

# Office of the State Coroner

Annual Report 2005-2006



Letter of transmission

26 June 2007

Hon Kerry Shine MP  
Attorney-General and Minister for Justice  
and Minister Assisting the Premier in  
Western Queensland  
Level 18 State Law Building  
50 Ann Street  
Brisbane Qld 4000

Dear Attorney

Section 77 of the *Coroners Act 2003*, provides that at the end of each financial year the State Coroner is to give to the Attorney-General a report for the year on the operation of the Act. In accordance with that provision I enclose that report for the period 01 July 2005 to 30 June 2006.

As required by section 77(2) of the Act, the report contains a summary of each death in custody investigation finalised during the reporting period and Appendix 4 contains guidelines used by me under section 14 of the Act. I advise that in the reporting period there were no directions given under section 14 of the Act.

Yours Sincerely



Michael Barnes  
State Coroner



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## Foreword



Throughout 2005–06 we have concentrated on consolidating and fine tuning the focus of the new coronial system introduced by the *Coroners Act 2003*.

As always, we have been dependent upon the cooperation and assistance provided to us by our interdisciplinary partners—the staff of Queensland Health Scientific Services, the Queensland Police Service and the other investigative agencies involved in death investigations. In particular, I wish to acknowledge the great support given to me by Dr Charles Naylor, the Chief Forensic Pathologist and Detective Inspector Gilbert Aspinall, the Officer in Charge of the Coronial Support Unit. Their commitment to the work of the Office of the State Coroner (the Office) and their willingness to facilitate my accessing information from throughout their respective professional networks has been crucial to the successful discharge of my function.

Responding in a meaningful way to sudden and unexpected death can be very stressful for the staff of the Office who must constantly deal with distressing information and interact with bereaved and emotional family members. I commend their dedication and acknowledge the altruism they demonstrate while seeking to help our clients deal with their loss.

I wish also to record my sincere gratitude and regard for the Deputy State Coroner, Ms Christine Clements, for her unwavering support and industry and to acknowledge the application of the local coroners who deal so effectively with the reportable deaths that occur throughout regional Queensland.

A handwritten signature in black ink, appearing to read 'M Barnes', written in a cursive style.

Michael Barnes  
State Coroner  
June 2007



# Our role

## Future challenges

The State Coroner is responsible for administering and overseeing the coronial system across the State. This involves advising local coroners and court staff on coronial issues and resolving issues raised by the families of the deceased and other agencies who contribute to coronial investigations. The State Coroner is supported in this by the staff of the Office.

The State Coroner is required by s14 of the *Coroners Act 2003* to issue guidelines to local coroners about the performance of their functions. Those guidelines can be accessed at [www.justice.qld.gov.au/courts/coroner/publications.htm](http://www.justice.qld.gov.au/courts/coroner/publications.htm).

### Workload

The number and complexity of coroners' cases continues to increase. In Brisbane in particular, there is an urgent need for another full time coroner. In the reporting year, 1,010 deaths were reported in Brisbane. These were mostly dealt with by the Deputy State Coroner. This represents almost one third of the deaths reported across the State. It is in the interests of the family of the deceased person and the public generally that coronial investigations are finalised expeditiously. More resources are needed to enable this to happen.

### Specialisation

Coronial investigations and inquests are functions very different from the general work of a magistrate. In the initial stages of a coronial investigation, liaison with police, pathologists and family members is frequently necessary at very short notice. This is very difficult for magistrates to interweave with their court work. Increasingly, coroners are expected to lead interdisciplinary investigations that seek to unpack complex causes of death and develop remedial strategies. These functions require coroners to develop close working relationships with other professionals involved in responding to unnatural deaths. They may also need coroners to analyse extensive technical information and generate responses to the dangers revealed by that analysis. It is difficult for magistrates who only infrequently fill the role of coroner to develop sufficient expertise to perform these functions effectively. The appointment of full time coroners throughout the State would address these difficulties.

### Data management

The *Coroners Act 2003* requires a register to be kept of all reportable deaths and the prevention focus of the coronial system requires an ability to search across various data fields in order to facilitate meaningful analysis of reported deaths. The Office has sought to satisfy these requirements by entering details of all deaths into the Queensland Wide Integrated Courts (QWIC) system. The QWIC application doesn't satisfy these purposes and cannot be used as an effective case management or monitoring tool. Therefore, the Office intends to custom design an appropriate digital database.

