance work in the course of his employment when he stepped into an unguarded hatch at the top of the tank and fell into the near empty tank. He died from multiple injuries sustained as a result of the fall.

Coroner Hennessy handed down findings on 14 August 2008.

Recommendation 10

That the Division of Workplace Health and Safety in conjunction with the State coroner expeditiously review the role of the Division in the coronial process with a view to consolidation of the Division's responsibilities as primary investigators for Coroners.

Response and action

Agreed and partially completed

Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland had prior to the findings of this inquest, either of its own initiative or in response to other external reviews (such as the Ombudsman and the findings of other coronial inquests) already commenced a schedule of work (including liaison and consultation with the state coroner) to address the subject of the inquest's Recommendations. This Recommendation will be considered and addressed as part of Department of Justice and Attorney-General's review of its current Workplace Health and Safety Enforcement Framework and implementation strategies to improve Workplace Health and Safety Queensland's response to investigation outcomes. This is expected to be completed by October 2010.

Recommendation 12

That the Division of Workplace Health and Safety in conjunction with the state coroner expeditiously establish requirements for Division Inspectors in a fatality investigation for a Coroner including the matters to be addressed in investigation reports and ensure that appropriate training of inspectors be provided in those issues. Consideration should be given to the approval of inspectors to make Recommendations relevant to matters under section 46 of the coroners Act in their reports.

Response and action

Agreed and partially completed

Responsible agency: Department of Justice and Attorney-General

A review of the current reporting template and mechanisms for providing Recommendations is underway.

Workplace Health and Safety Queensland is currently reviewing the mechanisms for organisational consideration and response to the outcome of comprehensive investigations particularly those involving a fatality. It is anticipated that this review will be completed by October 2009.

Recommendation 13

The Division of Workplace Health and Safety in conjunction with the state coroner expeditiously develop a protocol for communication between the Investigator and the coroner early and during the course of the investigation to identify the scope of the investigation including a commitment by the Division to compliance with the appropriate requests of the coroner where that might exceed the parameters of a prosecution investigation.

Response and action

Agreed and partially completed

Responsible agency: Department of Justice and Attorney-General

Consultation between Workplace Health and Safety Queensland and the Office of the State Coroner indicates greater satisfaction with communication and greater collaboration on coronial matters.

Further consultation will occur with the state coroner to review the appropriateness of the current Departmental Coronial Liaison Officer protocol to determine its adequacy to address this issue or the need for amendment. This Recommendation will be considered in association with Recommendation 10.

Recommendation 14

The Division of Workplace Health and Safety provide or facilitate training for all investigators in safety management systems, risk management practices, and root cause analysis methods such as the ICAM process to enable investigators to include such an analysis in appropriate investigation reports.

Response and action

Agreed and partially completed

Responsible agency: Department of Justice and Attorney-General

Work has commenced on an Advanced Investigation Skills course. These items will be considered during the finalisation of the course.

A draft version of the training manual has been developed. The related training modules and assessment criteria are yet to be developed. The complete course package is expected to be available for delivery by February 2010.

Recommendation 15

The Division of Workplace Health and Safety give consideration to the experience of inspectors in the industry in which an investigation takes place when allocating investigations to inspectors.

Response and action

Agreed and completed

Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland has considered the Recommendation and confirms that the current case management model applied by Workplace Health and Safety Queensland achieves the outcomes sought by the Recommendation. This model ensures that irrespective of the background of any inspector allocated to lead an incident investigation, the expertise and experience of the regional management team and staff can be accessed. Typically, an investigation is led by an inspector with expertise in investigations processes. This team leader will then co-opt into the team other staff with the other relevant expertise: where necessary, external expertise is utilised.

Recommendation 16

The Division of Workplace Health and Safety in promotion of its role in community safety ensure substantial communication by the Division of the relevant issues resulting from investigations to industry and encourage industry organisations and employers to implement controls in relation to such issues.

Response and action

Agreed and partially completed

Responsible agency: Department of Justice and Attorney-General

Safety alerts and the publication of prosecutions are the two key opportunities to communicate the results of investigation and strategies for workplaces to use to prevent similar occurrence. Safety alerts provide a particularly useful means to alert key stakeholders of risks that are unlikely to be foreseen by employers. A system for publishing successful prosecutions on the department's internet site has been implemented. A review of the current procedure for the development of safety alerts is underway. This review will focus on streamlining the processes to ensure timely publication of safety alerts and the implementation of an appropriate communication strategy for the safety alert.

Implementation of changes arising from the safety alert procedure review is currently being trialled.

Recommendation 17

The Division of Workplace Health and Safety and the Queensland Police Service, in consultation with the state coroner, ensure that the Memorandum of Understanding relating to coronial investigations clearly delineates the responsibilities of each organisation for various elements of the investigation.

Response and action

Agreed and partially completed

Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland is currently reviewing each of its current Memoranda of Understanding (MOU) as part of its response to the Robin Stewart-Crompton review.

Collaboration between Workplace Health and Safety Queensland and Queensland Police Service to review and enhance the Memorandum of Understanding in the aspects of coronial investigations is yet to be completed. It is expected that this process will be completed by 1 December 2009. However, the Queensland Police and the Office of the State Coroner will be included in the development of the revised MOU with Queensland Transport with respect to Maritime Safety and Rail Safety. This Recommendation will then be considered to see if the agreements reached as part of these MOU negotiations can be applied in other coronial investigations.

Response and action

Agreed and partially completed

Responsible agency: Queensland Police Service

The Memorandum of Understanding between Workplace Health and Safety Queensland and the Queensland Police Service is in the process of being reviewed and amended. The revised Memorandum of Understanding is expected to be ready for consideration by the Queensland Police Service executive in the second half of 2009.

Inquest into the death of Samantha Anne Maslen

On 5 June 2005, Ms Maslen was the front seat passenger in a car that was the subject of a police pursuit. The vehicle rolled when it swerved to avoid a tyre deflation device. Ms Maslen died as a result of her injuries.

Ms Maslen's death is one of seven that followed a police pursuit in the period of June 2005 to December 2006. In relation to each, the conduct of the officers involved will be judged against the Queensland Police Service policies in force at the relevant time. However, as those policies have changed significantly during that period, the state coroner refrained from making any Recommendations for future change until the evidence from all seven inquests has been considered and the impact of the changes are evaluated.

State Coroner Barnes handed down findings on 28 August 2008.

Comment 1 (page 21)

Arising from the evidence at this inquest, the issue of training of pursuit controllers has been raised, and warrants further evidence and consideration.

Similarly the policies surrounding the use of tyre deflation devices give rise, at least on first consideration, to some concerns, particularly in relation to the safety of officers deploying them, and potentially other members of the public. The state coroner acknowledges that this observation is based upon the limited information arising in this inquest, and expressed no opinion other than that it warrants further consideration.

Response and action

Under consideration

Responsible agency: Queensland Police Service

Beginning with a trial in two districts from 1 October 2006 and expanding to a statewide trial from 1 January 2008, the Queensland Police Service has introduced a rigorous and more restrictive safe driving policy to address the risks involved in urgent duty and pursuit driving. The new policy was complemented by new offence provisions to deal with motorists who seek to evade police. The policy introduced the concept of non-pursuit matters and gives detailed guidance on when a pursuit may be commenced, what risk factors must be considered and when a pursuit must be abandoned. Training was delivered to all staff (including civilian radio operators) up to and including Inspector in all districts and branches between 1 July and 31 December 2007. In addition, consistent with Recommendations from the Crime and Misconduct Commission and the state coroner, from semester one 2008, police pursuits have formed part of ongoing Operational Skills and Tactics training.

The state coroner has indicated that at the completion of the seven inquests connected to police pursuits, the policy issues arising from the inquests would be addressed. Accordingly, the specific Recommendations arising from this and the other inquests will be considered by the Queensland Police Service once the state coroner's final report is delivered.

Inquest into the death of Elise Susannah Neville

In January 2002, whilst on holidays, Elise Neville fell from the top bunk she was sleeping in. Her parents took her to the Caloundra Hospital and she was discharged back into the care of her parents. Later in the morning an ambulance was called to their unit and Elise was transported by ambulance back to the hospital and then air lifted to the Royal Children's Hospital in Brisbane. Elise's neurological condition continued to deteriorate following surgery and on 9 January 2002 a decision was made to cease life support.

Coroner Lock handed down findings on 12 September 2008.

Recommendation 2

Queensland Health conduct a review of the capacity of rural or remote hospital facilities or regions to perform emergency neurosurgical and vascular surgical procedures, and to identify what staff, training and technology would be required to allow such medical procedures to take place.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

The Queensland Emergency Medical System Coordination Centres in Brisbane and Townsville, tasking Queensland's retrieval teams, endeavour to retrieve sick and injured patients as rapidly and safely as possible, with the optimal clinical escort, to the most clinically appropriate health care facility. However this system does have finite resources and is impacted by influences beyond its control (weather, aircraft availability, concurrent conflicting tasks). Through the Queensland Trauma Plan, roll out of the Early Notification of Trauma Guidelines for both pre-hospital cases and Inter-facility transfers continues.

Funding was provided to establish four major trauma services (treat and manage severe and multiple injuries), these are located at Royal Brisbane and Women's Hospital, Princess Alexandra Hospital, Townsville and the Royal Children's Hospital (as an interim paediatrics strategy whilst the new Queensland Children's Hospital is considered/finalised and is planned to be the final major paediatrics trauma service).

The establishment of these services commenced from approximately October 2008. Royal Brisbane and Women's Hospital, Princess Alexandra Hospital and Royal Children's Hospital are well progressed and for all intents and purposes are up and running as major trauma services. Townsville has commenced developing as a Major Trauma Service and does provide treatment and management of severely injured trauma patients but has some way to go before the full major trauma service is functioning.

A statewide trauma clinical network was endorsed by Queensland Health and commenced in mid to late 2007 and has responsibility for leading implementation of the trauma plan with the exception of the injury prevention components (a separate Injury Prevention Council has been established to lead this. There is cross membership of the network and prevention council to ensure synergy and collaboration). The network reports to the Chief Health Officer as its sponsor.

The network has a small secretariat, including an education officer. The network has endorsed a statewide trauma Education Strategy and has formed an education sub-committee. The Secretariat Education Officer and Network Education Sub-Committee will drive and lead implementation of the education strategy in consultation and collaboration with the four major trauma services who also have education officers (or someone equivalent) as well as education officers in the Queensland Coordination Centre. Officers and services work in collaboration to provide local and statewide education about the major trauma services and clinical coordination (e.g. educate about the trauma plan, service and resource available to clinicians, including clinical protocols).

Processes are continually reviewed and improved as possible. It is anticipated that a Director for the Major Trauma Services will be appointed by end 2008. The *Early Notification of Trauma Guidelines* for both pre-hospital cases and inter-

facility transfers have been submitted to the Patient Safety and Quality Executive Committee and endorsement will be finalised by July 2009. Following endorsement they will be submitted to the Minister for Health through the Chief Health Officer advising that they have been endorsed and accepted as best practice by the key clinical groups involved in trauma and will be adopted as policy and implemented.

The Trauma Clinical Network education strategy is the mechanism to implement the guidelines and education will be ongoing throughout 2009. In North Queensland the use of the Acute Neurotrauma Guidelines continues, with a view to expand the concept statewide with the support of the Statewide Trauma Clinical network.

Recommendation 3

The proposal presently with Queensland Health for funding for medical crewing of retrieval teams for aircraft be approved and implemented as soon as possible.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

The proposal is currently incorporated into a Short Form bid being facilitated and submitted via the Integrated Patient Transport Unit, under the Chief Health Officer.

If unsuccessful, another avenue for funding this service must be found.

Recommendation 4

If it has not already occurred, the proposed delivery of the single pilot Instrument Flight Rules helicopter to the Sunshine Coast retrieval service proceed at the earliest opportunity.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Queensland Health

There is currently no Queensland Health retrieval service on the Sunshine Coast. The current Community Helicopter Rescue Service, via its contract with Department of Community Safety, now has an Instrument Flight Rules aircraft, however they are lacking the medical infrastructure to provide medical escorts on this machine.

Recommendation 5

The telemedicine project be brought on line across the state, and be adequately resourced in money and staff terms. As part of any implementation program there would be a review of which hospitals have perceived gaps in their treatment options so that they can be included.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Queensland Health

There are currently 34 emergency departments in rural areas with videoconferencing (increasing to 42 by end of 2009) that have access to, and training in, the use of this link to the Queensland Emergency Medical System Coordination Centres in Townsville and Brisbane. Statewide there are currently more than 550 videoconferencing systems that are used for more than 4000 sessions a month including clinical and medical education activities.

Additional bandwidth resources for video traffic are required to increase videoconference usage and improve quality. Extension of business hours to support videoconferencing (i.e. bridges, gateways, etc) for clinical activities beyond 9:00am-5:00pm is also required.

Recommendation 6

The request for a half to one full time senior medical officer for the Emergency Department at Caloundra Hospital be approved.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Approval for this was given prior to this Recommendation and funding was allocated on 28 August 2008. A 0.5 full time equivalent Senior Medical Officer commenced on 1 October 2008.

Recommendation 7

Although approval for the installation of a CT scanner has been given and is expected to be in place by August 2009, to be abundantly clear, a Computed Tomography (CT) scanner should be installed at Caloundra Hospital by August 2009.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

A Computed Tomography scanner has been obtained and currently in storage; it will be installed as soon as building works completed.

Construction of Computed Tomography Room scheduled to be completed July 2009.

Recommendation 8

The Medical Board of Queensland progress with some priority to the development of a Standard or other suitable policy alternative regarding the regulation of excessive working hours for doctors in the public and private hospitals sectors.

Response and action

Agreed and partially completed

Responsible agency: Medical Board of Queensland

Following receipt of feedback from stakeholders a further draft *Guideline on Safe and Healthy Work Practices – Fatigue* was considered by the Board at its meeting on 26 May 2009 where some minor amendments were made. The document is currently being prepared for publication.

Recommendation 9

The warning label on bunk beds as provided by the Australian Standard be reviewed by the Office of Fair Trading and other relevant authorities as soon as possible with a consideration that if there is to be a label for bunk beds it should not be age specific or at the very least increasing the age categories for the warning to up to age 14.

Response and action

Under consideration by the Australian Standards Technical Committee for bunk beds.

Responsible agency: Department of Employment, Economic Development and Innovation (the Office of Fair Trading represents the Queensland Government on the Australian Standards Technical Committee).

The Standards Technical Committee responsible for bunk beds met in March 2009. There was considerable discussion about the age suitability of bunk beds. The outcome from the Committee's deliberations was that there was agreement for the age warning on bunk beds to state that bunk beds are not suitable for children younger than 12.

This change will appear in the next published version of the Australian Standard. It is expected that this will occur in late 2009 or early 2010.

Recommendation 10

The working party set up to consider the feasibility of establishing and promoting government funded programmes focussing on removing unsafe bunk beds from private residences proceed to completing its deliberations as soon as possible and the outcome be made public.

Response and action

Agreed and partially completed

Responsible agency: Department of Employment, Economic Development and Innovation

The working party has met once and identified a number of issues that would impact on the practicalities of a government program to remove unsafe bunk beds.

- There is no single agency charged with such a responsibility.
- The determination of an unacceptable safety level of individual bunk beds may be difficult.
- Personnel would have to be trained to assess what constitutes an unsafe bunk bed. The number of people to undertake the safety assessment could be significant.
- Many bunk beds have a limited use period and may be stored away sometimes for many years. Some consumers may see such a program as a 'windfall' opportunity for bunk beds that are not currently in use.
- The logistics and funding required to collect and presumably destroy bunk beds could be significant and the costs to establish such a program could well exceed benefits.
- Bunk beds have a utility in homes where there are many children and small bedrooms. Therefore families may be disadvantaged by removing bunk beds unless the funding extends to a full replacement of a safer product.
- It is open to conjecture how successful such a program would be unless the funding extends to a full replacement of a safer product.

Further meetings of the working party will be held to settle on a way forward. This may involve an education campaign to raise the awareness of consumers and industry about the dangers associated with bunk beds. The working party will hold a meeting before 30 June 2009 to coincide approximately with the date of publication of the Regulatory Impact Statement.

Recommendation 11

The Office of Fair Trade conduct awareness campaigns directed towards the domestic market concerning the standard for bunk beds and the risks and dangers associated with non-compliant beds particularly for children.

