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Scope

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1. Human Rights

It is unlawful for Queensland Corrective Services (QCS) staff to act or make decisions in a way that is not compatible with human rights, or in making a decision, fail to give proper consideration to a human right relevant to the decision.

Giving proper consideration to human rights entails identifying human rights which may be relevant to a decision and considering whether the decision would be compatible with human rights.

A decision will be compatible with human rights when it does not limit a human right, or only limits a right to the extent that is reasonable and demonstrably justifiable.

Human rights which may be relevant include:

a) recognition and equality before the law;
b) freedom of thought, conscience, religion and belief;
c) property rights;
d) the right to privacy and to reputation;
e) the protection of families and children;
f) cultural rights – generally and for Aboriginal peoples and Torres Strait Islander peoples;
g) humane treatment when deprived of liberty; and
h) the right to health services.

2. Limitation of Human Rights

In determining whether a limitation may be reasonable and demonstrably justifiable, the following factors are relevant to consider:

a) The nature of the human right – this involves looking at the purpose and underlying value of the human right. For example, the right of thought, conscience, religion and belief provides that every person has the freedom to have or adopt a religion or belief of the person's choice.
b) The nature of the purpose of the limitation – this involves considering the actual purpose or legitimate aim/reason for limiting the human right. For example, where a prisoner has been declared deceased in shared accommodation, the surviving prisoner must be separated and treated as a suspect or a witness to the death in accordance with crime scene preservation requirements. This practice engages the right to humane treatment when deprived of liberty.
c) The relationship between the limitation and its purpose – this involves considering the rational connection between the limitation of the right, and whether this will actually help to achieve said purpose or legitimate aim. For example, separating a prisoner from others is a necessary requirement to preserve evidence in the crime scene area.
d) Whether there are any less restrictive and reasonable ways to achieve the purpose – this involves a 'necessity analysis' where it is necessary to consider the purpose of the limitation and if it can be achieved in any other way. For example, is there a way of preserving the crime scene without the process outlined above?
e) The importance between the purpose for the limitation and preserving the human right – this involves a balancing exercise of the benefits obtained by the limitation vs the harm caused to the human right. The greater the limitation of the right, the more important the purpose will need to be to justify the limitation.

A person's human rights should only be limited to the extent that is reasonably and demonstrably justified.

3. Provision of Health Services

Until otherwise advised by Queensland Health (Q Health) staff, officers must treat an apparent death in custody as a medical emergency. When this occurs officer/s must raise the alarm and every effort must be made to save life by applying first aid techniques inclusive of cardiopulmonary resuscitation (CPR) if applicable. This must occur regardless of whether the incident occurs inside of or external to a corrective services facility, including in a Q Health facility. The only exception is in circumstances where it is known that a prisoner has an Advance Health Directive (AHD) in place which indicates the prisoner has refused to consent to life saving techniques, refer to section 3.1 of this Custodial Operations Practice Directive (COPD).

To raise the alarm while inside a corrective services facility, [redacted] ensure Q Health centre staff acknowledge if they are on duty. If Q Health staff are not on duty, Queensland Ambulance Service assistance must be sought urgently by dialling 000. [redacted]

To raise the alarm while external of a corrective services facility, seek medical assistance by way of the nurse call button when in a Q Health facility, or by dialling 000 for Queensland Ambulance Service while in other environments. [redacted]

Once commenced, resuscitation must continue until otherwise instructed by a doctor, paramedic or registered nurse.

The declaration of life extinct must be made by either the attending medical officer, Queensland Ambulance Officer or a registered nurse from the centre-based Q Health staff.

3.1 Prisoners with an Advance Health Directive

An AHD is a legally enforceable document that allows a person to give directions about their future health care. An AHD operates only when a person's capacity becomes impaired, for example, a prisoner is suffering a medical episode and they are not responsive.

The Chief Superintendent should ensure that there is a process for Q Health to inform Queensland Corrective Services (QCS) staff of prisoners at the centre who have made an AHD.