### Access to medical expertise

The report of the Commission of Inquiry into Queensland Public Hospitals recognised the difficulty coroners have in assessing and investigating deaths that occur in a medical setting. It recommended that the Office be given dedicated medical expertise to assist the State Coroner in this regard. Since the publication of the report the medical profession and the public have become more vigilant in reporting such deaths to coroners and in querying the views of the clinicians involved in treating the deceased. Expert medical support is urgently needed by coroners.

### Liaison between the Chief Magistrate and the State Coroner

Coroners are independent judicial officers. Although the Chief Magistrate and the State Coroner have, by virtue of the *Magistrates Act 1991* and the *Coroners Act 2003*, authority over some aspects of the functions of magistrates and coroners, this authority is exercised in consultation between the Chief Magistrate or the State Coroner and the magistrate/local coroner concerned.

To avoid the possibility that directions or guidelines issued by the State Coroner conflict with arrangements or instructions given by the Chief Magistrate, s76 of the *Coroners Act 2003* requires the State Coroner to consult with the Chief Magistrate about:

- resources required to ensure the coronial system is administered efficiently;
- the amount of work conducted by magistrates as coroners; and
- any guidelines or practice directions proposed to be issued by the State Coroner.

During 2005–06, consultation continued to occur between the State Coroner and the Chief Magistrate and this has helped to ensure the smooth development of the coronial system. The Chief Magistrate has not raised any concerns in relation to guidelines proposed by the State Coroner and the Chief Magistrate has provided assistance and advice to the State Coroner regarding a number of operational matters.



# Our people

## Role and responsibility of coroners and their support staff

### State Coroner

The State Coroner is responsible for coordinating and overseeing the coronial system to ensure that it is administered efficiently and that investigations into reportable deaths are conducted appropriately.

In order to discharge the coordination function, the State Coroner has issued guidelines of general application which inform the way coroners manage coronial matters across the State. The State Coroner also provides daily advice and guidance to coroners in relation to specific cases and liaises with other professions and organisations involved in the coronial process, for example, police, pathologists and counsellors.

In order to discharge the monitoring function, the State Coroner reviews all reportable deaths as they are reported and once local coroners have finalised their investigation and made their findings. In performing this function the State Coroner is careful not to impinge on the judicial independence of local coroners.

Only the State Coroner or Deputy State Coroner may investigate deaths in custody. The State Coroner also conducts inquests into the more complex deaths that, if dealt with by a local coroner, would take him or her out of general court work to the detriment of the local court diary.

During the reporting period, the State Coroner sat in Brisbane, Mt Isa, Townsville, Hervey Bay, Bundaberg and Murgon. During 2005–06 the State Coroner presided over 23 inquests.

### Deputy State Coroner

The Deputy State Coroner, Ms Christine Clements, was appointed on 8 December 2003. Apart from the State Coroner, Ms Clements is the only other full time coroner.

Along with the State Coroner, the Deputy State Coroner may investigate deaths in custody and acts as the State Coroner as required.

The Deputy State Coroner has a very high workload. During 2005–06 there were 1,010 deaths reported in Brisbane; most of these were investigated by Ms Clements, including deaths occurring in hospitals in the Brisbane area. Ms Clements has developed considerable expertise in the investigation of medical related deaths.

The Deputy State Coroner finalised over 800 investigations including six matters that went to inquest.



## Role and responsibility of coroners and their support staff continued

### Local coroners

All magistrates may act as coroners. Other than deaths in custody, which must be investigated by either the State Coroner or Deputy State Coroner, police report deaths to the coroner nearest to the place of death.

Unless the file is transferred to the State Coroner, the local coroner is responsible for investigating the death. There are many steps involved in a coronial investigation some of which can be very time consuming. The coroner must consider the initial police report (the Form 1) and consider any family concerns before ordering an internal autopsy. The coroner is in control of and directs the coronial investigation. Police and other investigative agencies and experts engaged by the coroner prepare often lengthy and complex reports which must be considered before a decision is made as to whether an inquest should be held and findings are made in relation to the death. Family members are consulted before it is decided whether an inquest is needed. Because of the many steps involved in the process, coronial work makes demands that do not mesh easily with the workload and schedule of a busy magistrate.