Response and action

Agreed and partially implemented

Responsible agency: Department of Employment, Economic Development and Innovation

A draft communications plan has been prepared. The key elements of the plan are to:

- educate users and prospective users of bunk beds as to the dangers bunk beds pose if they do not comply with the mandatory safety standards
- encourage current users of bunk beds to ensure that their bunk beds are hazard free and as safe as possible
- educate users and prospective users in how to quickly check a bunk bed to ensure it is safe for children to use
- ensure manufactures and retailers are aware of their responsibilities in regard to providing a safe product
- raise awareness of short term accommodation providers of bunk bed safety (both the government and private sector).

This component of the project is ongoing but regular activities are planned over a 12 month period commencing from November 2009 and will be reviewed after 12 months.

A *Safe Holiday* brochure has been published. This publication highlights the dangers of unsafe bunk beds in holiday accommodation (as well as some other hazards in holiday accommodation such as unsafe blind cords and the safe use of spa pools). This brochure will be made available to holiday rental centres, real estate agents, tourist information centres, regional Department of Employment, Economic Development and Innovation offices and from the Office of Fair Trading website.

Recommendation 12

To the extent that it is necessary, all bunk beds used in Queensland Government agency owned, managed or funded establishments comply with the Australian Standard.

Response and action

Agreed and partially implemented

Responsible agency: Department of Employment, Economic Development and Innovation

The Minister for Tourism and Fair Trading will write to all potential government agencies that may have establishments with bunk beds recommending they meet key safety requirements of the Australian Standard.

A letter to respective government agencies has been prepared and is currently with the Minister for Tourism and Fair Trading for signature.

Recommendation 13

The Regulatory Impact Statement process commenced in June 2006 be finalised with priority.

Response and action

Agreed and partially implemented

Responsible agency: Department of Employment, Economic Development and Innovation

The research required to develop a Regulatory Impact Statement and meet the requirements of a public benefit test has been commenced.

Dedicated resources have been allocated to progress the Regulatory Impact Statement in a timely manner.

There are a range of options to consider in the Regulatory Impact Statement. These include a regulatory approach such as introducing a mandatory standard on suppliers of short term rental accommodation to only provide bunk beds that comply with key safety requirements. Other non-regulatory options, which may be equally effective, could include concentrated education campaigns directed towards industry and consumers.

The first draft of the Regulatory Impact Statement was completed by 31 December 2008. The release of the Regulatory Impact Statement will be subject to Cabinet approval. The issue is due to be considered by Cabinet on 20 July 2009.

Inquest into the death of a 12 year old boy who died at Kowanyama

In early 2004, in accordance with an arrangement brokered by Department of Families officers in the preceding week, the child moved from the house where he had been living with his adoptive mother to another residence. The following day, the child returned to his adoptive mother's house but in the evening he went missing and searchers failed to locate him. The next morning the child was found deceased in a wardrobe in the bedroom he had previously occupied in his adoptive mother's house.

The identity of the child has been de-identified pursuant to the confidentiality provisions of the *Child Protection Act 1999* (Chapter 6 Part 6).

State Coroner Barnes handed down findings on 19 September 2008.

Recommendation 1: part 1

As a matter of urgency the Department of Child Safety develop policies specific to the delivery of child protection services in Indigenous communities.

The Machinery of Government administrative arrangements in March 2009 saw the Department of Child Safety transition to the Department of Communities.

Response and action

Agreed and completed

Responsible agency: Department of Communities

Following extensive investigations and consultations, a report titled *Delivering Child Protection Services to Remote Aboriginal and Torres Strait Islander Communities in Far North Queensland- Cape Torres- Planning for the Future* was finalised in January 2007. The report contained 25 separate Recommendations which are being implemented over a period of time. The current structure of service delivery to the children of the Cape is a direct result of one of the Recommendations of the report.

The Practice Manual, developed in 2004 and constantly updated, now contains specific policy considerations when working with Aboriginal or Torres Strait Island children.

A community support team, based in the Far Northern Zonal Office, continues to work on establishing recognised entities in communities in Cape York and Torres Strait with interim services operational on Thursday Island, the Northern Peninsular Area, Pormpuraaw and Weipa/ Napranum.

No specific policy has been developed to address working in remote Aboriginal and Torres Strait Island communities because the issues faced in the far north are not isolated to that area but rather they reflect historical and systemic issues across the state.

The overall development of policy and practice has targeted many areas of practice, which has improved outcomes for all children in Queensland.

Initiatives such as the Frontline Work Analysis and Job Design Project has been undertaken to develop and retain staff and ensuring that staff is supported.

Workloads in 2004 were 65 children per Child Safety Officer and have now been reduced to an average of 22 children per Child Safety Officer.

Recommendation 1: part 2

Training packages to assist staff to apply these policies and to understand best practice in this context should also be developed.

Response and action

Agreed and completed in part, with ongoing implications and the potential for further development

Responsible agency: Department of Communities

Cultural Competence Training was developed and has been implemented across all departmental staff since 2006.

Consultation for the training program *Foundation Studies in Culture (Indigenous Engagement)* included staff from the former Indigenous Support and Development Branch in Cairns.

Training commenced in February 2006 and a total of 107 programs were delivered; 1,657 staff have successfully completed this program. Programs were delivered in Cairns in May, June, July and August 2007 and January and September 2008. Over the three year period, 113 staff have completed the training in Cairns.

The training program is specific to the relevant sections of the *Child Protection Act 1999* as it relates to Aboriginal and Torres Strait Island children, as well a knowledge and skill base to assist in identifying social and political issues that continue to impact upon Torres Strait Islander Children.

In recognition of unique and local needs of Aboriginal and Torres Strait families in remote areas, the training is designed to incorporate local Aboriginal and Torres Strait Islander input to develop a skill base to the specific areas and communities that the Child Safety Officers will work in. Unfortunately it has been very difficult to secure guest speakers.

Competencies once a person is engaged as a Child Safety officer also include a section about Aboriginal and Torres Strait Islander Communication Protocols.

Recommendation 2

Resources allocated to the Cape York Torres Strait Islands Child Safety Centre be reviewed to ensure it is sufficiently funded to fill all established positions and provide the training necessary to enable the Child Safety Officers (CSOs) to safely and effectively discharge their functions within the mandated timeframes.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Department of Communities

Using 2004-2005 as the base, funding has increased by 250.1 per cent to the end of financial year 2007-2008.

Funding for employee expenses amounted to $909,355 in the 2004/2005 financial year has increased to $4,994,295.00 in the 2007/2008 financial year.

Funding has been provided for established positions in Cape Torres CSSC, Torres Strait Branch, Weipa Branch, Kowanyama Branch and Cooktown offices. It is not possible to quantify at present the expenditure that each office has incurred specifically attributable to the provision of the positions.

The area that was previously serviced by one service centre is now serviced by 5 centres and has been classified as rural and remote.

Staffing has been increased from 30 positions in 2004 to 65 as at the end of July 2008.

Recommendation 3

The lead agency of the Cairns Suspected Child Abuse and Neglect team pilot and evaluate the constituting of a multi disciplinary, multi agency meeting with the same focus and role of the Suspected Child Abuse and Neglect team in a Cape Indigenous community.

Response and action

Agreed and completed

Responsible agency: Department of Communities

The Child Safety Directors Network was established following the release of the Blueprint for implementing the Recommendations that formed part of the CMC report *Protecting children: an inquiry into abuse of children in foster care.* The Child Safety Directors Network operates at the strategic whole of system level and leads the communication and strategic planning of the child protection system. At this level, emerging issues and gaps in service delivery are identified and enhance multi agency collaboration. The Child Safety Directors Network meets monthly and focuses on improving operational aspects of the child protection system.

A partnership agreement has been negotiated between all core members of Suspected Child Abuse and Neglect team to refocus, with a key element being the ability to discuss concerns that do not meet a notification threshold. This will allow Queensland Police, Health, and Education representatives to bring further information in relation to a particular case for discussion.

Inquest into the death of Michael Warren

Mr Warren, who suffered from Motor Neurone Disease, died on 14 August 2004 from complications of serious burns he received on 28 June 2004 when he was smoking a cigarette at the Beaudesert Hospital.

Deputy State Coroner Clements handed down findings on 25 September 2008.

Recommendation 1

Queensland Health amends its smoking policies to include the need for a safety assessment of fire/burns risk from smoking for those patients with impairments or diminished capacity.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The Alcohol, Tobacco and Other Drugs Branch has amended the Queensland Health Smoking Management Policy aiming to address the issues raised by the coroner. The amended policy includes the directive that medical and relevant non-medical staff should assess nicotine dependence and administer nicotine replacement therapy where necessary, and that if patients smoke during their hospital stay, standard duty of care applies. For patients with diminished capabilities, consideration of the hazards of fire and the risks of burns to the patient and others must be undertaken and documented in the relevant patient notes. Such patients may require supervision while they smoke. This amended policy was approved by the Director-General on 30 January 2009. The Alcohol, Tobacco and Other Drugs Branch is currently promulgating the policy by revising the implementation guide and related smoking cessation clinical chart.

Recommendation 2

Queensland Health note the remarks of the neurologist Dr McCombe who identified the special nursing care needs of people facing the inevitable decline in their capability for independent living due to Motor Neurone Disease. An awareness raising initiative concerning Motor Neurone Disease could help nursing staff appreciate the particular difficulties encountered by those suffering the disease.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The District Directors of Nursing are responsible for addressing nursing related Recommendations as required and apply these Recommendations to their District. Coronial Recommendations are now placed on the Office of the Chief Nursing Officer's website for follow up by the District Directors of Nursing.

The Office of the Chief Nursing Officer completed an environmental scan in early 2009 on available education regarding Motor Neurone Disease and found many larger districts were already doing Motor Neurone Disease nursing education. A standardised in-service program using a Powerpoint presentation had been shared around the state by the clinical network with most districts partaking in the training. The smaller districts who would rarely see or treat Motor Neurone Disease clients did not feel the need to do specialised education on Motor Neurone Disease to their staff. Instead, they felt nurses and other clinicians could use the Clinicians Knowledge Network (available on the Queensland Health intranet) for resources of which there are many resources available freely and quickly. This information on educational resources has been shared with the District Directors of Nursing for their action locally.

Recommendation 3

Queensland Health note the importance of regular hands on training of all staff who may be called upon to extinguish a fire or evacuate patients, staff and visitors. Sufficient resources to enable this training must be prioritised.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Since 2004, Queensland Health has progressively introduced mandatory actions and processes to improve fire safety management. In late 2004 Queensland Health established the Occupational Health and Workplace Safety Unit as a dedicated corporate function to facilitate the advancement of Occupational Health and Safety requirements within Queensland Health. In June 2005 Queensland Health introduced the requirement for each Health Service District to nominate a District Fire Safety Coordinator. The coordinator has responsibilities, through their relevant manager for the development of local procedures and systems for aligning district fire safety activities with Queensland Health corporate policies and strategies and healthcare fire safety accreditation standards.

In January 2006 the Queensland Health Occupational Health and Safety Board began to manage and develop Queensland Health's Occupational Health and Safety Management System utilising risk management principals. This includes addressing legislative compliance, industry exposures and systemic issues, with the aim of reducing harm to Queensland Health staff and patients. In March 2007 this Occupational Health and Safety Board began funding a statewide Fire Safety Team for the design, development and delivery of Agency fire safety initiatives, programs, processes, and systems for Queensland Health. From February 2008 a Statewide Mandatory Implementation Standard OHSMS 2-24#21 for Fire Safety ensures:

- a comprehensive fire risk management process to achieve a high level of safety for persons and property
- fire safety problems which arise are quickly and effectively contained and resolved
- All legal obligations are met in relation to fire safety
- comprehensive fire risk management process to achieve a high level of safety for persons and property
- fire safety problems which arise are quickly and effectively contained and resolved
- all legal obligations are met in relation to fire safety
- appropriate training and information is provided on fire safety to all relevant persons
- knowledge, training resources and lessons are shared throughout QH to help promote a continuous improvement culture.

The key mandatory actions and processes of OHSMS 2-24# are:

- The District Chief Executive Officer, Facility Manager or relevant Statewide Services Manager (or authorised delegate) has overall responsibility to ensure adherence to the Fire Safety Implementation Standard.
- Every Queensland Health staff member has a responsibility to immediately report all fire incidents to their Line Manager, via the Queensland Health Workplace Incident Report. Line Managers are to ensure that all fires are reported to the District Occupational Health and Safety Manager.
- All fires are to be immediately reported to the Queensland Fire and Rescue Service, regardless if the fire has been extinguished or the extent of any damage caused. This ensures that fire and electrical safety issues are thoroughly investigated.
- The District Occupational Health and Safety Manager ensures systems are in place to ensure a notification reaches Workplace Health and Safety Queensland within twenty-four hours of becoming aware of the fire.
- The District Manager or Facility Manager is responsible for ensuring the investigation occurs. The investigation of fire incidents is conducted by an appropriately experienced person (e.g. OHS Unit staff, District Fire Safety Coordinator).

- Each healthcare facility has an Emergency Planning Committee to coordinate the emergency management planning and training requirements. The Emergency Planning Committee shall include the chief and deputy chief wardens and others who may have specialist knowledge, for example, the Engineering Manager.
- Fire safety processes include the planning for emergency evacuation and the establishment and maintenance of an Emergency Control Organisation. During emergencies the Emergency Control Organisation (chief and deputy chief wardens) will ascertain the nature of the emergency, determine and initiate appropriate actions, coordinate staff and emergency procedures and supervise the management of the emergency situation within the healthcare facility
- Each building must have a written Fire and Evacuation Plan. This provides for the safe evacuation of mobility and sensory impaired persons and/or persons receiving critical care.
- Each building is to have trained Warden(s) to implement and coordinate the emergency procedures. Refresher training is required annually.
- Attendance records for all fire and evacuation training (including Warden training) including identifying reasons for non attendance and remedial action.
- At intervals of not more than twelve months, an evacuation exercise is required for each building. In locations where practical evacuation exercises are inappropriate, simulated exercises can be conducted.
- Records for each practical/simulated evacuation exercise for each building are to be maintained. This extends to evaluation of exercises, Recommendations, implementation and monitoring the effectiveness of a building's fire and evacuation plan.
- As a part of induction programs, all staff receive fire and evacuation instructions as soon as practicable, but no later than one month after commencing work. Refresher training occurs annually.
- Maintenance of fire safety installations and equipment is to be undertaken by an appropriate qualified person in accordance with the maintenance requirements of the *Building Fire Safety Regulation*, including keeping records of maintenance.
- A mandatory component of the Australian Council on Health Standards Evaluation and Quality Improvement Program accreditation process is building fire safety inspections. Whether or not they are occupied, owned or leased by Queensland Health, the Australian Council on Health Standards Evaluation and Quality Improvement Program process requires a building fire safety inspection report by the relevant state authority. Queensland Health only recognises the Queensland Fire and Rescue Service as the authority to undertake Australian Council on Health Standards fire safety inspections of Queensland Health occupied buildings whether owned, rented or leased.

Since 1 July 2008, Queensland Health has assisted the Queensland Fire and Rescue Service to develop their Fire Safety Adviser training course. The first two developmental Fire Safety Adviser pilot courses were exclusively for Queensland Health. To date, Queensland Health has seventy qualified Fire Safety Advisers, and is on target to have 100 qualified Fire Safety Advisers by 31 December 2008. To date, no other agency or industry body has achieved this level of Fire Safety Adviser compliance.

Section 36(1) of the new *Building Fire Safety Regulation 2008* states that First-response evacuation instructions may be given by a CD or the internet. This acknowledges that physical operation of fire equipment in the physical workspace is not always achievable or practicable in the work environment.

Queensland Health is currently in negotiations with the Queensland Fire Rescue Service to develop a compliant First-response evacuation instructional DVD, which specifically covers the use and operation of fire hose reels, fire blankets and all types of fire extinguishers.

Inquest into the death of Jillian Peta McKenzie

Mrs McKenzie visited Babinda Hospital complaining of feeling unwell and experiencing chest pain. Mrs McKenzie was examined and discharged. She returned home and died in the early hours the following morning, 13 September 2006.

Coroner Comans handed down findings on 3 October 2008.