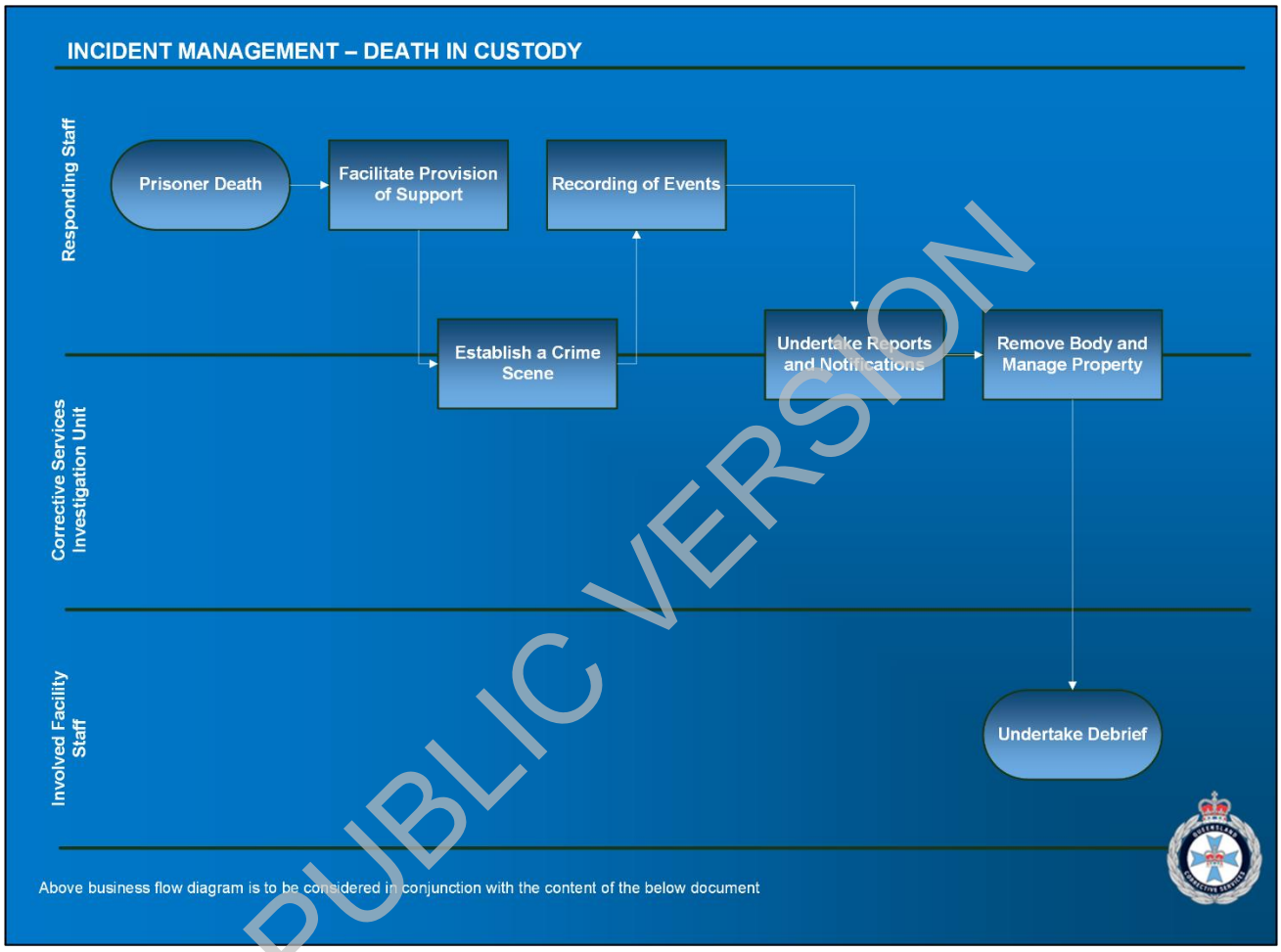
Where QCS is advised by Q Health that a prisoner has made an AHD, all reasonable efforts must be made to inform the officers managing the prisoner about this Directive. Officers must abide by the requirements of the Directive, which may include a refusal to consent to CPR.

There may be circumstances where an officer may treat a prisoner while not aware of the AHD, for example, an officer may commence CPR on an unconscious prisoner without knowing the AHD was in place. This will not be in breach of the AHD providing the officer ceases treatment upon being informed of the existence of an AHD.

The potential impact on staff who manage prisoners with an AHD which is implemented is acknowledged, as is the potential impact on prisoners who may observe an AHD being carried out. Support via the preferred service provider is to be offered to all staff involved in the incident (the circumstances relating to the incident are to be provided to the service provider by the Chief Superintendent of the corrective services facility or nominee) refer to the Critical Incident Support resources for the appropriate course of action.