### Office of the State Coroner

The role of the Office is to support the State Coroner in delivering a more consistent and efficient coronial system across the State. The Office maintains a register of reportable deaths, supports the State involvement in the National Coroners Information System (NCIS) and provides ongoing legal and administrative support to the State Coroner, Deputy State Coroner, local coroners and court registry staff in Magistrates Courts across the State. The Office also ensures that there is publicly accessible information available for families and others regarding the coronial system and provides a central point of contact for coronial matters.

The Office is also responsible for administering the Burials Assistance Scheme and the conveyance of human remains through the management of contracts with government funeral directors throughout the State.

At the end of the reporting period, there were 17 officers employed by the Office to provide legal and administrative support to coroners, court staff and coronial clients throughout the State.



# Reportable deaths

## Introduction

Under the *Coroners Act 2003* reportable deaths, as defined in s8 of the Act, must be reported to a coroner. Section 7 of the Act requires anyone becoming aware of an apparently reportable death must report it to the police or a coroner.

Section 8 defines the categories of reportable deaths as deaths where:

- the identity of the person is unknown
- the death was violent or otherwise unnatural
- the death happened in suspicious circumstances
- the death was not reasonably expected to be the outcome of a health procedure
- a 'cause of death' certificate has not been issued and is not likely to be issued for the person
- the death was a death in care
- the death was a death in custody.

### Unidentified bodies

Even if there is nothing suspicious about the death, unless police inquiries can establish the identity of the deceased with sufficient certainty to enable the death to be registered, the death must be reported to a coroner. Various means such as fingerprints, photographs, dental examinations or DNA can then be used to identify the person.

### Violent or unnatural

Car accidents, drowning, electrocutions, suicides and industrial and domestic accidents are all reported to coroners under this category. The purpose of the report is to enable the coroner to investigate the circumstances of death to determine whether it should be referred to a prosecuting authority or whether an inquest is warranted with a view to developing recommendations to reduce the likelihood of similar deaths recurring.

### Suspicious circumstances

Suspicious deaths are reported to a coroner to enable their circumstances to be further investigated. If police consider there is sufficient evidence to prefer criminal charges in connection with the death they may do so and the holding of an inquest must be postponed until those charges are resolved.

### **Not reasonably expected to be the outcome of a health procedure**

A death must be reported to a coroner if it *“was not reasonably expected to be the outcome of a health procedure”*.

Deciding whether a death that occurs in a medical setting should be reported and if so determining how it should be investigated poses considerable challenges for a coroner. A submission dated 14 October 2005 by the State Coroner to the Queensland Public Hospitals Commission of Inquiry described these difficulties in detail and made suggestions as to how they could be addressed. The submission was included as an appendix to the previous *Annual Report December 2003–June 2005*. In that submission, the State Coroner submitted that:

- there was no need to amend the current definition of reportable death because the current wording sufficiently describes those deaths which warrant external scrutiny
- there needs to be ongoing training provided to doctors to ensure they are aware of their obligation to report reportable deaths
- a senior clinician, not involved in the treatment of the deceased should be required to review each hospital death to determine whether it should be reported
- there should be some systematic auditing of compliance with the reporting obligation
- coroners need better access to independent medical opinion to assist them to determine whether deaths that are referred to them by hospitals are reportable and/or warrant investigation. Similar assistance is required to help them effectively investigate such deaths.

The Honourable Geoffrey Davies AO delivered his Report on the Queensland Public Hospitals Commission of Inquiry on 30 November 2005. In that report, Commissioner Davies made the following recommendations regarding the coronial system:

- the *Coroners Act 2003* be amended to include an automatic reporting requirement for all deaths occurring within 30 days of an elective health procedure (meaning a health procedure that can be delayed for a period of 24 hours without death being a likely outcome).
- a dedicated medical officer be appointed to the Office of the State Coroner to assist in determining whether deaths happening within the stipulated timeframe are required to be further investigated and to assist in the conduct of that investigation
- a panel of specialised persons trained in the various health service disciplines be appointed who could assist coroners as required to investigate medical matters
- a process of auditing compliance with the reporting obligation be undertaken at all public hospitals
- Queensland Health put in place a policy to ensure investigation is undertaken in relation to each death that occurs in a facility operated by them and that a report of that investigation be provided to the coroner and the family of the deceased
- continuing training be provided to all doctors to ensure they remain aware of their obligations to report.