Recommendation 1

The appropriate authorities in Queensland Health ensure that the measures taken at Babinda Hospital (referred to in B1 to B6 of Professor Brown's supplementary report) in response to Jillian's death are implemented at all level one hospitals in Queensland and include:

Recommendation 1: part 1

Implementation of the New Heart Foundation Guidelines for the management of Acute Coronary Syndromes 2006 by incorporating them into their current guidelines documents and training schemes for suspected cardiac chest pain.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Queensland Health Clinical Practice Improvement Centre has undertaken a review of chest pain management protocols through extensive consultation with statewide clinical networks and experts including; Cardiac Networks, Emergency Department Networks, Queensland Ambulance Service, consumers, Safe Medication Practice Centre and Patient Safety Centre. As a result of this review the Chest Pain Management Protocol and Acute Coronary Syndrome suite of pathways and management plans for the management of chest pain and Acute Coronary Syndrome were developed based on the National Heart Foundation guidelines and trialled at selected tertiary centres.

These pathways provide best practice guidelines at point of care. The Chest Pain Management Protocol and Clinical Pathway and the Acute Coronary Syndrome suite of pathways, were trialled and evaluated for statewide use during 2008. The chest pain management protocol, medical assessment tool and clinical pathway was implemented statewide in January 2009. The chest pain suite of documents are suitable to be used in any level hospital in Queensland. The statewide Acute Coronary Syndrome suite of management plans and clinical pathways endorsed for tertiary level facilities, required modification for use in non tertiary facilities. The trial of the non tertiary Acute Coronary Syndrome suite of documents commenced in three trial sites in May 2009. The trial sites are Ayr, Warwick and Logan Hospitals. Some of the hospitals using the pathways are Townsville Hospital, Gold Coast Hospital, Prince Charles Hospital, Royal Brisbane Women's Hospital, Princess Alexandra Hospital, Ayr Hospital, Logan Hospital, Warwick Hospital and Longreach Hospital. In addition there is currently a submission from the statewide Cardiac Clinical Network to Executive Management Team for promotion of improved resource allocation for risk stratification of chest pain around the state at district level.

Recommendation 1: part 2

Upgrade of the Primary Clinical Care Manual by Queensland Health and Royal Flying Doctor Service to version five to include the current guidelines for suspected cardiac pain.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The Primary Clinical Care Manual (2007) is reviewed every two years under the *Health (Drugs and Poisons) Regulation 1996*. The Primary Clinical Care Manual 2007 is the principal clinical reference and policy document for Indigenous health workers, registered nurses, medical officers and other health professionals working in rural

and remote Queensland, and contains health management protocols that support the advanced practice of authorised Indigenous health workers, rural and isolated practice and sexual and reproductive health endorsed registered nurses. The interventions recommended in the Primary Clinical Care Manual are based on the best available evidence. The 2007 Primary Clinical Care Manual fifth edition specifically includes a section on cardiovascular emergencies for the management of chest pain, angina and heart attack and is consistent with the Heart Foundation Guidelines for the management of Acute Coronary Syndromes 2006.

The Primary Clinical Care Manual is currently being updated and the sixth edition is due out in June 2009. All current Guidelines will be reviewed during this process including the Addendum 2007 to the National Heart Foundation Guidelines for the management of Acute Coronary Syndromes 2006.

Recommendation 1: part 3

Upgrade the Resident Medical Officer manual to include specifically a section on Acute Coronary Syndrome.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

As of January 2009, Queensland Medical Education and Training will be facilitating a process to develop core content for a Resident Medical Officer manual for all Queensland Health facilities, with the intention that individual facilities will be able to add local content should they wish to do so.

A Prevocational Medical Education and Training Network Oversight Committee will be established to oversee the project and to address a number of other high priority areas. The core content of a Resident Medical Officer manual would include web links to useful resources such as the Acute Coronary Syndrome Clinical Guidelines that all Interns and Post-Graduate Year Two doctors from 2008 Rural and Remote Medical Education Online pilot sites can already access via Rural and Remote Medical Education Online, the online clinical development support system currently being evaluated for roll-out to all Queensland Health prevocational doctors. The core manual is likely to take 12 months (December 2009) to be fully developed, however access to Rural and Remote Medical Education Online for all Post-Graduate Year Two relieving doctors is likely to occur before this time.

Recommendation 1: part 4

Queensland Health purchase of a point of care testing kit for measuring the cardiac specific biomarker toponin using the iSTAT system. In addition, nursing staff be regularly trained in the use of the important bedside testing kit used to rapidly diagnose Acute Coronary Syndrome in the patient presenting with chest pain.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Queensland Health

As part of individual hospital and district responsibility most districts have acquired i-STAT analysers and are guided by Pathology Queensland expertise. Pathology Queensland presently controls approximately 155 i-STAT analysers located from Thursday Island to Stanthorpe and west to Thargomindah. All i-STAT analysers are networked to a Pathology Queensland server located at Herston with patient results passed ultimately to the statewide Pathology Computing (Auslab) service. The Point of Care Testing service is managed from Pathology Queensland's Central Laboratory at Herston with local user training and support from local Pathology Queensland staff in the districts. The local sites are supported with monthly quality and management reports from statewide Point of Care Testing team at Herston.

The service is managed to National Association of Testing Authorities (NATA) accreditation (Medical Testing) standards, in both laboratories and district hospital based installations. This service is regarded as one of the largest and best managed Point of Care Networks in the world.

This is an ongoing program of implementation as and when facilities have available funds. Most health facilities of similar size and capability as Babinda hospital have an i-STAT analyser or are presently installing an analyser.

Recommendation 1: part 5

A clear guideline for the management of Acute Coronary Syndrome with established communication channels according to the National Heart Foundation guidelines 2006 to include decision support for when and how to transfer a patient with chest pain and or Acute Coronary Syndrome to an alternate, higher level facility for ongoing care.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Queensland Health Clinical Practice Improvement Centre has undertaken a review of chest pain management protocols through extensive consultation with statewide clinical networks and experts including; Cardiac Networks, Emergency Department Networks, Queensland Ambulance Service, consumers, Safe Medication Practice Centre and Patient Safety Centre. As a result of this review the Chest Pain Management Protocol and Acute Coronary Syndrome suite of pathways and management plans for the management of chest pain and Acute Coronary Syndrome were developed based on the National Heart Foundation guidelines and trialled at selected tertiary centres.

These pathways provide best practice guidelines at point of care. The Chest Pain Management Protocol and Clinical Pathway and the Acute Coronary Syndrome suite of pathways, were trialled and evaluated for statewide use during 2008. The Chest pain management protocol, medical assessment tool and clinical pathway was implemented statewide in January 2009. The chest pain suite of documents are suitable to be used in any level hospital in Queensland. The statewide Acute Coronary Syndrome suite of management plans and clinical pathways endorsed for tertiary level facilities, required modification for use in non tertiary facilities. The trial of the non tertiary Acute Coronary Syndrome suite of documents commenced in three trial sites in May 2009. The trial sites are Ayr, Warwick and Logan Hospitals. Some of the hospitals using the pathways are Townsville Hospital, Gold Coast Hospital, Prince Charles Hospital, Royal Brisbane Women's Hospital, Princess Alexandra Hospital, Ayr Hospital, Logan Hospital, Warwick Hospital and Longreach Hospital. In addition there is currently a submission from the statewide Cardiac Clinical Network to Executive Management Team for promotion of improved resource allocation for risk stratification of chest pain around the state at district level.

Recommendation 1: part 6

Establishment of regular ongoing medical and nursing staff orientation programs specific to local facilities and capabilities to include familiarization of staff with medical emergency procedures and equipment.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Each Health Service District manages its own orientation programs which are audited as part of standard accreditation processes by independent and external bodies such as the Australian Council of Health Standards and the Postgraduate Medical Education Council of Queensland. Where the transfer of a junior medical officer is to relieve in a more senior position on the approved

Queensland Country Relieving Doctors program, the Executive Director of Medical Services for the transferring facility must certify that the nominated registrant has completed:

- The Queensland Health Clinical Rural Skills Enhancement Workshop (or equivalent program approved by the Board)
- Any emergency practice term required by the Board. Orientation is to be delivered on arrival by the Executive Director of Medical Services (or delegate) and is to cover all areas identified on the Queensland Country Relieving Doctors Program Orientation Checklist, including emergency procedures and the facility's retrieval system.

Recommendation 2: part 1

If a junior doctor is sent to relieve at a hospital such as Babinda, the most senior available doctor be sent.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

Queensland Health has for a number of years experienced significant workforce shortages in prevocational third year doctors due to historically limited numbers of university medical places and increasing specialisation of the medical workforce (i.e. fewer available prevocational third year doctors). While the availability of third year doctors is expected to progressively improve as Queensland's additional medical graduates commence work, at present necessity requires that second year doctors be sent to relieve at rural hospitals.

To address this, Queensland Health is taking a number of actions:

- development of specific job descriptions for relieving doctors to ensure clarity around their scope of practice whilst relieving
- implementation of guidelines for credentialing of rural medical officers, including junior doctors sent to relieve at rural hospitals. It is proposed that the guidelines will limit practice to that of a competent resident medical officer in a senior medical officer or medical officer/ superintendent with right of private practice position
- implementation of systems to determine the skill set of relieving doctors, match this skill set to that required at the rural hospital wherever possible and communicate the relieving doctor's skill set to the rural hospital

Recommendation 2: part 2

If a second year doctor or any other junior doctor is to be sent to relieve at a hospital such as Babinda, then only a doctor who has completed the Continuing Rural Skills Enhancement Course and who has completed the junior doctor curriculum framework by completion of the competencies based modules should be sent.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

Queensland Health has increased the frequency of Clinical Rural Skills Enhancement courses from six per annum to 12 per annum. Queensland Health has also increased the number of places available in ten of the 12 Clinical Rural Skills Enhancement courses this year. At this time, completion of an internship is the only measure of a junior doctor's progress against the Australian Curriculum Framework for Junior Doctors.

Queensland Health is facilitating implementation of the Australian Curriculum Framework for Junior Doctors by allocating $1.2 million in the 2008-2009 financial year to the development of training courses, education modules and short education videos, as well as the purchase of neonatology training equipment. However, first and second year doctors also develop knowledge, skills and behaviours consistent with the Australian Curriculum Framework for Junior Doctors via supervised practice and opportunistic learning in the workplace. The Australian Curriculum Framework for Junior Doctors is aspirational. It sets out the broad

range of capabilities that a junior doctor should have ideally made satisfactory progress towards achieving before entering vocational training.

There is currently no national or state mechanism for verifying an individual doctor's progress against the Australian Curriculum Framework for Junior Doctors. The Australian Curriculum Framework for Junior Doctors is intended to guide the self development of prevocational doctors and to support medical education staff in maximising appropriate learning opportunities for prevocational doctors. The Australian Medical Association Council of Doctors in Training is vehemently opposed to the Australian Curriculum Framework for Junior Doctors being used as an assessment checklist. Directors of Medical Services, or equivalent, assess each individual doctor's capabilities against the needs of the position/s to be relieved before they are released to the Queensland Country Relieving Doctors Program.

Although Queensland Health's Directors of Medical Services Advisory Committee has already agreed that completion of the Clinical Rural Skills Enhancement course should be mandatory before a second year doctor is sent to relieve at a rural hospital, Queensland Health will mandate this as a policy.

Recommendation 2: part 3

There be clear lines of communication set up for all junior doctors relieving at hospitals such as Babinda to access senior practitioners at all times.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

In the Clinical Rural Skills Enhancement course, two sessions are dedicated to support for doctors relieving at rural hospitals. These include a session on support networks for rural practice, which covers orientation and local clinical support for the relieving doctor and a session on perspectives in rural health, which covers when, who and how to call for help.

Under the Queensland Country Relieving Doctors program, a junior doctor relieving in a rural hospital is also provided with the name and contact details for a local clinical support officer. The local clinical support officer is usually a local senior doctor or a senior doctor within reasonable proximity to the rural hospital. However, in some cases the most appropriate senior clinician to provide support may be a rural hospital's director of nursing. The local clinical support officer must ensure that the relieving doctor is provided with a satisfactory orientation to the rural hospital and be available 24 hours per day to provide personal and professional support. Queensland Health will reiterate this policy and direct all hospitals and units providing relief to ensure that the policy is adhered to.

Queensland Health will also implement guidelines for credentialing of rural medical officers that specify the supervision arrangements for a junior doctor relieving at a rural hospital. It is proposed that the Executive Director of Medical Services at the junior doctor's primary employing hospital specify the minimum standard of supervision at the receiving hospital.

Such supervision should preferably be to the standard of the Remote Vocational Training Scheme. For international medical graduates, supervision as prescribed by the Medical Board of Queensland must also be provided, preferably by the same supervisor. If the junior doctor is relieving in a medical officer/superintendent with right of private practice position or in a hospital with no medical superintendent, alternative and agreed remote supervision arranged in consultation with the District Chief Executive Officer.

Inquest into the death of Annette Maxfield

On 24 November 2004, Mrs Maxfield underwent surgery at the Mount Isa Base Hospital, she died later that day as a result of severe haemorrhaging that could not be controlled.

State Coroner Barnes handed down findings on 10 October 2008.

Comment 1 (page 23)

The state coroner referred two medical practitioners to the Medical Board of Queensland for alleged unprofessional conduct.

Response and action

Agreed and partially completed

Responsible agency: Medical Board of Queensland

With respect to the first practitioner, exhibits were requested from the Office of the State Coroner to enable a report to be prepared for Medical Board consideration. Further information has recently been sought from the coroner's office and will be assessed for disciplinary action in the near future.

The Board considered a number of complaint matters with respect to the second practitioner, including the information referred to it by the state coroner relating to Ms Maxfield. The Board is currently seeking comments from the Commissioner, Health Quality and Complaints Commission regarding the Board's investigation report and its proposed disciplinary action.

Inquest into the death of Joseph Douglas Duncan

Mr Duncan died on 9 January 2006 from injuries sustained in a car crash when the car he was a passenger in was involved in a police pursuit.

Mr Duncan's death is one of seven that followed a police pursuit in the period of June 2005 to December 2006. In relation to each, the conduct of the officers involved will be judged against the Queensland Police Service policies in force at the relevant time. However, as those policies have changed significantly during that period, the state coroner refrained from making any Recommendations for future change until the evidence from all seven inquests has been considered and the impact of the changes are evaluated.

State Coroner Barnes handed down findings on 24 October 2008.

Comment 1 (page 15)

At the completion of the seven inquests connected to police pursuits, the state coroner will address the policy issues thrown up by these cases.

In this case there seemed a degree of uncertainty about when the pursuit controller assumed control of the pursuit. The policy is silent on that issue and on whether the transfer of control should be communicated to the pursuing officer.

Response and action

Under consideration

Responsible agency: Queensland Police Service

Beginning with a trial in two districts from 1 October 2006 and expanding to a statewide trial from 1 January 2008, the Queensland Police Service has introduced a rigorous and more restrictive safe driving policy to address the risks involved in urgent duty and pursuit driving. The new policy was complemented by new offence provisions to deal with motorists who seek to evade police. The policy introduced the concept of non pursuit matters and gives detailed guidance on when a pursuit may be commenced, what risk factors must be considered and when a pursuit must be abandoned. Training was delivered to all staff (including civilian radio operators) up to and including Inspector in all districts and branches between 1 July and 31 December 2007. In addition, consistent with Recommendations from the Crime and Misconduct Commission and the state coroner, from semester one 2008, police pursuits have formed part of ongoing Operational Skills and Tactics training.

The state coroner has indicated that at the completion of the seven inquests connected to police pursuits, the policy issues arising from the inquests would be addressed. Accordingly, the specific Recommendations arising from this and the other inquests will be considered by the Queensland Police Service once the state coroner's final report is delivered.

Inquest into the death of Melanie Kate Boyd

On the evening of 22 June 2006 Ms Boyd consumed prescription drugs with alcohol at a party, she became extremely drowsy and was put to bed. Ms Boyd's friends became concerned for her welfare when she failed to rise the following morning. An ambulance was called but attempts to revive her were unsuccessful.

Coroner Smith handed down findings on 5 November 2008.

Recommendation 1

The Minister for Education supply to all secondary schools in Queensland details of the findings in relation to the death of Melanie, for incorporation into their Drug Education Programme as an important case study that young people may be able to relate to, with strong emphasis being given to the fact that her death was directly linked to the inordinate delay in the calling of assistance from the ambulance service, owing to a belief by the students, that the police authorities would be contacted, which is not necessarily the case.