Refer to the Management of Associated Prisoners after a Death in Custody and Undertake Debrief sections of this COPD.

4. Death in Custody



The death of a prisoner in custody must be managed with integrity and respect for the rights and humanity of the deceased. All deaths in custody are subject to a coronial inquiry and will be reported to the Coroner by staff of the Queensland Police Service (QPS), except in circumstances where the prisoner has self-administered, or been administered, a voluntary assisted dying substance under the *Voluntary Assisted Dying Act 2021* as this is not a reportable death. Refer to section 8(5) of the *Coroners Act 2003*.

The responsibilities of corrective services officers managing a death in custody in a corrective services facility include compliance with the COPD Incident Management: Incident Management Process. Standard precautions must be utilised in dealing with any bodily secretions in accordance with the COPD Incident Management: Incident Management Process.

The Administrative Form 185 Prisoner Death in Custody – Management Checklist must be completed by the nominated officer as soon as practicable when managing a prisoner death in custody and then maintained in the offender file.

5. Facilitate Provision of Support

Provision must be made for rapid and easy access to a corrective services facility for support agencies responding to the incident that may include, but is not restricted to:

a) Queensland Ambulance Service Officers;
b) an external Health Practitioner;
c) the Coroner;
d) a religious visitor;
e) an Aboriginal or Torres Strait Islander Legal Service representative;
f) an elder, respected person or Indigenous spiritual healer who is relevant to the prisoner;
g) Corrective Services Investigation Unit (CSIU) officers;
h) police officers;
i) morgue, funeral home/undertaker representatives;
j) corrective services dogs and their handlers; and
k) counselling service providers.

Corrective services officers must obtain identification details from attending ambulance officers. Officers controlling access to a facility should be aware that the ambulance service might respond with two vehicles:

a) an ambulance transport vehicle; and
b) a paramedic medivac vehicle.

6. Establish a Crime Scene

Staff must ensure the scene is preserved within the limits of providing medical assistance to a prisoner. In some cases, the integrity of the potential crime scene may be compromised to attempt to save the life of a prisoner by staff applying first aid and/or a Health Practitioner providing medical treatment.

Once life extinct has been declared, a crime scene must be established regardless of whether it is obvious a crime has occurred or not, unless otherwise determined by the Queensland Police Service (QPS) investigating officer or located in a health facility. The crime scene must be established in the area the prisoner was located when life extinct was declared. This location may be in or outside of a corrective services facility.

When the death occurs within shared cell accommodation, the other prisoner occupying the cell must be treated as a suspect or witness. All suspects and witnesses should be separated and as soon as practical, secured and monitored in a location away from other prisoners.

Refer to the Appendix IM12 Requirements for Preservation of a Crime Scene.

7. Recording of Events

If possible, the recording of events should be completed by the first officer responding to the incident and include the:

a) details for the provision of health services rendered (if any);

b) time the deceased was found or the time declaration of life extinct was made;
c) location of the body when found;
d) circumstances under which the body was found;
e) description of the scene where the body was found;
f) description of any weapon or other device found at the scene;
g) names of prisoners at the scene when the deceased was found;
h) names of other staff who assisted in managing the incident;
i) names of any witnesses to the incident; and
j) times of attendance and identity of all persons entering and exiting the crime scene;
k) time the Administrative Form 186 Transfer of Custody of Body to Queensland Police Service was completed;
l) time the body was removed by the Coroner;
m) details of times items were moved or removed from the crime scene; and
n) the time the running log ended, why it ended and who authorised the running log to cease.

If possible, an electronic record should be kept of all entries to the scene and all life-saving attempts.

7.1 Documentation

If possible, a copy of the following documentation must be provided for investigation management:

a) a printout of a complete profile of the deceased from the intelligence profile database;
b) the prisoner's Offender File;
c) print outs of all information that can be extracted from IOMS including incident and breach information, the Immediate Risk Needs Assessments, Risk Assessment Team documentation and the Sentence Management Decision-Making Record (SM-DMR);
d) any psychological or detention unit notes or files kept separately from the prisoner's Offender File;
e) the Notification of Life Extinct Certificate;
f) any other documentation or reports relevant to the incident including initial officer statements and memos, running logs, nominal rolls, phone records, recordings of phone conversations, debrief minutes and movement logs; and
g) a record of what documentation has been provided and to whom must be kept and, if original documentation has been provided, receipts obtained.