At the end of June 2006, the Government had not yet determined its response to Commissioner Davies' recommendations in relation to coronial matters. Coroners continue to have difficulty investigating medical deaths and the provision of expert medical assistance to coroners is essential to the efficient and effective investigation of such deaths.

## **Cause of death certificate has not issued and is not likely to be issued**

Medical practitioners are obliged to issue a cause of death certificate if they can ascertain the “probable” cause of death. The degree of certainty required is the same as when they are diagnosing an illness. Doctors are prohibited from issuing a cause of death certificate if the death appears to be one that is required to be reported to a coroner, so this category focuses on deaths which do not appear unnatural, violent or suspicious but which are uncertain in their cause. They are reported to a coroner so that an autopsy can seek to discover the pathology of the fatal condition.

## **Deaths in care**

Deaths of categories of vulnerable members of society (namely children in the care of the Department of Child Safety, the mentally ill and the disabled) are reported to a coroner, irrespective of their cause.

During the reporting period, 53 deaths in care were reported. The deaths comprise less than 2% (1.7%) of the total deaths reported during 2005–06. It is doubtful that this figure accurately reflects the total number of deaths in this category. The Office is concerned about under-reporting of this category, largely attributable to the following reasons:

- the section, particularly as it relates to people with a disability living in one of the facilities listed in section 9(1)(a), is difficult for some coroners, police, medical staff and court staff to interpret and apply;
- despite the education and training provided to hostel owners/operators, police and medical staff, many are still not aware of their obligations under the Act – particularly because the deaths are reportable irrespective of their cause or where the person dies;
- although lists indicating which facilities are captured by section 9(1)(a) have been provided to coroners and police, the lists are not exhaustive and frequently change;
- it is not immediately apparent when police enter these facilities that they are in fact within the ambit of section 9;
- Hostel owners/operators often do not feel they are qualified to give an opinion as to whether a person suffers from a disability in accordance with the definition in section 5 of the *Disability Services Act 1992*. It is then necessary for police and/or coronial staff to locate the deceased’s local medical officer, other health professional, carer, family member, etc to provide this advice. This process can sometimes take many days to complete.

The Office would like to acknowledge the assistance provided by the staff of the Community Visitor Program. The partnership which has developed between these two agencies has been instrumental in increasing the number of deaths reported in this category and has enabled coroners to more effectively assess the quality of care provided to the deceased person.

## Reportable deaths continued

### Deaths in custody

This term is defined in section 10 of the Act to include those who are at the time of their death actually in custody, trying to escape from custody or trying to avoid being placed into custody.

“*Custody*” is defined to mean detention under arrest or the authority of a court order or an act by a police officer or Corrective Services officer, court officers or other law enforcement personnel.

Detention in watch-houses, prisons etc is clearly covered but the section also extends the definition by reference to the legal context that makes the physical location of the deceased irrelevant. For example, a sentenced prisoner who is taken to a doctor or a hospital for treatment is still in custody for the purposes of the *Coroners Act 2003*.

During the reporting period, five deaths in custody were reported. However, findings in relation to 14 deaths in custody were finalised during the reporting period. It is mandatory for an inquest to be held for deaths in custody.

### Indigenous remains

The *Coroners Act 2003* recognises the sensitivity of Indigenous remains. When dealing with Indigenous burial remains, a balance must be struck between the need to ensure the death was not a homicide and the need to avoid the unnecessary disturbance of the remains. As soon as it is established that remains are Indigenous burial remains, the coronial investigation must cease. Management of the site is then transferred to officers from the Cultural Heritage Coordination Unit of the Department of Natural Resources and Water and representatives of the traditional owners of the land where the remains were found.

Once a coroner has established that the remains are in fact Indigenous burial remains, s12 of the Act precludes a coroner from investigating further, unless the Minister directs.