Response and action

Agreed and completed

Responsible agency: Department of Education and Training

The Minister for Education and Training wrote to all Queensland State Secondary Principals and to the heads of Catholic Education and Independent Schools Queensland on the 27 November 2008 in accordance with Recommendations in the coroner's report. He also wrote to the Queensland Studies Authority (QSA) on 6 February 2009. The Minister included copies of the of the coroner's report into the death of Melanie Boyd with this correspondence.

Education Queensland has included the information provided by the coroner relating to Melanie Boyd's death as a case study for circulation to all Queensland schools for inclusion in their drug education program.

Education Queensland updated the materials and resources published on the department's drug education website on 3 March 2009. This update included provision of additional information for schools in relation to calling for an ambulance when illicit drugs have been taken.

These materials were developed in collaboration with the Queensland School Drug Education Strategy Executive Group and are available to all education sectors.

Recommendation 2

That the Minister for Education advise all secondary schools in Queensland to update their current Drug Education Programmes in relation to prescription drugs in the light of this death, and direct them to highlight the fact that some students may hold the erroneous belief that prescription drugs are less dangerous than street drugs.

Response and action

Agreed and completed

Responsible agency: Department of Education and Training

The Minister for Education and Training wrote to all Queensland State Secondary Principals and to the heads of Catholic Education and Independent Schools Queensland on the 27 November 2008 in accordance with Recommendations in the coroner's report. He also wrote to the Queensland Studies Authority (QSA) on 6 February 2009. The Minister included copies of the coroner's report into the death of Melanie Boyd with this correspondence.

Education Queensland has included the information provided by the coroner relating to Melanie Boyd's death as a case study for circulation to all Queensland schools for inclusion in their drug education program.

Education Queensland updated the materials and resources published on the department's drug education website on 5 March 2009. This update included the provision of additional information for schools in relation to pharmaceutical and prescription drugs.

These materials were developed in collaboration with the Queensland School Drug Education Strategy Executive Group and are available to all education sectors.

Recommendation 3

That the Minister for Education advise all secondary schools in Queensland to update their current Drug Education Programmes and highlight the important disclosure that when an emergency triple 0 call is responded to by the ambulance service to treat an injured or sick person (including in relation to drug taking), that does not automatically mean that the ambulance service have to report the incident to the Police Service. The Queensland Ambulance Service is bound by section 49 of the *Ambulance Service Act 1991*, not to provide information that would identify a person who has received ambulance treatment and/or transport. The Queensland Ambulance Service does not notify the Queensland Police Service when they respond to an emergency when illicit drugs are involved except when:

1. The paramedics' physical safety or the physical safety of others are at risk.
2. A death has occurred at the scene.
3. Paramedics respond to a person who has suffered a violent injury such as a stabbing or shooting.

Response and action

Agreed and completed

Responsible agency: Department of Education and Training

The Minister for Education and Training wrote to all Queensland State Secondary Principals and to the heads of Catholic Education and Independent Schools Queensland on 27 November 2008 in accordance with Recommendations in the coroner's report. He also wrote to the Queensland Studies Authority (QSA) on 6 February 2009. The Minister included copies of the coroner's report into the death of Melanie Boyd with this correspondence.

Education Queensland updated the materials and resources published on the department's drug education website on 3 March 2009. This update included the provision of additional information for schools in relation to calling for an Ambulance when illicit drugs have been taken.

These materials were developed in collaboration with the Queensland Ambulance Service, as part of the Queensland School Drug Education Strategy in 2009.

Recommendation 4

That the Minister for Education advise all secondary schools in Queensland to consider implementing for students in grades nine, ten, eleven and twelve, comprehensive first aid courses to ensure that they have a clear practical understanding of how the human body works, and the potential serious consequences of passing out, or going to sleep, after excessive drug and/or alcohol consumption, which can lead to inhalation of stomach contents, and ultimate death.

Response and action

Agreed and completed

Responsible agency: Department of Education and Training

The Minister for Education and Training wrote to all Queensland State Secondary Principals and to the heads of Catholic Education and Independent Schools Queensland on the 27 November 2008 in accordance with Recommendations in the coroner's report. He also wrote to the Queensland Studies Authority (QSA) on 6 February 2009. The Minister included copies of the coroner's report into the death of Melanie Boyd with this correspondence.

Investigation into the provision of comprehensive (16 hours) first aid training for students in Years 9-12 was undertaken.

Currently, in Queensland state schools, as part of the *CPR for Life in Schools* program, all Year 12 students undertake mandatory cardio-pulmonary resuscitation training. The *CPR for Life in Schools*

is an awareness program where students learn about maintaining an airway, rescue breathing and circulation compressions.

This CPR focused first aid training not only teaches students CPR, but also gives them the confidence to take control of a crisis situation.

In support of coronial Recommendation four, the Queensland Government has decided to extend the current *CPR for Life in Schools* program to include mandatory CPR training for year 10 students.

This initiative will be introduced into Queensland state schools from 2010 and become a mandatory part of the Year 10 curriculum from 2011.

Recommendation 5

That the Commissioner of the Queensland Ambulance Service consider, if he is not already doing so, providing copies of the flyer titled 'calling for an ambulance when illicit drugs have been taken' to various sections of the community, and in particular all secondary schools in Queensland on a regular basis, to ensure that important message is distributed as widely as possible.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Department of Community Safety

Currently, the community can access the Queensland Ambulance Service *Calling for an ambulance when illicit drugs have been taken* flyer at the Queensland Ambulance Service website www.ambulance.qld.gov.au.

During the first half of 2009, the Queensland Ambulance Service has extended its distribution of this message by accessing existing communication channels, distribution networks and links to appropriate websites through other Queensland Government agencies.

So far 4,400 flyers have been distributed to other Government agencies for use in their community education materials.

The Queensland Ambulance Service will continue to work with other agencies to embed this important message into community education materials and resources provided by Education Queensland, Queensland Police Service, Queensland Health, Department of Communities and Queensland Ambulance Service.

Education Queensland has used the flyer as part of its Queensland School Drug Education Strategy forums in State and Catholic schools throughout Queensland.

The Drug and Alcohol Coordination Unit of the Queensland Police Service has included the flyer in its education material distributed throughout the state. A PDF file of the flyer has also been sent to the QPS for placement on its website.

Queensland Health has extensive community based health and youth networks. The Queensland Ambulance Service is working with Queensland Health to ensure the flyer is available to the community through these networks.

The Queensland Ambulance Service is working with the Department of Communities to ensure the flyer is widely distributed as part of promotional material for this year's schoolies festival on the Gold Coast and in other centres around the state where young people gather for end of school celebrations. The Queensland Ambulance Service is also working with the Department of Communities to have the flyer distributed through other programs.

Queensland Ambulance Service will also identify appropriate non-government and community based organisations and provide these organisations access to electronic versions of the flyer.

Coronial Investigation into the death of Kenneth Daniel Marshall

Mr Marshall died due to drowning in the vicinity of Deep Water Bend of the Pine River at Bald Hills on 25 October 2007. Mr Marshall fell overboard when his aluminium mono hull vessel hit the wake of a larger vessel travelling ahead of him.

Deputy State Coroner Clements handed down findings on 30 October 2008.

Recommendation 1

At the request of the coroner, Maritime Queensland has considered proposals to highlight safety issues which may help to prevent another death occurring in similar circumstances. An education campaign via visual display and printed material will be implemented over the next twelve months. This will promote the safety advantages of wearing a lanyard when operating any craft and especially small open dinghies. The information will be included in the Guide for Recreational Boating and Fishing in Queensland and the Commercial and Fishing Ships Operational Handbook. Maritime Safety Queensland will feature displays at various boat and aquatic shows featuring the safety advantages of wearing a lanyard when operating vessels, especially small open dinghies. A message will be broadcast as part of Channel Seven's Creek to Coast programme and on commercial radio through 4KQ's Coastwatch programme.

Response and action

Agreed and partially completed

Responsible agency: Department of Transport and Main Roads

Maritime Safety Queensland has undertaken work to comply with these findings.

- Maritime Safety Queensland has included messages that raise awareness of the dangers of operating open dinghies without a lanyard in its Fishing Ships Operational Handbook.
- The next edition of the Guide to Recreational Boating and Fishing in Queensland, to be distributed in July 2009 will also include this message. This publication has an annual circulation of 100,000 copies.
- Maritime Safety Queensland will include feature displays about the safety advantages of wearing a lanyard when operating any craft and especially small open dinghies when it attends boat shows and aquatic events.
- On 23 May 2009, the Channel 7 Creek to Coast program broadcast a safety message promoting the wearing of safety lanyards and the 4KQ radio broadcast at the Sanctuary Cove Boat Show held on 22-24 May 2009 also featured a safety message relating to the wearing of lanyards.

Maritime Safety Queensland has advised the coroner that introducing legislation to require mandatory wearing of lanyards is problematic. Maritime Safety Queensland also advised the coroner that a legislated requirement to remain seated was also considered unworkable.

Inquest into the death of Paul Gerrard Howe

Mr Howe died on 16 June 2007 whilst employed as a truck driver. He was driving a fully laden tipper that lost control when driving down a steep descent.

Coroner Killeen handed down findings on 26 November 2008.

Recommendation 1

Recommendation to Queensland Transport and Sunshine Coast Regional Council.

Clearly visible and prominent warning signs be erected on Jones Road prior to the first descent and prior to the second and final descent on Jones Road informing motorists of:

1. the steep descent, including a percentage gradient;
2. that drivers reduce speed; and
3. inform drivers of heavy trucks to use low gears when descending Jones Road.

The Machinery of Government administrative arrangements in March 2009 saw the Department of Transport transition to the Department of Transport and Main Roads.

Response and action

Not applicable to the Department of Transport and Main Roads and not being implemented

The placing of signage on roads is not within the jurisdiction of the Department of Transport and Main Roads. As Jones Road is under the control of the Sunshine Coast Regional Council, the implementation of the coroner's Recommendation is a matter for the council.

Inquest into the death of Kristina Ann Tynan

Ms Tynan was a passenger in a car which was the subject of a police pursuit on 22 May 2006. Ms Tynan died from injuries sustained when the car crashed into a lagoon after the pursuit was terminated.

Ms Tynan's death is one of seven that followed a police pursuit in the period of June 2005 to December 2006. In relation to each, the conduct of the officers involved will be judged against the Queensland Police Service policies in force at the relevant time. However, as those policies have changed significantly during that period, the state coroner refrained from making any Recommendations for future change until the evidence from all seven inquests has been considered and the impact of the changes re evaluated.

State Coroner Barnes handed down findings on 27 November 2008.

Comment 1 (page 2)

There are two aspects of the investigation which raise some concern:

- Neither officer in the pursuing vehicle was required to undertake a breath test following the pursuit.
- The driver of the crashed vehicle, Mr Keyworth, was initially interviewed, both at the roadside and later in hospital, by Senior Constable Behne – the senior officer in the pursuit vehicle.

Response and action

Under consideration

Responsible agency: Queensland Police Service

Beginning with a trial in two districts from 1 October 2006 and expanding to a statewide trial from 1 January 2008, the Queensland Police Service has introduced a rigorous and more restrictive safe driving policy to address the risks involved in urgent duty and pursuit driving.

The new policy was complemented by new offence provisions to deal with motorists who seek to evade police. The policy introduced the concept of non-pursuit matters and gives detailed guidance on when a pursuit may be commenced, what risk factors must be considered and when a pursuit must be abandoned. Training was delivered to all staff (including civilian radio operators) up to and including Inspector in all districts and branches between 1 July and 31 December 2007. In addition, consistent with Recommendations from the Crime and Misconduct Commission and the state coroner, from semester one 2008, police pursuits have formed part of ongoing Operational Skills and Tactics training.

The state coroner has indicated that at the completion of the seven inquests connected to police pursuits, the policy issues arising from the inquests would be addressed. Accordingly, the specific Recommendations arising from this and the other inquests will be considered by the Queensland Police Service once the state coroner's final report is delivered.

Regarding the two aspects of the investigation which raised some concern with the state coroner in this instance, the Queensland Police Service already provides policy in relation to breath testing of officers involved in a pursuit. Queensland Police Service policy currently requires the breath testing of officers involved in critical incidents, including vehicle pursuits in which a person dies or because of which a person is admitted to hospital for treatment of injuries. Additionally, it is current policy that wherever practicable, members who are involved in an incident causing death or serious injury, or who are witnesses to the incident, do not undertake, or continue to perform duties associated with the investigative process, or other duties at the scene.

Inquest into the death of Oliver Steven McVey

Baby Oliver was identified as having a congenital heart defect. The condition was successfully dealt with in surgery, however he died on 15 April 2006 due to complications from the re-insertion of an endotracheal tube which was being changed in an attempt to overcome ventilation problems.

Deputy State Coroner Clements handed down findings on 28 November 2008.

Recommendation 1

- The Mater Hospital considers the importance of continuity of care, good handover procedures.
- The Director of Nursing at the Mater Hospital considers issues raised by the mother regarding the standard of care.
- That the Mater Hospital considers the importance of sufficient accurate recording of observations.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The Mater Mothers Hospital has introduced the Neonatal Daily Care Record for the improvement of handover procedures. The documented records all observations for a 24 hour period from midnight, information required to be reported at nurse shift handover, feeding, checking of equipment and care related activities required to be conducted that day. A *Minimum requirement for observations* document is also laminated and positioned at the bedside of each infant.

The Director of Nursing and Midwifery Services at the Mater Mothers Hospital has considered the issues raised by Mrs McVey regarding the standard of care given to Oliver. In response, care paths have been introduced that are specific to developmental needs and include the parents in all areas of care delivery, with a focus on informing the parents of what is happening and what to expect. A re-configuration of cots within the neonatal unit has also occurred, which supports better quality service delivery and contemporary practice. The new Mater Mothers Hospital includes new, updated and standardised equipment throughout, and all monitors have standardised minimum and maximum alarm levels.

All nursing staff are oriented to these practices. The *Orientation Brochure for Agency Staff* is given to all agency, casual and deployed staff, and includes information on topics such as observation frequency, frequently used policy numbers, information required for shift handover, documentation requirements and safety requirements to help standardise nursing practices within the Mater Hospital Neonatology Department.

The Mater Mother's Hospital has also funded 20 staff to attend the Australian Catholic University Tertiary Graduate Certificate for Neonatal Nurses, allowing for the number of core staff to be increased and therefore decreasing the reliance of agency staff. A *Minimum requirement for observations* document is also laminated and positioned at the bedside of each infant, and observation requirements outlined within the *Orientation brochure* for agency staff.

Recommendation 2

The Mater Hospital needs to consider how they monitor compliance with adequate, regular and detailed general record keeping in the medical record.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Quarterly chart audits are conducted relating to nursing documentation, of which the findings are reported to staff at departmental work team meetings. Strategies for improvement are discussed at the team meetings and issues escalated to the Deputy Nursing Director for the department. Medical staff are also informed of findings and strategies for improvement.

Guidelines for medical staff documentation in patient records are outlined in the *Neonatal Medical Officer Orientation* booklet and an audit on medical documentation was conducted in January 2009.

The audit covered aspects such as percentage of medical entries in the notes and percentage of clinical examinations recorded according to each category of unit type and babies under private or public care. Audit results showed that the guidelines within the Medical Orientation Manual on the frequency of examination are being adhered to.

Recommendation 3

Queensland Health consider formalising a process for parents to record their concerns and questions.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Queensland Health Service Districts use a range of processes to provide parents with the opportunity to record any concerns or questions about a baby who is being treated in a level two or three special care nursery. Most district special care nurseries use multiple processes such as providing opportunities for individual discussion with the treating clinician, documentation of parental concerns in the chart by nursing staff, parental involvement in development of a care plan and the opportunity for parents to use a message board or cot-side chart to communicate with nursing staff. Parents also have the ability to escalate concerns through the Nurse Unit Manager or Patient Safety Officer.

Queensland Health will write to all District Chief Executive Officers to promote documentation and/or implementation of formal processes to enable clear and prompt communication between parents and the clinicians involved in treating their baby or child, particularly where multiple clinicians are involved. Additionally, the Mater Hospital will be implementing BADGER, a computerised medical record which provides access for parents from the bedside and off campus.

The Hospital will also be implementing notice boards at the end of each infant's bed to provide an area for parents to place notes to staff as needed. The Mater Hospital is also currently reviewing the introduction of Parent Journals for staff to update baby's progress and outlining condition and treatment definitions and explanations.

Recommendation 4

That Queensland Health considers funding randomised controlled clinical trials to assess the benefit of echocardiographs in early diagnosis.