Where incidents are investigated by the Critical Incident Review and Inspection Group, the Administrative Form 187 Critical Incident Review and Inspection Group Evidence Request Checklist provides information on the items required to be submitted.

The Chief Superintendent of a corrective services facility or nominee must keep a record of the details of a deceased prisoner in accordance with section 24(2) of the *Corrective Services Act* 2006 (CSA) and section 20 of the Corrective Services Regulation 2017 (CSR).

8. Undertake Reports and Notifications

A critical incident report of a death of a prisoner in custody must comply with the COPD Incident Management: Incident Management Process.

In accordance with section 24(1) of the CSA, after a prisoner dies, the Chief Superintendent of the corrective services facility, or delegate, must notify each of the following:

a) if the corrective services facility is a prison — a Health Practitioner appointed for the facility;

b) the police officer in charge of the police station nearest to the place where the prisoner died;
c) the person nominated by the prisoner as the prisoner's contact person. This notification is to be delivered by a Queensland Police Service (QPS) officer attached to the Corrective Services Investigation Unit (CSIU).
d) a religious visitor; and for an Aboriginal or Torres Strait Islander prisoner:
    i. an Aboriginal or Torres Strait Islander legal service representing Aboriginal or Torres Strait Islander persons in the area in which the prisoner died; and
    ii. if practicable, an elder, respected person or Indigenous spiritual healer who was relevant to the prisoner; and
e) the Superintendent, Director, Critical Incident Review and Inspection Group, Professional Standards Group.

Refer to the Queensland Corrective Services Instrument of Delegations of Chief Executive Powers.

8.1 Notification to prisoner's nominated contact person

A QPS officer attached to the CSIU will notify a deceased prisoner's nominated contact person as soon as possible after death has been established. Every effort must also be made to identify a deceased prisoner's next of kin and provide this information to CSIU, so if practicable, they are also notified of the prisoner's death.

If the deceased prisoner's contact person cannot be located, CSIU should be advised.

If circumstances warrant, the Chief Superintendent or nominated corrective services officer should render assistance to the bereaved in contacting other members of the deceased prisoner's family and provide any other assistance deemed appropriate using, if necessary, the services of other staff or a religious visitor. For example, if the deceased prisoner's contact person is a prisoner in the same or another corrective services facility, assistance could be provided in contacting other relatives and making funeral arrangements.

8.2 Funeral assistance scheme

The Chief Superintendent or nominated corrective services officer should, having regard to the deceased prisoner's personal circumstances or their family's circumstances, provide information regarding assistance available for the burial or cremation of the deceased prisoner. The bereaved may be advised that assistance is available from:

a) Coroners Court of Queensland: phone: (07) 3738 7050; or https://www.courts.qld.gov.au/courts/coroners-court/funeral-assistance.
b) Elsewhere — the local Magistrates Court.

More details may be obtained from the Queensland Government website: https://www.qld.gov.au/law/births-deaths-marriages-and-divorces/deaths-wills-and-probate/funeral-assistance.
There is no provision for QCS to subsidise funerals or to reimburse money already paid for a funeral. This information must be made clear to the deceased prisoner's nominated contact person at the time of providing the above information and file noted.

8.3 Media notification

The media contact for QCS is responsible for establishing with CSIU or Duty Executive if next of kin have been informed before releasing information to the media.

If the next of kin has not been informed, no information that is likely to enable those persons to identify the deceased prisoner should be released to the media. A notification to the media about a death in custody may only be made by the media contact for QCS.

8.4 Death of a foreign national

If the prisoner is identified as a foreign national, action must be undertaken in accordance with Detention or Death of a Foreign National in Australia protocol: https://www.dfat.gov.au/about-us/foreign-embassies/protocol/detention-or-death-foreign-national-australia.

8.5 Reportable offenders

If a reportable offender who has been identified with the Child Protection Offender Registry (CPOR) is listed as a Victim in a death incident, an automated notification to CPOR will be generated by IOMS, in accordance with the COPD Community Engagement: Dangerous Prisoners (Sexual Offenders) Act and Reportable Offenders. A relevant system generated case note will be automatically generated on the file.

8.6 Prisoner with VR flag

If the prisoner is identified as having a VR flag raised on IOMS, the Victims Register must be notified via telephone, followed by an email to [redacted]

Contact with the eligible person should be made in a timely manner taking into consideration the circumstances of the incident and the impact it may have on the victim in accordance with section 324A of the CSA.