During the reporting period, nine matters were investigated by coroners where the remains were confirmed as Indigenous burial remains.



# Coronial investigations

## Purpose of coronial investigations

The purpose of a coronial investigation is to establish, the identity of the deceased, when and where they died, the medical cause of death and the circumstances of the death. Where an inquest is held, coroners may make recommendations designed to reduce the likelihood of similar deaths occurring in the future.

### Autopsies

Coroners usually order an autopsy as part of the coronial investigation to assist with the determination of the cause of death and/or to assist in the identification of the body.

Under the previous coronial regime, full internal autopsies were ordered in almost all cases and the views of family members were not considered when ordering autopsies. The *Coroners Act 2003* requires coroners to specify whether the examining doctor should undertake a full internal autopsy, a partial internal autopsy focusing on the likely site of the fatal disease or injury or an external examination only. It also recognises that many members of the community have strong objections—sometimes based on religious beliefs—to invasive procedures being performed on the bodies of their deceased loved ones. Accordingly, the *Coroners Act 2003* requires coroners to consider these concerns when determining the extent of the autopsy ordered.

Although family members may not prevent an autopsy being undertaken if a coroner considers it necessary, a coroner who wishes to override a family's concerns must give the family reasons for this which enlivens a right to have the coroner's decision judicially reviewed. No such

review applications were lodged during 2005–06 and family concerns have been appeased with the assistance of coronial counsellors from Queensland Health Scientific Services.

The QWIC database indicates that autopsies were performed in 2,780 cases (see Table 1 below). Full internal autopsies were conducted in 65% of cases, partial internal autopsies were conducted in 28% of cases and external examinations were undertaken in 7% of cases.

**Table 1**

**Percentage of orders for autopsy issued by type of autopsy to be performed**

Type of Autopsy	01/07/05–30/06/06
Order for External Autopsy	7.12%
Order for Internal Autopsy—Partial	27.73%
Order for Internal Autopsy—Full	65.11%
Order on Cremated Remains	0.04%

**Number of orders for autopsy issued by type of autopsy to be performed**

Type of Autopsy	01/07/05–30/06/06
Order for External Autopsy	198
Order for Internal Autopsy - Partial	771
Order for Internal Autopsy - Full	1,810
Order on Cremated Remains	1
<b>Total</b>	<b>2,780</b>

## Measuring outcomes

### Finalisation of coronial cases

Coroners are aware that delays in finalising coronial matters can cause distress for family members and therefore coroners and the Office constantly strive to conclude matters expeditiously.

In many cases however, closure of coronial files is delayed by the police investigation or the involvement of other agencies that also have responsibility to review the circumstances of the death. For example, the Department of Child Safety reviews the deaths of children who have had contact with the Department and the Division of Workplace Health and Safety investigates many industrial accidents. In most cases, it is appropriate for coronial findings to await the deliberations of these other agencies in order that the coroner can reflect upon not only the issue of causation but also whether any preventative measures should be recommended. In many cases, the specialist agencies are best placed to devise such reforms and the coroner need then only note the changes that have been mooted and if appropriate, add his or her voice to the call for improvement. Of course, if criminal charges are an inquest can not proceed until those charges have been dealt with.

Appendix 3 shows the finalisation rates achieved during the reporting period.

### Judicial reviews

Decisions by coroners may be subject to review under the *Judicial Review Act 1991*. During the reporting period, the Court of Appeal and the Supreme Court considered four judicial review applications made in relation to decisions by coroners under the relevant legislation. They are outlined below.

**Atkinson v Morrow & Anor** [2005] QCA 363 arose out of the inquest into the death of Mr Rodney O'Sullivan which was conducted under the *Coroners Act 1958*. Evidence indicated that Mr O'Sullivan may have been suffering from drug induced psychosis when he asked police for a lift out of town. The officers transported him from Monto to Mulgildie and dropped him out of town. Mr O'Sullivan's body was found some time later. The coroner requested a statement from police regarding police procedures and guidelines for dealing with similar situations. The question in the judicial review application was whether the coroner exceeded his jurisdiction in requesting the statement and admitting it into evidence. The Judge at first instance and the Court of Appeal on appeal rejected the application for review. The Court of Appeal held that the requirement for the coroner to determine "how the death occurred" should not be construed narrowly. The coroner has jurisdiction to determine the means by which the person died but also to investigate all the circumstances surrounding the death.