Response and action

Not agreed and not being implemented

Responsible agency: Queensland Health

In response to this Recommendation, expert opinion has been provided by the Director of Neonatology at the Mater Mothers Hospital, as well as the Chair of the Queensland Health Maternity and Neonatal Statewide Clinical Network.

The opinion of both experts is that conducting research into the diagnosis of this condition should not be supported as the condition is extremely rare. It is rare to have a patent ductus arteriosus in this group and it would be unusual to have to ligate more than one baby born at greater than 29 weeks gestation per year.

The Director of Neonatology at the Mater Mothers Hospital goes on to state that echocardiography is only indicated to confirm the clinical diagnosis and that research of this type would also not be feasible due to the high numbers of infants of a certain gestation needed to produce a statistically significant outcome.

Even with such an outcome, it would not be clinically useful as a treatment of patent ductus arteriosus does not depend merely on making diagnosis but on a full clinical assessment.

Both doctors agree that this is more an issue of improved access to echocardiography services, of which the Mater Mothers Hospital now has due to the Queensland Paediatric Cardiac Centre being based on site, as well as there being more echo expertise amongst the neonatologists on staff.

Recommendation 5

The Mater Hospital address how it will properly teach its medical staff about the appropriate and safe use of ventilators.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The safe and proper use of ventilators is primarily the responsibility of the consultant staff (neonatologists) rather than the junior medical staff. Neonatologists are all well versed in the use of ventilators, and registrars and fellows are always supervised, particularly when a baby is being ventilated. Registrars and fellows are educated in use of ventilation during ward rounds and it is also covered in their introduction to the Mater Neonatology Service. The Neonatal Service also runs regular workshops on high frequency ventilation for nursing and medical staff.

Recommendation 6

The Mater hospital considers the utility of Laryngeal Mask Airways in similar life threatening circumstances.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Laryngeal mask airways are available on the resuscitation trolley on the Neonatal Nurseries at the Mater Mothers Hospital.

The use of these airways is taught at the neonatal resuscitation courses that are run several times a year. The application and use of Laryngeal Mask Airways is included in the Neonatal Resuscitation Program Workshop.

Recommendation 7

Queensland Health ensures that when unexpected deaths occur in hospitals the on call coroner or on call forensic pathologist must be contacted to discuss whether medical lines and other apparatus are to be removed from the deceased person prior to autopsy.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Information on scene preservation, particularly the removal of medical lines and other medical apparatus is available within the coroners Investigation Guide, which has links to the document *Preserving evidence when a reportable death occurs in a healthcare setting*, written by the state coroner. This document is also available online via the Patient Safety Centre website. The Patient Safety Centre has also recently launched an elearning program on all aspects of coronial management, including when to consider preserving the scene. This program is targeted towards junior doctors, however all Queensland Health staff can access it.

Inquest into the death of Jane Rose Sturgiss

Ms Sturgiss died as a result of a single vehicle accident on 21 May 2007 on the Leichhardt Highway north of Taroom.

Coroner Cornack handed down findings on 10 December 2008.

Recommendation 1

Queensland transport promote of continue to promote the risk of speeding and fatigue in motor vehicle crashes.

Response and action

Agreed and completed with ongoing implications

Responsible Agency: Department of Transport and Main Roads

Queensland Transport conducts ongoing road safety campaigns that focus on the issues of fatigue and speeding. The latest campaign *Here for Life* was launched on 19 May 2009. This campaign focuses on the sentimental moments such as birthdays, anniversaries and holidays, that motivate Queenslanders to drive safely and be here for life.

The *Here for Life* road safety campaign features an interactive social networking website www.hereforlife.qld.gov.au where everyday Queenslanders can share 'lifepix', read other people's stories and actively demonstrate their support for safe driving. The campaign also incorporates television, outdoor and online advertising.

The Department of Transport and Main Roads anticipates that showing people's motivations for driving safely will highlight the fact that road safety is a community issue.

Recommendation 2

The Office of Workplace Health and Safety promote healthy practices about courier drivers to prevent similar deaths by encouraging employers not to have unrealistic expectations of employees travelling such long distances after a full day's work.

Response and action

Agreed and completed

Responsible agency: Department of Justice and Attorney-General

In December 2008 Workplace Health and Safety Queensland's website was updated to include information for delivery and courier drivers in the road transport industry.

The information available to persons operating in this industry sector includes the topics of:

- fatigue
- driving and maintenance
- electrical
- environment
- hazardous substances
- manual tasks
- people and traffic
- slips, trips and falls
- working temperatures.

The website is also linked to the Queensland Transport website where additional information on fatigue management is available.

Inquest into the death of Craig Robert Shepherd

Mr Shepherd was the driver of a motorcycle which was the subject of a police pursuit. Mr Shepherd died from injuries sustained when he attempted to take a tight turn at too high a speed, causing him to lose control.

Mr Shepherd's death is one of seven that followed a police pursuit in the period June 2005 to December 2006. In relation to each, the conduct of the officers involved will be judged against Queensland Police Service policies in force at the relevant time. However, as those policies have changed significantly during that period, the state coroner refrained from making any Recommendations for further change until the evidence from all seven inquests has been considered and the impact of the changes are evaluated.

State Coroner Barnes handed down findings on 12 December 2008.

Comment 1 (page 21)

The state coroner is of the view that Queensland Police Service policy was breached when the pursuit was not terminated when the motorcycle entered onto Beechmont Road. The state coroner is of the view the policy was breached when the police communications centre was not advised the pursuit was underway.

Comment 2 (page 25)

The state coroner intends referring the conduct of the four officers to the Queensland Police Service for the consideration of the taking of disciplinary action.

Response and action

Under consideration

Responsible agency: Queensland Police Service

Beginning with a trial in two districts from 1 October 2006 and expanding to a statewide trial from 1 January 2008, the Queensland Police Service has introduced a rigorous and more restrictive safe driving policy to address the risks involved in urgent duty and pursuit driving.

The new policy was complemented by new offence provisions to deal with motorists who seek to evade police. The policy introduced the concept of non-pursuit matters and gives detailed guidance on when a pursuit may be commenced, what risk factors must be considered and when a pursuit must be abandoned. Training was delivered to all staff (including civilian radio operators) up to and including Inspector in all districts and branches between 1 July and 31 December 2007. In addition, consistent with Recommendations from the Crime and Misconduct Commission and the State coroner, from semester one 2008, police pursuits have formed part of ongoing Operational Skills and Tactics training.

The state coroner has indicated that at the completion of the seven inquests connected to police pursuits, the policy issues arising from the inquests would be addressed. Accordingly, the specific Recommendations arising from this and the other inquests will be considered by the Queensland Police Service once the state coroner's final report is delivered.

Regarding the referral of the officer's conduct for consideration of taking disciplinary action, any disciplinary matter referred to the Queensland Police Service will be dealt with in accordance with existing policy and relevant legislation. The Queensland Police Service has a comprehensive complaint management and discipline process, designed to satisfy the requirements of the *Police Service Administration Act 1990*, *Police Service (Discipline) Regulations 1990* and *Crime and Misconduct Act 2001*, The Queensland Police Service provides clear guidelines in relation to standards of conduct for its members.

Inquest into the death of Robert Harris

Mr Harris had a history of mental health issues. He was an out patient of Cairns Integrated Mental Health Service when he died on 28 June 2006.

Coroner McGinness handed down findings on 15 December 2008.

Recommendation 1

Queensland Health continues to develop and implement a competency based training module on Clinical Documentation Standards to provide for competency based education modules to mental health and primary health staff in the Cairns Integrated Mental Health Service. Education modules should include risk assessment, mental status examination, Mental Health First Aid and Indigenous Mental Health First Aid training. The evidence of Mr Freele was that this has already commenced with the appointment of two clinicians to educate staff. Clearly, these positions need to be extended. Further funding is required.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Cairns Integrated Mental Health Service commenced participation as a pilot site in the trial of the statewide standardised mental health clinical documentation suite in May 2007.

130 staff including medical officers, nurses, allied health, health workers, administration officers and consumer and carer representatives, participated in the initial documentation training that was facilitated by the Patient Safety Centre in May 2007.

The Patient Safety Centre returned to Cairns in June 2008 to deliver five additional training sessions and a further 65 staff participated. This included staff from the Tablelands, Innisfail, Cape York and Torres Strait Mental Health Services. The Queensland Centre for Mental Health Learning came to Cairns in May 2007 and August 2008 to deliver Mental State Examination and Suicide Risk Assessment and Management training sessions.

In total these sessions have been attended by 194 staff including nurses, allied health and medical officers from Cairns, Tablelands, Innisfail, Cape York and Torres Strait Mental Health Services. Sessions have been deemed mandatory by the Cairns Integrated Mental Health Service Executive.

Recommendation 2

The Cairns Integrated Mental Health Service introduce a training package with competency based assessment for all clinicians working in acute mental health services where they might have responsibility for initial assessment. The package should cover history taking, mental state examination, provisional diagnosis, risk assessment and initial management planning.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Queensland Centre for Mental Health Learning has delivered Cairns Integrated Mental Health Service with training in *Critical Components of Risk Management and Assessment* over the past three months.

This training package covers the principals of risk assessment and management, risk and protective factors, the range of risks in clinical practice, cultural issues in risk management; the use of the *Mental Health Act* in risk management, clinical management strategies to reduce risk, the importance of linking the risk management plan to risk assessment and completion of a competency based assessment.

127 participants have attended this training this year and Queensland Centre for Mental Health Learning will continue to provide training for mental health staff as needed.

Recommendation 3

Enhancement of the Cairns Integrated Mental Health Service internal audit system to allow clinical audits to be regularly conducted in all Cairns Integrated Mental Health Service services.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The Cairns Integrated Mental Health Service's internal audit system has developed as a result of participating in the trial of the statewide standardised mental health clinical documentation.

Clinical file audits were conducted at the three, six and 18 month points of the trial. A total of 135 files across seven individual teams including the Mental Health Unit and Acute Care Team were audited on each occasion. Each team involved in the audit received an individual team report and an overall service report identifying their results including noted areas of improvement and those areas identified as requiring further improvement.

An audit of clinical documentation was undertaken in March/April 2009 using a newly developed statewide clinical documentation audit tool. This audit was conducted across 10 adult mental health teams throughout the service including the Mental Health Unit, with a total of 120 charts audited. Audit data has been collated and the reports are nearing completion. Each team involved will receive a copy of their individual team report and a copy of the service-wide report. A copy of the service-wide report will also be forwarded to the Patient Safety Centre.

The statewide Child and Youth documentation audit has also been completed and the reports nearing completion. The Older Persons statewide audit will be conducted in June 2009 after all staff are trained in the use of the audit tool, provided by the Patient Safety Centre. Cairns Integrated Mental Health Service's Quality and Safety positions are members of the North Queensland Mental Health Network Quality and Safety Subgroup. The Subgroup lobbied the Network for funding to implement a Clinical Audit position for a two year period and was successful in doing so. The Clinical Audit position has been instrumental in completing an audit of all consumers discharged from the Mental Health Unit in October 2008. The audit focussed on discharge follow up practices, and both hospital and community charts were audited. The outcome report is nearing completion which will include Recommendations for improvement.

Recommendation 4

Redesign of the Cairns Base Hospital Emergency Department be undertaken as soon as possible to provide a better environment for optimum assessment and treatment for the increased population. This will enable mental health patients presenting to the Emergency Department to be appropriately assessed and managed within the Emergency Department environment until discharged to another area in the hospital or other service. Some funding has already been allocated.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

The redesign of the Cairns Base Hospital Emergency Department is currently underway and due for completion in 2010.

A dedicated Mental Health Pod has been included as part of the redesign. This area will be utilised for the assessment of mental health consumers and is not an inpatient area. The design of the Mental Health Pod is being informed by Mental Health and Emergency Department staff in the Emergency Department and Mental Health Design and Planning meetings. These meetings are integrated in to the overall redevelopment of the Cairns Base Hospital complex. The Cairns Integrated Mental Health Service has attempted to earmark funding associated with the hospital redevelopment, for two new recurrent nursing positions to provide 24 hours a day, seven days a week coverage to the Emergency Department however this funding has not been forthcoming.

Recommendation 5

Urgent Funding for the Cairns Acute Care Team to expand their clinical cover to the Cairns Base Hospital Emergency Department and the community so as to provide immediate clinical care and support for the redesigned Emergency Department Mental Health area (referred to during the inquest as a 'Pod'). As a priority, the Cairns Acute Care Team expands their clinical cover in Cairns Base Hospital Emergency Department to 24 hours a day, 7 days a week.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

A Mental Health Emergency Department Liaison Clinical Nurse Consultant position was established and trialled from existing Mental Health Unit funds in September 2007 to September 2008.

The position was advertised and permanently appointed to in October 2008. Funding was secured from 2008-2009 enhancement funds to enhance the staffing of the Acute Care Team by an additional three clinicians and one registrar. Appointments to all of these positions have been finalised and the successful applicants have commenced. Funding has been secured from 2009-2010 enhancement funds to enhance cover to the Emergency Department through the establishment of an additional Mental Health Emergency Department Liaison clinician position.

This position will be recruited after June 30, 2009. To date there are still insufficient funds to provide cover to the Emergency Department 24 hours a day, seven days a week.

Recommendation 6

Allocation of funding to the Cairns Integrated Mental Health Service for the creation of a second Acute Care Team Psychiatry Registrar position to provide efficient Psychiatric medical treatment in a timely manner and decrease the 'after hours' burden in the Emergency Department. This position would cover Emergency Department Mental health emergencies during working hours five days per week and also participate in the Psychiatry Registrar After Hours On Call Roster. The addition of more Psychiatric Registrars to the After Hours On Call pool decreases the Registrar On Call burden.

Response and action

Agreed and completed

Responsible agency: Queensland Health

As noted above, funding for an additional Acute Care Team Registrar position was secured from the 2008-2009 enhancement funds and this position has been appointed to.

The implementation of an additional Acute Care Team Registrar has enabled Registrar cover to the Emergency Department five days a week and enhancement of the After Hours on-call pool of registrars. A consultant psychiatrist also attends the Emergency Department from Monday to Friday and an on call consultant psychiatrist is available to attend the Emergency Department on weekends.

Recommendation 7

The Clinical Director of the Cairns Integrated Mental Health Service to ensure all clinical staff in the Emergency Department are aware of Queensland Health's guidelines relating to the management of people with suicidal behaviour or risk.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The Cairns Integrated Mental Health Service Management of Consumers with Suicidal Behaviour or Risk procedure that was developed and implemented in 2005 was updated in June 2008 and is available to all staff on the Cairns & Hinterland Health Service District site on the Queensland Health intranet. Part of the role of the Mental Health Emergency Department Liaison

Clinical Nurse Consultant is to provide education to Emergency Department staff regarding current mental health clinical practice guidelines and procedures.

Recommendation 8

Queensland Health immediately ceases the practice of requesting patients with mental health issues to guarantee their own safety.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Queensland Health

Queensland Centre for Mental Health Learning provides a range of training packages for Risk Assessment and Management and Suicide Prevention. The training does not include requesting the client to guarantee their own safety.

The training promotes an alternative strategy in developing a safety plan (or crisis Intervention plan) with the person. This is the act of planning, in collaboration with the person, a response to either the immediate suicidal episode or the possibility of recurring suicidal behaviour. Workers must balance their crisis intervention response to the presentation of the person and the person's ongoing treatment and community resource needs.

Recommendation 9

The Cairns Integrated Mental Health Service introduce a system to review separations from the Cairns Base Hospital Emergency Department. A Consultant Psychiatrist should be allocated this duty. The psychiatric duties should include conducting a chart review of all separations to ensure the adequacy of the following: history and collateral history, description of mental state, risk assessment, clear clinical reasoning, management plan, Recommendations for ongoing management, compliance with *Mental Health Act*, and provision of a summary to the referrer or GP. The Psychiatrist should be responsible for pursuing and correcting any deficiencies.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The Cairns Integrated Mental Health Service *Consultant review of charts for patients seen in Cairns Base Hospital Emergency Department by night or weekend psychiatric registrars on call* workplace protocol was developed and implemented in June 2007.

The workplace protocol is available for all staff to access on the Cairns & Hinterland Health Service District site on the Queensland Health internal website. The workplace protocol outlines the process for consultants to review all charts for patients who were seen in the Emergency Department over night or on a weekend by a psychiatric registrar.