Outside of normal business hours, the Chief Superintendent of the corrective services facility is to make telephone contact with the On-call Sentence Management Services (SMS) Manager and follow up with an email to [redacted] advising of the incident and the prisoner's VR status. Contact with eligible persons will be made by the On-call SMS Manager.

Refer to the Administrative Form 185 Prisoner Death in Custody – Management Checklist for contact information.

Refer to the COPD Incident Management: Incident Management Process.

9. Investigations

An investigation other than a criminal investigation must be undertaken for all incidents of death of a prisoner.

If the death is other than by apparent natural causes at least two inspectors must be appointed in accordance with section 295 of the CSA to investigate the incident.

If the death is by apparent natural causes either:

a) an inspector must be appointed under section 295 of the CSA to investigate the incident; or
b) a person/s nominated by the person responsible for incident investigation or the relevant Assistant Commissioner must be assigned to investigate the incident.

Without limiting the scope of an investigation, an examination must be made to establish compliance with this COPD.

10. Removal of Body

The body of a deceased prisoner must not be moved from the scene of death until a doctor or registered nurse and an officer of the CSIU has authorised the removal, in addition to a doctor or registered nurse certifying the notification of life extinct. A receipt for the body must be provided to the Chief Superintendent of the corrective services facility by the agency removing the body at the time of removal via the Administrative Form 186 Transfer of Custody of Body to Queensland Police Service.

11. Management of Deceased Prisoner's Property

Following the death in custody of a prisoner, pending authorisation by the Chief Executive or delegate, all non-perishable goods and items of property belonging to the deceased prisoner must be recorded and then removed to a secure place. A description of all perishable goods belonging to the deceased prisoner must be recorded as accurately as possible prior to their disposal.

After the investigating police or QCS investigator/s have given their approval in writing, the Chief Executive or delegate must contact the deceased prisoner's executor or administrator, as appropriate, for written instructions regarding disposal of the prisoner's property. Refer to section 43(8) of the CSR.

If the deceased prisoner dies intestate or if the executor or administrator cannot be determined or located, the Chief Executive or delegate must notify the Public Trustee. Refer to section 29 of the *Public Trustee Act 1978* (PTA).

Attempts must also be made to contact the executor or trustee of the prisoner's estate. If contact is made a cheque must be drawn in favour of the prisoner's estate and forwarded to the executor of the estate. If the executor or trustee cannot be located, funds must be held for a minimum of two years as per section 102B and 98 of the PTA before forwarding to the Public Trustee as Unclaimed Money.

12. Management of Associated Prisoners after a Death in Custody

Following a death in custody, consideration must be given to the welfare and well-being of prisoners associated with the deceased person. This includes, but not limited to:

a) prisoners housed in the same accommodation unit as the death in custody;
b) prisoners identified as having a family tie or kinship with the deceased;
c) prisoners, where known identified as having a close friendship with the deceased; and/or
d) any other prisoner thought to be affected by the death in custody.

This may include interviewing all prisoners who are identified in any of the above points. If during this process a prisoner displays any sign of at risk behaviours, a Notification of Concern (NOC) is to be raised. Refer to the COPD At Risk Management: At Risk.

13. Undertake Debrief

Following a death in custody debriefing of persons involved must include, but is not limited to:

a) all employees affected by the traumatic event should be encouraged to participate in the crisis response, however participation is voluntary, refer to the Critical Incident Support resources available on the QCS intranet for the appropriate course of action;
b) an operational debrief, facilitated by the relevant manager, for all staff involved in the management of the incident;

c) the services of counselling through a preferred service provider are to be offered to all staff involved in the incident (the circumstances relating to the incident are to be provided to the counselling service provider by the Chief Superintendent of the corrective services facility or nominee);
d) appropriate access to a counsellor for prisoners who either experienced the incident or who had significant contact with the deceased prisoner; and
e) if relevant, an appropriate Aboriginal or Torres Strait Islander organisation, other cultural group representative or a religious visitor should be involved in the debriefing.

It is important to note that operational debriefing or counselling should not commence until such time as the QPS have interviewed the staff or prisoners directly involved in the incident. This will ensure that the process of an investigation by the QPS is not compromised. Minutes from operational debriefs should be provided to the inspectors conducting the internal investigation.

Refer to the Appendix IM17 Requirements for Incident Debriefing and Post Incident Analysis.