**Commissioner of Police v Clements & Ors** [2005] QSC 203 arose in relation to the inquest into the death of Mulrunji on Palm Island. Senior Sergeant Hurley was the officer in charge of the police station and watchhouse. The main issue before the Court was the Deputy State Coroner's decision to allow access to documents detailing the complaint history of Senior Sergeant Hurley. Justice Wilson dismissed the application for review in relation to this decision.

The Deputy State Coroner's decision to allow the documents to be inspected was based on a "legitimate forensic purpose" test, as enunciated in *R v Spizzirri* [2002] 2 Qd R 686. The argument by the applicant was that the Deputy State Coroner had erred in finding a legitimate purpose in the context of the inquest because the complaint files could not be relevant to the Coroner's function under ss 45 and 46 of the Act.

The Court recognised that although not bound by the rules of evidence, relevance still dictates the evidence and submissions which a coroners court could receive. Relevance was dictated by a coroner's powers to investigate, make findings in relation to a particular death but also to comment on broader systemic issues connected with the death such as public health or safety, the administration of justice or way to prevent similar deaths in the future. Because of the coroner's ability to comment on systemic issues, a liberal approach was to be adopted in assessing relevance. The Court was satisfied as to the relevance of the complaint file. The pursuit of information about systemic issues connected to the death was a sufficient legitimate forensic purpose justifying access to the documents. It was also held, following *Spizzirri*, that obtaining information for use in cross-examination as to credit was also a legitimate forensic purpose justifying access to the complaint file.

**Doomadgee & Anor v Deputy State Coroner Clements & Ors** [2005] QSC 357 and **Hurley v Deputy State Coroner Clements & Ors** [2005] QSC 357. These applications statutory review were heard together and involved decisions about the admission of "propensity evidence" to the effect that Senior Sergeant Hurley has previously assaulted Indigenous people. The Deputy State Coroner decided to admit the evidence for the purposes of coronial comment (s46 of the Act) but not for the purpose of findings (s45 of the Act).

The court examined ss45 and 46 of the Act recognising the wide scope of the coronial inquiry. There was consideration of the scope of s46, particularly that a comment made by the Coroner must be on a thing "connected with" the death under investigation and that the thing must relate to "public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future". Section 46 was to be construed liberally given that the section was remedial in nature. The court considered the "propensity evidence" may be relevant to comments that might be made by the Coroner under s46. The application for review of this aspect of the Coroner's decision was dismissed.

The court considered that the "propensity evidence", if accepted, was logically probative of the fact in issue (whether the death was caused by the deliberate application of force) and therefore was relevant and able to be considered by the Deputy State Coroner for the purposes of s45 of the Act. Accordingly, the Deputy State Coroner's decision that it was impermissible to receive the evidence under s45 was erroneous. The court however noted the Coroner's view that in light of other available evidence the "propensity evidence" had limited probative value. No order was made by the court on the application for review of this aspect of the Coroner's decision.

## Notable inquests

### State Coroner

#### Deaths in Custody investigations

##### Andrew Penetito Ioane

On the evening of 14 December 2004, 17 year old Andrew Ioane met up with two 15 year old friends. They decided to go joyriding in a car. At about 3.40am, Andrew was driving the car when he and his friends came to the attention of police. Police chased the car which reached speeds of 150km/hr passing through busy intersections. The crash occurred at 3.55am. The chase lasted for a little over 13 minutes and had covered just over 19kms.

The State Coroner accepted that none of the officers exhibited a wilful disregard of their common law and statutory duties; rather they manifested an all too common approach to a universal problem whereby one policing objective—law enforcement—was given undue precedence over another—public safety. In his view the relevant policy police operate under compounded this tendency.

The State Coroner recommended that the Police Operational Skills Training include a compulsory module on police pursuits with officers who act as pursuit controllers given priority to receive this training. The Queensland Police Service has introduced a new pursuit driving policy that seeks to address the concerns highlighted by this case.