Recommendation 10

Whenever possible, two mental health workers complete a mental health risk assessment. In the event of any difference of opinion, a Consultant Psychiatrist review the assessment

Response and action

Agreed and completed with ongoing implications

Responsible agency: Queensland Health

Queensland Health, through Queensland Centre for Mental Health Learning, provide training in mental health assessment and risk assessment and management.

Clinicians undertaking this training are encouraged to consult the clinical team, which includes the consultant psychiatrist, as part of the decision making process. Where there is a difference of opinion the consultant psychiatrist makes the final decision. Where the client is in

the care of a team, the clinical team is required to review the clinical care at a minimum of three monthly. Where there is a significant change in the circumstances of the client the review should be conducted earlier.

Recommendation 11

Queensland Health amend its Guidelines for the management of patients with suicidal behaviour or risk to include a requirement that where there is a dispute between clinicians as to the likelihood, magnitude or immediacy of risk, a Consultant Psychiatrist review the matter.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The *Guidelines for the Management of patients with suicidal behaviour or risk* was reviewed in February 2007.

The document states that where any doubt exists surrounding a person's risk then a more senior clinician should be consulted. The guideline goes on to say that hospital protocols should specify lines of responsibility and how to access senior medical clinicians (including specialist Child and Youth clinicians) for assessment, second opinions, and treatment planning.

The Guidelines are currently under further review by the office of the Principal Advisor in Psychiatry, Mental Health Branch for ongoing quality improvement.

Recommendation 12

The Cairns Integrated Mental Health Service introduce a system to allocate a Consultant Psychiatrist to supervise each mental health patient's management. This would ensure consistency in treatment and identify to patients and their families a specific Consultant Psychiatrist with whom they can communicate.

Response and action

Agreed and completed

Responsible agency: Queensland Health

There is a Consultant Psychiatrist attached to each clinical team in the Cairns Integrated Mental Health Service whose role it is to provide clinical leadership and support to the clinical staff within the team. Consultant psychiatrists participate in multi-disciplinary clinical case reviews of consumers seen by the Cairns Integrated Mental Health Service.

Recommendation 13

The Cairns Integrated Mental Health Service consider the Recommendation by Dr Kingswell that the service consider introducing stricter requirements for the direct involvement of consultant psychiatrists in the assessment and management of patients over 50 years of age presenting to mental health services for the first time with depressive illness, particularly in the setting of a first suicide attempt.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

The existing Cairns Integrated Mental Health Service's (CIMHS) *Management of consumers with suicidal behaviour or risk* procedure does make reference to suicide behaviour in a middle-aged or elderly person constituting high risk, however this procedure requires further review and update to clearly articulate requirements around the assessment and management of consumers over 50 years of age presenting with suicidal behaviour.

The existing CIMHS *Clinical Risk Assessment* procedure to also be reviewed and updated accordingly.

Recommendation 14

Plans and funding to increase the number of Mental Health Inpatient Beds at the Cairns Base Hospital continue so as to meet existing and projected need.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

16 additional Mental Health Unit beds are planned to be available by 2014 and six to 10 of these are planned for implementation by 2011.

A number of Cairns Integrated Mental Health Service staff and a consumer and carer representative have formed the Cairns Base Hospital Mental Health Unit Redevelopment Working Group. This Working Group will inform plans for the redevelopment and expansion of the Cairns Base Hospital Mental Health Unit.

Recommendation 15

The Queensland Health Patient Safety Unit and the Queensland Director of Mental Health should follow up on the Recommendation from the Lees Inquest that all findings from Coronial inquests into the deaths of mental health patients be summarised and distributed on a regular basis to Executive and Clinical Directors of District Mental Health Services.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The Patient Safety Centre has undertaken a commitment to provide a quarterly report to the Director of Mental Health and the Chairs of each of the Area Mental Health Networks for distribution amongst clinical directors of mental health services. The quarterly report includes a synopsis of all coronial inquest findings handed down during the previous quarter.

Recommendation 16

The Director of Mental Health accelerate the implementation of a statewide electronic network of patient information that allows treating health professionals, including both inpatient and community professionals, such as general practitioners, to rapidly access patient data throughout the State. Queensland Health must provide the necessary funding as a matter of priority. This should incorporate Mental Health Database applications and clinical notes.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The implementation of the Consumer Integrated Mental Health Application in November 2008 provides the capacity for inpatient and community public mental clinicians to access detailed clinical information, including the clinical notes, of mental health consumers throughout the state.

The Mental Health Branch has initiated the process to secure additional funds to enable the phase two development of the application. Initial consultation has identified adding the capacity to securely transfer key pieces of clinical information to general practitioners and other relevant external stakeholders as a priority for phase two. Providing the ability for direct access by external health providers to confidential consumer information within Integrated Mental Health Application is dependant on the successful deployment of the Non-Queensland Health Employee External Access Project which is currently in the planning phase.

Recommendation 17

Consideration be given to establishing a regular formal minuted meeting between the public and private sector medical staff that facilitates frank discussion of problems experienced from both perspectives and generates workable action plans to resolve identified difficulties.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

Mental Health Services in Queensland have undertaken a Clinical Service Capability Framework review which involved both public and private service providers. This working relationship has been effective in a numbers of ways and highlights the need for more formal links. The Queensland Electroconvulsive Therapy Committee includes private psychiatrists as members of the committee and associated training program.

The issue is to be referred to the Statewide Mental Health Network for consideration and action.

Recommendation 18

The Cairns Integrated Mental Health Service receive funding to implement the 'Partners in Mind' primary mental health care framework. This will improve referral pathways and collaborative management of mental health patients between the public and private system.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

Queensland Health and General Practice Queensland continue to support the implementation of the Partners in Mind Framework across seven demonstration sites within Queensland.

A consultant has been employed to review and revise the Queensland Framework for Primary Mental Health Care and to evaluate the implementation and effectiveness of the Partners in Mind Framework. The results of this evaluation will be provided to Queensland Health in November 2009 and will inform the future implementation of the framework across Queensland.

Cairns Integrated Mental Health Service has been identified as a future Partners in Mind site, contingent on the outcome of the evaluation. As part of the Queensland Government's response to the Council of Australian Government National Action Plan on Mental Health 2006-2011, the Cairns Health Service District received funding to employ a Service Integration Coordinator to implement the Queensland Care Coordination model.

The model focuses on improving the collaboration between State and Commonwealth Government agencies, non-government organisations and the private sector to provide consumers with severe mental illness and complex care needs with a coordinated, multi-agency support response.

It is anticipated that Service Integration Coordinators will ensure integration with primary health care providers and engage housing, employment, disability support and other agencies to provide a seamless system of care for people with a severe mental illness. The Cairns Integrated Mental Health Service continues to facilitate the Mental Health/General Practitioner Partnerships meetings for the purpose of discussing the ongoing development, implementation and evaluation of share care arrangements between mental health and General Practitioners and other initiatives that aim to enhance the relationship between the two service providers to ensure collaborative management of mental health consumers.

Examples of some initiatives that have been developed as a result of these meetings include the Cairns Integrated Mental Health Service Flipchart that was developed specifically for General Practitioners to inform them of the services provided by the Cairns Integrated Mental Health Service that they can access and the implementation of the Option A clinics.

Recommendation 19

Statewide development and implementation of a family focussed model of care that recognises the importance of the views and needs of families and carers of patients in the development of care plans. This should be underpinned by policy statements, clinical care guidelines and competency based training around the topic. This should also include the provision of information to families concerning mental health illness.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The standardised suite of mental health clinical documentation incorporates prompts throughout to ensure clinicians include the views and needs of families and carers of clients with a mental illness.

The user guidelines also contain information on the inclusion of needs of families and carers. Training of all clinicians has been implemented by the Patient Safety Centre. Negotiations are currently being undertaken by the Patient Safety Centre to have online training available for all staff throughout Queensland.

Recommendation 20

Medium to high risk mental health patients should only be placed under the supervision of family members or friends when the mental health clinicians are satisfied that the family/lay carers have the capacity to provide appropriate supervision, are properly informed of the risks that they are assuming, and they have enough information to do their job including when and who to call for assistance.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Queensland Health

The standardised suite of mental health clinical documentation, implemented following a pilot in 2008, include a range of prompts regarding the role of families and carers and the associated support in place for consumers at risk. It also includes a user guide containing a matrix of decision making prompts relating to different levels of risk which includes the availability of supports and the willingness and capacity of support persons should a person be considered at risk. Documentation to support an individual at risk is also available by way of a Relapse Prevention Plan which includes strategies to maintain mental health, relapse triggers, early warning signs and strategies and actions to mange early warning signs.

A statewide risk management training program has been implemented. Three positions have been created to ensure the consistency of risk assessment in all areas of mental health service delivery. This one day training package incorporates the statewide suite of clinical documentation, recovery and relapse prevention plans as the working documents for case studies.

Recommendation 21

Queensland Health continues to review the provisions of the *Health Services Act 1991* Qld as they relate to the disclosure of confidential information and implement such changes to remove any doubt that the confidentiality of information relating to a person receiving a health service is balanced with the duty of care to that person, the rights of the public to protection against the risk of harm and the rights of carers and support networks to meet their responsibilities to the person and other members of the household.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Section 621 of the Health Services Act has been reviewed and these powers have been delegated to a level such that in an emergency situation appropriate information can be provided at a local level. Queensland Health continues to monitor the effectiveness of part seven generally. These activities will be ongoing and we are confident that the s.62I delegations provide an avenue for disclosing confidential information in emergency situations.

Recommendation 22

Queensland Health to develop, implement and provide training in statewide guidelines to all mental health workers defining the issues of confidentiality of mental health the circumstances in which it is appropriate for mental health staff to share information regarding the person.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

In March 2007, a draft document *Confidentiality – A quick guide for mental health professionals* was developed by the Mental Health Branch.

Furthermore, the Queensland Police Service signed a Memorandum of Understanding in April 2006 which provides protocols and guidelines for the sharing of information in mental health crisis situations. The Memorandum of Understanding is a prescribed agreement under s.35 of the Health Services Regulation 2002 which provides an adequate legislative basis for the sharing of information in mental health crisis situations.

The Queensland Centre for Mental Health Learning is also providing training in a Vocational Graduate Certificate in Mental Health Practice, content of which covers confidentiality in mental health settings.

Recommendation 23

Removal of the requirement in s 62I Health Services Act to have the authority of the chief executive in writing for a disclosure to be made of confidential information that is necessary to assist in averting a serious risk to the life, health or safety of a person, including a person to whom the confidential information relates; or public safety. (Section 62I has been reviewed since June 2006 and the powers of the Chief Executive are now delegable. In Cairns there are now delegations in place to enable timely exchange of information in emergency situations relating to mental health service provision. It remains to be seen how effective this amendment will be).

Response and action

Agreed and completed

Responsible agency: Queensland Health

Section 621 of the Health Services Act has been reviewed and these powers have been delegated to a level such that in an emergency situation appropriate information can be provided at a local level. Queensland Health continues to monitor the effectiveness of part seven generally. These activities will be ongoing and we are confident that the s.62I delegations provide an avenue for disclosing confidential information in emergency situations.

Recommendation 24

The Queensland Government increase funding to a range of community-based services to assist both adults and children with mental health problems in the Cairns and the Integrated Mental Health Service Clinical Network. The Queensland Government ensures this includes both clinical and non-clinical services, both generic and mental health-specific services, in addition to nurses, allied health workers, psychiatrists, psychiatry registrars and indigenous mental health workers and life promotion officers.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

The 2007-2008 State Budget committed $528.8 million over four years towards mental health reform. Additional funding of $88.6 million was allocated in the 2008-2009 State Budget bringing total funding to $617.4 million.

A significant proportion of this funding was allocated towards improving capacity to provide community-based public mental health services. In total, more than 365 new doctors, nurses and allied health positions have been established since 2007-08. Another 91 positions are expected to be established in the 2009-2010 financial year.

These positions include district-based, statewide, and administrative support services. Of the new community mental health positions established in the last three years, 24.2 full time equivalent positions have been allocated to Cairns and Hinterland Mental Health Services. When fully recruited, this enhancement will result in a 15.7per cent increase in the number full time equivalent positions at Cairns and Hinterland Mental Health Services. By 2009-2010, Cairns and Hinterland will have 82 per cent of the number of community mental health staff needed by 2017.

These new positions include doctors, nurses, allied health, and administrative support staff across a range of mental health programs for children, adults and older people.

Recommendation 25

Queensland Health invest in programs of intensive post-discharge support for patients in the Cairns District Health Service Area who have presented with suicide ideation or who have been assessed at risk of suicide or self harm.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The Acute Care Team implemented their Acute Care at Home service through funds that were secured in the 2007-08 financial year.

The service is available to meet the needs of consumers who require follow up in the community and are experiencing acute symptoms of their illness either leading up to a possible inpatient admission or upon discharge from an inpatient admission. Referrals are made to this service from case management teams and/or the Mental Health Unit. An audit of seven day post discharge follow up occurred in March 2009 and focussed on discharge follow up practices, looking at both hospital and community charts. The outcome report is nearing completion which will include Recommendations for improvements in discharge planning and follow up practices.

Recommendation 26

When presenting with patients suffering from suspected mental health issues to Cairns Base Hospital Emergency Department, the Queensland Police Service provide a written summary of the circumstances of the patient coming into contact with the police and any available collateral information. Where there has been an attempted suicide, the document should record relevant details including times, location of attempt, means of attempt, any medication or other relevant real evidence, any information supplied by witnesses or next of kin, suicide notes, calls for assistance, details of patients' families and their contact details and any other collateral information that police, in their experience, believe may assist the Cairns Integrated Mental Health Service.

Response and action

Agreed and partially completed

Responsible agency: Queensland Police Service

It is a current legislative requirement that Queensland Police Service officers provide a completed Emergency Examination Order form to medical staff when presenting with patients suspected of suffering from acute and significant mental illness. The Emergency Examination Order form requires that officers provide a written summary of the circumstances of the patient coming into contact with police particularly those circumstances which lead the officer to believe that the person is suffering from a mental illness that creates an imminent and significant risk of physical harm being sustained by a person.

To support the legislative requirements and to address this Recommendation, draft amendments to operational procedures have been prepared and are currently in consultation with relevant stakeholders. It is anticipated the draft amendments will be finalised by December 2009.

Recommendation 27

The Cairns Base Hospital Emergency Department reinstate, as soon as possible, lines of communication with Queensland Police Service to ensure a better working relationship, co-operation and the timely exchange of information. The Mental Health Intervention Project is currently addressing this Recommendation. The Executive Director of medical services at the Cairns Base Hospital should consider making liaison meetings the responsibility of the Director of Emergency Medicine, who should receive reports as to the frequency and outcomes of any meetings.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The Mental Health Intervention Coordinator position was implemented in 2008 and facilitates liaison between Mental Health, The Queensland Police Service and the Queensland Ambulance Service. The Mental Health Intervention Coordinator, Mental Health Nursing Director and other key Mental Health staff attend the Police Liaison meetings.

Recommendation 28

Queensland Police Service introduce a policy for the disclosure to families of the existence and content of any suicide notes (subject to issues of confidentiality and ongoing police investigations).

Response and action

Agreed and partially completed

Responsible agency: Queensland Police Service

It is current Queensland Police Service policy that in circumstances where a deceased person leaves a suicide note or recording, investigating officers should locate relatives or other witnesses that can identify the deceased's handwriting or voice. The note or recording is then treated as evidence for any ensuing coronial investigation. As evidence seized for a coronial investigation, the note or recording may be released upon an order from the relevant coroner.

In response to this Recommendation, draft amendments to operational procedures have been prepared requiring officers investigating attempted suicides to disclose appropriate details of the incident including relevant contents of any suicide note to the person's family, next of

kin or carer, where such disclosure may assist in ensuring the health and safety of the person who attempted suicide. The draft amendments are currently in consultation with relevant stakeholders and are expected to be finalised by December 2009.

Recommendation 29

Queensland Police Service consider introducing a policy that all items found and suspected of being used in a suicide attempt are to be seized for safety reasons.

Response and action

Agreed and partially completed.

Responsible agency: Queensland Police Service

Queensland Police Service officers currently have a legislative authority to seize things under defined circumstances. Among these circumstances is that the person intends to use a thing to cause harm to himself, herself or someone else. It is Queensland Police Service policy that officers should not, under normal circumstances, take possession of a mentally ill person's property unless absolutely necessary or where relevant statutory provisions allow. Among the circumstances under which it is considered appropriate to seize a mentally ill person's property is where seizure is for the safety of the mentally ill person or other persons. Seized property is to be returned or otherwise dealt with in accordance with legislation.