##### Stuart Ronald Williams

Stuart Ronald Williams, an Indigenous male of 45 years, died on 17 May 2004 in the Capricornia Correctional Centre at Rockhampton. Mr Williams had an extensive history of heart disease and was on medication. Although strongly advised to stop smoking, he continued to smoke until just prior to this death. Mr Williams had refused an offer of coronary angiography by the Department of Corrective Services.

A comprehensive police investigation was conducted into the circumstances of this death. The investigation and autopsy revealed that Mr Williams died of natural causes namely heart failure. The State Coroner found that Mr Williams had been provided with an appropriate level of care and treatment while in custody. The investigation revealed no suspicious circumstances.

##### Wayne Barry Matschoss

Wayne Barry Matschoss was 60 years old when he died on 27 October 2004 in the custody of the Department of Corrective Services as an inpatient at the Rockhampton Base Hospital. Throughout his period of incarceration Mr Matschoss was frequently in need of medical attention and had a history of heart disease. He had been a heavy smoker and drinker and also suffered from epilepsy and neurological problems.

A thorough investigation was conducted into the circumstances of this death. The investigation and autopsy revealed that Mr Matschoss died of natural causes, namely heart failure. The investigation revealed no suspicious circumstances. The State Coroner found that Mr Matschoss had been provided with an appropriate level of care and treatment.

##### Wayne Matthew Pettigrew

Wayne Matthew Pettigrew was 54 years old when he died while in the Princess Alexandra Hospital Secure Unit. At the time, he was in the custody of the Department of Corrective Services. On 11 November 2003 Mr Pettigrew was diagnosed by Dr McDonald of the Princess Alexandra Hospital with cancer of the liver. Dr McDonald advised that Mr Pettigrew should not expect to survive more than a few months. On 9 January 2004, Mr Pettigrew was admitted to the Princess Alexandra Hospital Secure Unit and received palliative care. His condition continued to deteriorate. On 17 January 2004, Mr Pettigrew passed away surrounded by his family.

The investigation revealed no suspicious circumstances and the State Coroner found that Corrective Services staff did all within their power to provide appropriate medical assistance and treatment to Mr Pettigrew.

#### **Albert William Hendy**

Albert William Hendy was found dead on his bed in Room 30, Block D at the Department of Corrective Services' Western Outreach Centre (WORC) at Wacol on 12 March 2005.

Mr Hendy suffered from various medical conditions but was receiving treatment Corrective Services authorities. While Mr Hendy gave differing versions of how he sustained a minor head injury on the day of his death, he had maintained it occurred accidentally and there was no evidence to the contrary. The head injury was given appropriate attention by Corrective Services staff and he was promptly transported to the Princess Alexandra Hospital. The head injury played no part in Mr Hendy's death. While being treated for this injury, Mr Hendy did not complain of any other symptoms and, once his wound was dressed, he was returned to the WORC.

The State Coroner found that Corrective Services staff followed medical emergency and death in custody protocols. Corrective Services staff did all within their power to resuscitate Mr Hendy when he was found unconscious in his room. None of the correctional officers, inmates or medical personnel at the Princess Alexandra Hospital caused or contributed to the death and that, under the circumstances, nothing could have been done to save Mr Hendy who passed away suddenly from natural causes not previously diagnosed.

#### **Jamie Hewson**

On 8 April 2004 Jamie Hewson was on his family's farm near Kilkivan when a neighbour advised police that he had threatened her with a rifle. The police went to investigate and a siege ensued. The Special Emergency Response Team (SERT) were called in. The siege ended 18 hours later when police shot and killed Mr Hewson.

One of the issues considered by the State Coroner was the overflying of the scene by news helicopters. The air space over the incident area was eventually declared as restricted air space. However, the State Coroner commented that in hindsight this should have been done as soon as the emergency situation was declared. The State Coroner recommended that police review information provided to incident commanders to ensure it gives sufficient prominence to the need to seek air exclusion or restriction orders in appropriate cases. He also commented that "undoubtedly, the QPS needs a SERT like capability but it also needs to recognise the dangers of developing within such a unit, a perception that the actions of its members are not able to be externally critiqued".

#### **Raymond Francis Bourke**

On 7 June 2004, police searched a property at Kin Kin for an illicit drug laboratory they believed was there. Raymond Bourke was suspected of being involved in the manufacture of methylamphetamine at this location. On seeing police, Mr Bourke fled on a motor cycle. He was later found by a police officer with a bullet wound to his head. He died later that day.