In response to this Recommendation, draft amendments to operational procedures have been prepared and are currently in consultation with relevant stakeholders. It is anticipated the proposed amendments will be finalised by December 2009.

Comment 1 (page 22)

Coroner McGinness endorsed the Recommendations made by Coroner Privitera in the inquest into the death of Charles Barlow, Patrick Lusk and Emily Baggott handed down on 15 December 2006.

Inquest into the death of Patricia Van Putten

Ms Van Putten had a history of mental health issues. She was an out patient of Cairns Integrated Mental Health Service when she died on 18 February 2006.

Coroner McGinness handed down findings on 15 December 2008.

Recommendation 1

Urgent funding for the Cairns Acute Care Team to expand of their clinical cover to 24 hours a day, seven days a week.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

A Mental Health Emergency Department Liaison Clinical Nurse Consultant position was established and trialled from existing Mental Health Unit funds in September 2007 to September 2008.

This position was advertised and permanently appointed to in October 2008. Funding was secured from 2008-2009 enhancement funds to enhance the staffing of the Acute Care Team by an additional three clinicians and one registrar. Appointments to all of these positions have been finalised and the successful applicants have commenced.

Funding has been secured from 2009-2010 enhancement funds to enhance cover to the Emergency Department through the establishment of an additional Mental Health Emergency Department Liaison clinician position. This position will be recruited after 30 June 2009. To date there are still insufficient funds to provide cover to the Emergency Department 24 hours a day, seven days a week.

Recommendation 2

An increase in the capacity of the rural mental health teams to facilitate best practice case management and follow up care. This would be achieved by adding clinical positions to each of the Innisfail and Tablelands community Mental Health Teams. Such enhancement will enable after hours and weekend follow up support when required.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

No additional funding has been received for additional case management positions for the Innisfail and Tablelands teams.

Both teams have their Clinical Nurse Consultant positions filled and this provides additional clinical leadership to staff. Both teams are facilitating their staff to participate in the range of education workshops that are currently being provided across the district. For example, Queensland Centre for Mental Health Learning Risk Assessment and Management Training.

Plans are also being made to deliver further education to Emergency Department and hospital staff. After hours and weekend follow up continues to be provided in consultation with the Cairns Acute Care Team and/or after hours Registrar and/or Consultant Psychiatrist as per current procedures and workplace protocols.

Recommendation 3

Queensland Health continues to develop and implement a competency based training module on Clinical Documentation Standards to provide for competency based education modules to mental health and primary health staff in the Cairns Integrated Mental Health Service. The evidence of Mr Freele in the Harris Inquest was that this has already commenced with the appointment of two clinicians to educate staff. Clearly, these positions need to be extended. Further funding is required.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Cairns Integrated Mental Health Service commenced participation as a pilot site in the trial of the statewide standardised mental health clinical documentation suite in May 2007.

A total of 130 staff including medical officers, nurses, allied health, health workers, administration officers and consumer and carer representatives, participated in the initial documentation training that was facilitated by the Patient Safety Centre in May 2007. The Patient Safety Centre returned to Cairns in June 2008 to deliver five additional training sessions and a further 65 staff participated. This included staff from the Tablelands, Innisfail, Cape York and Torres Strait Mental Health Services. The Queensland Centre for Mental Health Learning came to Cairns in May 2007 and August 2008 to deliver Mental State Examination and Suicide Risk Assessment and Management training sessions.

In total these sessions have been attended by 194 staff including nurses, allied health and medical officers from Cairns, Tablelands, Innisfail, Cape York and Torres Strait Mental Health Services. These sessions have been deemed mandatory by the Cairns Integrated Mental Health Service Executive.

Recommendation 4

The Cairns Integrated Mental Health Service introduce a training package with competency based assessment for all clinicians working in acute mental health services where they might have responsibility for initial assessment. The package should cover history taking, mental state examination, provisional diagnosis, risk assessment and initial management planning.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Queensland Centre for Mental Health Learning has delivered Cairns Integrated Mental Health Service with training in *Critical Components of Risk Management and Assessment* over the past three months.

The training package covers the principals of risk assessment and management, risk and protective factors, the range of risks in clinical practice, cultural issues in risk management, the use of the Mental Health Act in risk management, clinical management strategies to reduce risk, the importance of linking the risk management plan to risk assessment and completion of a competency based assessment.

127 participants attended this training this year and Queensland Centre for Mental Health Learning will continue to provide training for mental health staff as needed.

Recommendation 5

Enhancement of Cairns Integrated Mental Health Service internal audit system to allow clinical audits to be regularly conducted in all Cairns Integrated Mental Health Services including rural teams.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The service's internal audit system has developed as a result of participating in the trial of the statewide standardised mental health clinical documentation.

Clinical file audits were conducted at the three, six and 18 month points of the trial. A total of 135 files across seven individual teams including the Mental Health Unit and Acute Care Team were audited on each occasion. Each team involved in the audit received an individual team report and an overall service report identifying their results including noted areas of improvement and those areas identified as requiring further improvement. An audit of clinical documentation was undertaken in March and April 2009 using a newly developed statewide clinical documentation audit tool. This audit was conducted across 10 adult mental health teams throughout the service including the Mental Health Unit, with a total of 120 charts audited. Audit data has been collated and the reports are nearing completion. Each team involved will receive a copy of their individual team report and a copy of the service-wide report. A copy of the service-wide report will also be forwarded to the Patient Safety Centre.

The statewide Child and Youth documentation audit has also been completed and the reports nearing completion. The Older Persons statewide audit will be conducted in June 2009 after all staff are trained in the use of the audit tool, provided by the Patient Safety Centre. Cairns Integrated Mental Health Service Quality and Safety positions are members of the North Queensland Mental Health Network Quality and Safety Subgroup. This Subgroup lobbied the Network for funding to implement a Clinical Audit position for a two year period and was successful in doing so. The Clinical Audit position has been instrumental in completing an audit of all consumers discharged from the Mental Health Unit in October 2008. The audit focussed on discharge follow up practices, and both hospital and community charts were audited. The outcome report is nearing completion which will include Recommendations for improvement.

Recommendation 6

Queensland Health immediately cease the practice of requesting patients with mental health issues to guarantee their own safety.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Queensland Health

Queensland Centre for Mental Health Learning provides a range of training packages for Risk Assessment and Management and Suicide Prevention. The training does not include requesting the client to guarantee their own safety. The training promotes an alternative strategy in developing a Safety Plan or Crisis Intervention Plan with the person. This is the act of planning, in collaboration with the person, a response to either the immediate suicidal episode or the possibility of recurring suicidal behaviour. Workers must balance their crisis intervention response to the presentation of the person and the person's ongoing treatment and community resource needs.

Recommendation 7

The Director of Mental Health accelerate the implementation of a statewide electronic network of patient information that allows treating health professionals, including both inpatient and community professionals, such as general practitioners, to rapidly access patient data throughout the State. Queensland Health must provide the necessary funding as a matter of priority.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The implementation of the Consumer Integrated Mental Health Application in November 2008 provides the capacity for inpatient and community public mental clinicians to access detailed clinical information, including the clinical notes, of mental health consumers throughout the state.

The Mental Health Branch has initiated the process to secure additional funds to enable the phase two development of the application. Initial consultation has identified adding the capacity to securely transfer key pieces of clinical information to General Practitioners and other relevant external stakeholders as a priority for phase two. Providing the ability for direct access by external health providers to confidential consumer information within Integrated Mental Health Application is dependant on the successful deployment of the Non-Queensland Health Employee External Access Project which is currently in the planning phase.

Recommendation 8

Consideration is given to establishing a regular formal minuted meeting between the public and private sector medical staff that facilitates frank discussion of problems experienced from both perspectives and generates workable action plans to resolve identified difficulties.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

Mental Health Services in Queensland have undertaken a Clinical Service Capability Framework review which involved both public and private service providers. This working relationship has been effective in a numbers of ways and highlights the need for more formal links. The Queensland Electroconvulsive Therapy Committee includes private psychiatrists as members of the committee and associated training program.

The issue is to be referred to the Statewide Mental Health Network for consideration and action.

Recommendation 9

The Cairns Integrated Mental Health Service receive funding to implement the 'Partners in Mind' primary mental health care framework. This will improve referral pathways and collaborative management of mental health patients between the public and private system.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

Queensland Health and General Practice Queensland continue to support the implementation of the Partners in Mind Framework across seven demonstration sites within Queensland.

A consultant has been employed to review and revise the Queensland Framework for Primary Mental Health Care and to evaluate the implementation and effectiveness of the Partners in Mind Framework. The results of this evaluation will be provided to Queensland Health in November 2009 and will inform the future implementation of the framework across Queensland.

Cairns Integrated Mental Health Service has been identified as a future Partners in Mind site, contingent on the outcome of the evaluation. As part of the Queensland Government's response to the Council of Australian Government National Action Plan on Mental Health 2006-2011, the Cairns Health Service District received funding to employ a Service Integration Coordinator to implement the Queensland Care Coordination model.

The model focuses on improving the collaboration between State and Commonwealth Government agencies, non government organisations and the private sector to provide consumers with severe mental illness and complex care needs with a coordinated, multi-agency support response.

It is anticipated that Service Integration Coordinators will ensure integration with primary health care providers and engage housing, employment, disability support and other agencies to provide a seamless system of care for people with a severe mental illness. The Cairns Integrated Mental Health Service continues to facilitate the Mental Health/General Practitioner Partnerships meetings for the purpose of discussing the ongoing development, implementation and evaluation of share care arrangements between mental health and General Practitioners and other initiatives that aim to enhance the relationship between the two service providers to ensure collaborative management of mental health consumers.

Examples of some initiatives that have been developed as a result of these meetings include the Cairns Integrated Mental Health Service Flipchart that was developed specifically for General Practitioners to inform them of the services provided by the Cairns Integrated Mental Health Service that they can access and the implementation of the Option A clinics.

Recommendation 10

Statewide development and implementation of a family focussed model of care that recognises the importance of the views and needs of families and carers of patients in the development of care plans. This should be underpinned by policy statements, clinical care guidelines and competency based training around the topic. This should include the provision of information to families concerning mental health illness.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The standardised suite of mental health clinical documentation incorporates prompts throughout to ensure clinicians include the views and needs of families and carers of clients with a mental illness.

The user guidelines also contain information on the inclusion of needs of families and carers. Training of all clinicians has been implemented by the Patient Safety Centre. Negotiations are currently being undertaken by the Patient Safety Centre to have online training available for all staff throughout Queensland.

Recommendation 11

Medium to high Risk Mental health patients should only be under the supervision of family members or friends when the Mental Health clinicians are satisfied that the family/lay carers have the capacity to provide appropriate supervision, are properly informed of the risks that they are assuming and have enough information to do their job such as when to call for assistance including when and who to call for assistance.

Response and action

Agreed and completed with ongoing implications

Responsible agency: Queensland Health

The standardised suite of mental health clinical documentation, implemented following a pilot in 2008, include a range of prompts regarding the role of families and carers and the associated support in place for consumers at risk. It also includes a user guide containing a matrix of decision making prompts relating to different levels of risk which includes the availability of supports and the willingness and capacity of support persons should a person be considered at risk. Documentation to support an individual at risk is also available by way of a Relapse Prevention Plan which includes strategies to maintain mental health, relapse triggers, early warning signs and strategies and actions to mange early warning signs.

A statewide risk management training program has been implemented. Three positions have been created to ensure the consistency of risk assessment in all areas of mental health service delivery. This one day training package incorporates the statewide suite of clinical documentation, recovery and relapse prevention plans as the working documents for case studies.

Recommendation 12

Queensland Health continues to review the provisions of the *Health Services Act 1991 Qld* as they relate to the disclosure of confidential information and implement such changes to remove any doubt that the confidentiality of information relating to a person receiving a health service is balanced with the duty of care to that person, the rights of the public to protection against the risk of harm and the rights of carers and support networks to meet their responsibilities to the person and other members of the household.

Response and action

Agreed and completed

Responsible agency: Queensland Health

Section 621 of the *Health Services Act* has been reviewed and these powers have been delegated to a level such that in an emergency situation appropriate information can be provided at a local level. Queensland Health continues to monitor the effectiveness of part seven generally. These activities will be ongoing and we are confident that the s.62I delegations provide an avenue for disclosing confidential information in emergency situations.

Recommendation 13

Queensland Health to develop, implement and provide training in statewide guidelines to all mental health workers defining the issues of confidentiality of mental health and the circumstances in which it is appropriate for mental health staff to share information regarding the person.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

In March 2007, a draft document *Confidentiality – a Quick Guide for Mental Health Professionals* was developed by the Mental Health Branch.

Furthermore, the Queensland Police Service signed a Memorandum of Understanding in April 2006 which provides protocols and guidelines for the sharing of information in mental health crisis situations. The Memorandum of Understanding is a prescribed agreement under s.35 of the *Health Services Regulation 2002* which provides an adequate legislative basis for the sharing of information in mental health crisis situations.

The Queensland Centre for Mental Health Learning is also providing training in a Vocational Graduate Certificate in Mental Health Practice, content of which covers confidentiality in mental health settings.

Recommendation 14

Removal of the requirement in s62I Health Services Act to have the authority of the chief executive in writing for a disclosure to be made of confidential information that is necessary to assist in averting a serious risk to the life, health or safety of a person, including a person to whom the confidential information relates; or public safety. (S62I the Act has been reviewed since 2006 and the powers of the Chief Executive are now delegable. In Cairns there are apparently delegations in place. It remains to be seen how effective this amendment will be).

Response and action

Agreed and completed

Responsible agency: Queensland Health

Section 621 of the *Health Services Act* has been reviewed and these powers have been delegated to a level such that in an emergency situation appropriate information can be provided at a local level. Queensland Health continues to monitor the effectiveness of part seven generally. These activities will be ongoing and we are confident that the s.62I delegations provide an avenue for disclosing confidential information in emergency situations.

Recommendation 15

The Queensland Government increase funding to a range of community-based services to assist both adults and children with mental health problems in the Cairns and the Integrated Mental Health Service Clinical Network. The Queensland Government ensure this includes both clinical and non-clinical services and support, both generic and mental health-specific services, in addition to nurses, allied health workers, psychiatrists, psychiatry registrars, indigenous mental health workers and life promotion officers.

Response and action

Agreed and partially completed

Responsible agency: Queensland Health

The 2007-2008 State Budget committed $528.8 million over four years towards mental health reform. Additional funding of $88.6 million was allocated in the 2008-2009 State Budget bringing total funding to $617.4 million.

A significant proportion of this funding was allocated towards improving capacity to provide community-based public mental health services. In total, more than 365 new doctors, nurses and allied health positions have been established since 2007-2008. Another 91 positions are expected to be established in the 2009-2010 financial year.

These positions include district based, statewide, and administrative support services. Of the new community mental health positions established in the last three years, 24.2 full time equivalent positions have been allocated to Cairns and Hinterland Mental Health Services. When fully recruited, this enhancement will result in a 15.7per cent increase in the number full time equivalent positions at Cairns and Hinterland Mental Health Services. By 2009-2010, Cairns and Hinterland will have 82 per cent of the number of community mental health staff needed by 2017.

These new positions include doctors, nurses, allied health, and administrative support staff across a range of mental health programs for children, adults and older people.

Recommendation 16

Queensland Health invest in programs of intensive post-discharge support for patients in the Cairns District Health Service Area who have presented with suicide ideation or who have been assessed at risk of suicide or self harm.

Response and action

Agreed and completed

Responsible agency: Queensland Health

The Acute Care Team implemented their Acute Care at Home service through funds that were secured in the 2007-2008 financial year.

The service is available to meet the needs of consumers who require follow up in the community and are experiencing acute symptoms of their illness either leading up to a possible inpatient admission or upon discharge from an inpatient admission. Referrals are made to this service from case management teams and/or the Mental Health Unit. An audit of seven day post discharge follow up occurred in March 2009 and focussed on discharge follow up practices, looking at both hospital and community charts. The outcome report is nearing completion which will include Recommendations for improvements in discharge planning and follow up practices.

Comment 1 (page 22)

Coroner McGinness endorsed the Recommendations made by Coroner Privitera in the inquest into the death of Charles Barlow, Patrick Lusk and Emily Baggott handed down on 15 December 2006.

Inquest into the death of Rhonda Joy Steggall

On 21 December 2006 Mrs Steggall was involved in a single vehicle accident on a country road near Rockhampton. Mrs Steggall lost control of her vehicle on a bend in the road which had been subject to road works in the preceding days by Rockhampton Regional Council.

Coroner Hennessy handed down findings on 17 December 2008.

Recommendation 1

The Department of Main Roads consider changes to the Manual of Uniform Traffic Control Devices (part 3 – 2007 Works on Roads) in order to require signage to remain in place until the hazard ceases to exist or warn of a change in road conditions including changed lane width, changed grade or physical attribute of the road surface including roughness or slipperiness of surface.

The Machinery of Government administrative arrangements in March 2009 saw the Department of Main Roads transition to the Department of Transport and Main Roads.

Response and action

Agreed and implementation is under consideration

Responsible agency: Department of Transport and Main Roads

The Department of Transport and Main Roads is still considering this Recommendation.

Comments have been sought from an appropriate officer within the Department of Transport and Main Roads with sufficient expertise in the Manual of Uniform Traffic Control Devices directed towards determining the most appropriate response to this Recommendation.

Inquest into the death of John Ernest Venturato

Mr Venturato died on 6 September 2005 whilst driving his vehicle along the Bruce Highway. His car collided with a house being transported in the opposite direction. The house, which spanned the entire width of the two lane highway, was being transported in a convoy in the early hours of the morning.

Coroner Brassington handed down findings on the 22 December 2008.

Recommendation 1

A traffic safety management plan be developed and distributed to all escort members before the escort takes place and that plan be required as part of the permit process where the wide load effectively blocks the road to other road users.

Response and action

Under consideration

Responsible agency: Queensland Police Service

The Queensland Police Service currently provides policy guidance on the issue of excess dimension vehicle and/or load permits and the conduct of escorts of such vehicles and/or loads. This policy emphasises that the safety of all road users is the primary responsibility of Queensland Police Service officers. In early 2008, the Queensland Police Service introduced a training course specifically for officers undertaking such escorts. The training course includes theoretical and practical components. As from 27 February 2009 only officers who have completed the relevant training will be permitted to conduct such escorts.

A review of wide load escorts is currently being undertaken by the Queensland Police Service. The coroner's Recommendation is being examined as part of this review. The review is nearing completion and the Recommendations arising from the review are expected to be forwarded to the Queensland Police Service senior executive for consideration by the end of 2009.

Response and action

The Department of Transport and Main Roads will contribute where requested – under consideration

Responsible agency: Department of Transport and Main Roads

Approval to move vehicles wider than 5.5m is solely a matter for the Queensland Police Service. The Department of Transport and Main Roads will work with the Queensland Police Service to identify improvements to systems and processes in relation to risk identification and conditions. Initial discussions have commenced.

Recommendation 2

The procedures and permit conditions from Main Roads and Queensland Police Service be more explicit when describing the risk of transporting a wide load on a two lane road.

Response and action

Under consideration

Responsible agency: Queensland Police Service

The Queensland Police Service currently provides policy guidance on the issue of excess dimension vehicle and/or load permits and the conduct of escorts of such vehicles and/or loads. This policy emphasises that the safety of all road users is the primary responsibility of Queensland Police Service officers. In early 2008 the Queensland Police Service introduced a training course specifically for officers undertaking such escorts. The training course includes theoretical and practical components. As from 27 February 2009 only officers who have completed the relevant training will be permitted to conduct such escorts.

A review of wide load escorts is currently being undertaken by the Queensland Police Service. The coroner's Recommendation is being examined as part of this review. The review is nearing completion and the Recommendations arising from the review are expected to be forwarded to the Queensland Police Service senior executive for consideration by the end of 2009.

Response and action

The Department of Transport and Main Roads will contribute where requested- under consideration

Responsible agency: Department of Transport and Main Roads

Approval to move vehicles wider than 5.5m is solely a matter for the Queensland Police Service. The Department of Transport and Main Roads will work with the Queensland Police Service to identify improvements to systems and processes in relation to risk identification and conditions. Initial discussions have commenced.

Recommendation 3

More informative signs be used when transporting very wide loads (over 5 m) on two lane rural lanes in Queensland.

Response and action

Not agreed and not being implemented

Responsible agency: Department of Transport and Main Roads

Warning signs are regulated nationally via the National Transport Commission's Oversize and Overmass Regulations. Queensland has adopted these national regulations. The issue of appropriate warning signs was considered when the national regulations were developed and 'wide load' was considered the most appropriate warning sign. This sign is now used uniformly across Australia.

Recommendation 4

More attention be given to the appropriate spacing between the first pilot vehicle, police vehicles and the wide load while the escort is underway. This aspect should be included in any training given to police officers.

Response and action

Under consideration

Responsible agency: Queensland Police Service

The Queensland Police Service currently provides policy for the conduct of excess dimension vehicle/load escorts. This policy emphasises that the safety of all road users is the primary responsibility of Queensland Police Service officers. In early 2008 the Service introduced a training course specifically for officers undertaking such escorts. The training course includes theoretical and practical components. As from 27 February 2009 only officers who have completed the relevant training will be permitted to conduct such escorts.

A review of wide load escorts is currently being undertaken by the Queensland Police Service. The coroner's Recommendation is being examined as part of this review. The review is nearing completion and the Recommendations arising from the review are expected to be forwarded to the Queensland Police Service senior executive for consideration by the end of 2009.

Recommendation 5

The lighting practices be reviewed to demonstrate if issues of glare are likely to be a problem for drivers, particularly older drivers.

Response and action

Under consideration

Responsible agency: Queensland Police Service

The Queensland Police Service currently provides guidance to officers issuing permits for the movement of excess dimension vehicles/loads on the type of lighting to be required for use on such vehicles/loads.

A review of wide load escorts is currently being undertaken by the Queensland Police Service. The coroner's Recommendation is being examined as part of this review. The review is nearing completion and the Recommendations arising from the review are expected to be forwarded to the Queensland Police Service senior executive for consideration by the end of 2009.

Response and action

Under consideration

Responsible agency: Department of Transport and Main Roads

The use of warning lights is a complex issue. Previously the use of strobe lights has been rejected. The Transport Commission has advised that a current proposal to allow the use of Light Emitting Diodes (LED) lights as warning lights is under consideration nationally. This will also take into consideration glare issues.

Comment 1 (page 38)

The Department of Transport's submission states the guidelines governing the operation of oversize vehicles are developed for loads under 5.5m while for loads over 5.5m with a police escort the police officer issuing the permit is actually responsible for setting the appropriate conditions that may apply to ensure the safe movement of the vehicle. The Queensland Transport does acknowledge that it is not the practice for the permits to depart from the performance guidelines issued by the Department. This is understandable given the individual Queensland Police Service officers issuing permits may lack the requisite expertise to depart from the guidelines. Nevertheless the present system of guidelines and police permits does not comprehensively assign responsibility to who determines signage for wider loads than 5.5m. The present Queensland Transport review may wish to consider this issue.

The Machinery of Government administrative arrangements in March 2009 saw Queensland Transport transition to the Department of Transport and Main Roads.

Response and action

The Department of Transport and Main Roads will contribute where requested- under consideration

Responsible agency: Department of Transport and Main Roads

Approval to move vehicles wider than 5.5m is solely a matter for the Queensland Police Service. The Department of Transport and Main Roads will work with the Queensland Police Service to identify improvements to systems and processes in relation to risk identification and conditions. Initial discussions have commenced.

The Department of Transport and Main Roads has conducted a review of the guidelines for the general movement of oversized loads (under 5.5m) and this is currently with Queensland Police Service for comment prior to finalisation.

Warning signs are regulated nationally via the National Transport Commission's Oversize and Overmass Regulations. Queensland has adopted these national regulations. The issue of appropriate warning signs was considered when the national regulations were developed and 'wide load' was considered the most appropriate warning sign. This sign is now used uniformly across Australia.

Comment 2 (page 41)

Given the complex issues relating to these Recommendations the coroner considers it more appropriate to refer the issue to the Queensland Police Service and Queensland Transport for consideration as to whether review of existing notification procedures should be considered.

Response and action

Under consideration

Responsible agency: Queensland Police Service

It is current Queensland Police Service policy that clear directions are given to all road users. It is important that road users quickly understand what the escorting officer is trying to convey to them so that they may take evasive action before the excess dimension vehicle passes. It is also

stated in Queensland Police Service policy that adequate warning is to be given to motorists with as little inconvenience as possible to minimise danger when it is necessary for excess dimension vehicles and/or loads to contravene road rules.

A review of wide load escorts is currently being undertaken by the Queensland Police Service. The coroner's Recommendation is being examined as part of this review. The review is nearing completion and the Recommendations arising from the review are expected to be forwarded to the Queensland Police Service senior executive for consideration by the end of 2009.

Response and action

Under consideration

Responsible agency: Department of Transport and Main Roads

Approval to move vehicles wider than 5.5m is solely a matter for the Queensland Police Service which includes the operation of police escorts. The Department of Transport and Main Roads will work with the Queensland Police Service to identify improvements to notification procedures. Initial discussions have commenced. Improvements identified will be reflected in the existing review of the guidelines for the general movement of oversize loads (under 5.5m) by the Department of Transport and Main Roads.

Comment 3 (page 45)

The coroner drew the matter of delivery of information in an efficient and effective manner to the attention of the Department (formerly Queensland Transport and the Department of Main Roads) for consideration in the review

Response and action

Agreed in part and completed with ongoing implications

Responsible agency: Department of Transport and Main Roads

The current Guidelines have been in place since 2001 (Form seven) and 1999 (Form six). Form seven was revised in March 2008 (version 2.1) to reflect the changes to local government areas that came into effect in March 2008. There was no change to conditions.

The Department of Transport and Main Roads publishes the Guidelines on its website and the Guidelines are available through the government bookshop.

The Department of Transport and Main Roads consults with industry associations including pilot vehicle operators and transport operators about developments or amendments to the Guidelines. An extensive review of the Guidelines is currently being undertaken by the Department of Transport and Main Roads in consultation with representatives from the Queensland Police Service, the Queensland Trucking Association, National Pilot Vehicle Association and a number of companies involved in the movement of oversized vehicles.

At the time of next update a targeted communication plan will be implemented.

Comment 4 (page 46)

The Queensland Police Service may wish to consider, if it has not done so, enforcing set rest periods, including when 'special' duties are undertaken, to ensure officers are not placed in a position where decisions may be influenced by fatigue.

Response and action

Agreed and partially completed

Responsible agency: Queensland Police Service

The issue of fatigue management in conjunction with the performance of special services is outlined in Schedule One to the Queensland Police Service Certified Agreement Five, 2007. The provisions of the agreement require that suitable breaks are taken before and after the commencement of special services, taking into consideration the fatigue management provisions of the Risk Management Code of Practice 2007 and the Fatigue Management Guide, both as amended from time to time and produced by

Workplace Health and Safety Queensland. Current Queensland Police Service policy also requires that officers in charge of stations and establishments consider fatigue issues when allocating special services to officers.

Nevertheless, a review of existing policy in relation to fatigue management has been undertaken by the Queensland Police Service and draft policy amendments have been prepared. The draft amendments are currently in consultation with relevant stakeholders and it is anticipated that the amendments will be finalised by late 2009.

Comment 5 (page 46)

Professor Troutbeck recommends that the Queensland Police Service and Queensland Transport (the Department) review the procedures of transporting wide indivisible loads on two lane rural roads. He also recommends that the Queensland Police Service risk matrix make a distinction between wide loads carried on two lane roads and those carried on roads with more than two loads (lanes). However, information has been provided that such a review is already underway. These Recommendations may be more appropriately considered in that review. These findings may provide some assistance to that review.

Response and action

Under consideration

Responsible agency: Queensland Police Service

The Queensland Police Service currently provides policy for the conduct of excess dimension vehicle/load escorts. A review of wide load escorts is currently being undertaken by the Queensland Police Service. The comment provided by Professor Troutbeck is being considered as part of this review.

The review is nearing completion and the Recommendations arising from the review are expected to be forwarded to the Queensland Police Service senior executive for consideration by the end of 2009.

Response and action

Under consideration

Responsible agency: Department of Transport and Main Roads

Approval to move vehicles wider than 5.5m is solely a matter for the Queensland Police Service which includes the operation of police escorts. The Department of Transport and Main Roads will work with the Queensland Police Service to identify improvements to systems and processes in relation to risk identification and conditions. Initial discussions have commenced. Improvements identified will be reflected in the existing review of the guidelines for the general movement of oversize loads (under 5.5m) by the Department of Transport and Main Roads.

Inquest into the death of Peter Joseph Trcka

Mr Trcka was discovered missing on 1 March 2006 from the trawling vessel in which he was employed as a fisherman. The vessel was moored in the vicinity of Otter Reef, situated 28 nautical miles southeast of Mission Beach. The coroner found Mr Trcka was lost at sea when he fell overboard from the trawling vessel.

Coroner Brassington handed down findings on 24 December 2008.

Recommendation 1

The Director of the Division of Workplace Health and Safety and the General Manager Maritime Safety Queensland review the operation of the Memorandum of Understanding in this case to consider whether changes are needed to encourage more collaboration in responding to incidents that appear to enliven the jurisdiction of both agencies and also recommended that the General Manger Maritime Safety Queensland review the policies governing the investigation of marine incidents to ensure that incidents involving serious injury and loss of life are properly investigated, and that issues arising from such investigations are responded to in the manner most likely to promote marine safety in Queensland.

Response and action

Agreed and partially completed

Responsible agency: Department of Justice and Attorney-General

A review of the operation of the Memorandum of Understanding between Workplace Health and Safety Queensland and Maritime Safety Queensland has been undertaken in relation to this case, other similar cases and the Recommendations of the Service Delivery and Productivity Commission. An instruction has been issued to Workplace Health and Safety Queensland Inspectors in relation to conducting joint investigations with Maritime Safety Queensland in response to incidents over which both agencies have jurisdiction, as an interim measure until the Memorandum of Understanding is finalised.

Collaboration between Workplace Health and Safety Queensland and Maritime Safety Queensland to review and enhance the Memorandum of Understanding is ongoing. It is expected that the process will be completed by October 2009 and in conjunction with the Recommendations into the inquests of Mr Mosby and Mr Irwin.

Response and action

Agreed and partially completed

Responsible agency: Department of Transport and Main Roads

Significant work has been undertaken on the draft Memorandum of Understanding which relies upon the development of detailed protocols on such matters as investigations, enforcement and compliance monitoring. The draft Memorandum of Understanding prepared by Maritime Safety Queensland has been developed in consultation with the Queensland Police Force. The consultation assisted in contextualising the document for police matters, in particular criminal code and coronial investigations.

This draft Memorandum of Understanding is currently with the Office of Workplace Health and Safety Queensland for their consideration and further development. Maritime Safety Queensland participates in regular meetings with the Office of Workplace Health and Safety Queensland, and the next such meeting is scheduled for Tuesday 19 June 2009.

Until the draft Memorandum of Understanding is finalised, interim arrangements have been implemented that cover fatal and serious incidents, so as to ensure that both Maritime Safety Queensland and Workplace Health and Safety Queensland investigate incidents on board commercial ships appropriately.

Recommendation 2

Maritime Safety Queensland investigate to identify the most appropriate type of Personal Floatation Device (PFD) and Emergency Position Indicating Radio Beacons (EPIRB) for seamen on commercial fishing vessels and then mandate by regulation that commercial fishermen wear Personal Floatation Devices and carry Emergency Position Indicating Radio Beacons when on deck at sea.

Response and action

Agreed and partially completed

Responsible agency: Department of Transport and Main Roads

A report on the south east and northern trials was finalised in September 2008. Policy options were discussed with industry in November and December 2008. On 6 February 2009, the Maritime Safety Queensland Program Management Committee endorsed the following Recommendation:

'To require owners and operators to conduct a risk assessment to determine when crew will wear PFDs and include the procedure for the mandatory wearing of PFDs in a ship's operating documents as one of the key procedures for onboard operations required from 1 October 2009 under the implementation of National Standards for Commercial Vessels Part E Operational Practices. Commercial fishing ship owners and operators to be held accountable for the sufficiency of the aforementioned arrangements under their general safety obligation under TO(MS)A 1994'.

Queensland
Government