The evidence indicated that Mr Bourke died as result of a self inflicted gunshot wound. It seemed likely that when Mr Bourke saw the police at the premises where he had been involved in manufacturing illicit drugs, he realized that it was likely that he would be charged with criminal offences and sentenced to a lengthy term of imprisonment. As a result, he decided to commit suicide. The State Coroner found that police officers involved in this matter did not cause or contribute to Mr Bourke's death and they acted appropriately during and after the death.

## Notable inquests continued

### David Edward Smith

On 28 September 1994, 21 year old David Edward Smith was found dead in his cell at the Sir David Longland Correctional Centre. He had been violently murdered by other prisoners. Mr Smith had been transferred to Unit 5B in which he was killed less than 24 hours before his death. When told of the decision to transfer him Mr Smith immediately protested to numerous officers indicating that he feared for his life. At one stage he asked to be placed on protection rather than being placed in 5B. His objections were overruled.

The State Coroner found that correctional officers all the way up the chain of command to the Acting General Manager failed to give sufficient consideration to the risks or perform a basic risk assessment before forcibly moving Mr Smith into the unit. The changes made to policies and procedures by the Department of Corrective Services as a result of the recommendations of the external inspectors and the continuing reform of the prison system appear to have addressed the formal and structural issues that contributed to the death.

The State Coroner commented that policies and procedures will not guarantee safety if employees fail to respond with clarity and commitment.

### Anthony Kenneth Hansen

Mr Hansen was an inmate at the Maryborough Correctional Centre. On 24 August 2003, he was admitted to the medical ward at the correctional centre with flu-like symptoms. He continued to receive treatment however, on 27 August, his condition deteriorated and he was transported to hospital where he later died of adult respiratory distress syndrome.

The State Coroner found that there was no evidence to suggest that anyone should be committed to stand trial for causing the death. The circumstances of this matter were such that it was not necessary to consider any riders or recommendations as he did not consider the death was preventable.

### Paul Andrew Meech

Paul Andrew Meech died on 1 August 2003 while detained at the Harvey Bay watchhouse. Mr Meech had suffered a long history of mental illness which required ongoing attention and frequent admission to mental health facilities.

In the weeks before his death he had a number of short term admissions to the Maryborough Mental Health Unit (MMHU). In the days preceding his death Mr Meech had also come into repeated contact with police because of his aggressive and violent behaviour.

On 30 July 2003 police took Mr Meech to the MMHU and he was placed under an involuntary order. The following day Mr Meech was assessed, the psychiatrist concluding that Mr Meech's extreme behaviour was not due to 'mental illness' within the meaning of the Mental Health Act but rather due to drug or alcohol abuse. He was therefore released from the MMHU. Mr Meech was arrested by police on 1 August and placed in the watchhouse where he subsequently died.

The inquest considered the assessment and supervision of Mr Meech in the watchhouse and his treatment by the MMHU, in particular the decision to release Mr Meech which was based on a restrictive interpretation of the Mental Health Act.

The State Coroner recommended that:

- operational police be reminded of the need to physically inspect prisoners in accordance with the requirements of Operational procedures Manual
- watchhouse managers be directed to develop and implement procedures for the inspection of prisoners in padded cells that will enable inspections to be undertaken in all circumstances that may exist in their respective watchhouses

- the QPS Property and Facilities Branch urgently review the doors on all padded cells to determine whether they should be replaced by doors that allow officers to visually inspect prisoners
- the Director of Mental Health seek legal advice about whether the Mental Health Act should be interpreted narrowly as contended by Mr Meech's treating psychiatrists. If the advice is to the effect that the clinicians took an unnecessarily restrictive view then the advice should be circulated to all mental health staff. If the advice confirms the narrow interpretation then legislative change should be considered.
- DCS develop a comprehensive system for assessing prisoners' risk of self harm to include the monitoring of the telephone calls of those identified as being at risk
- DCS immediately cover with mesh any bars accessible to prisoners in cells at Borallon and continue with its program to make suicide resistant all cells in use in the prison system.

#### **Phillip Bruce Partridge**

Phillip Bruce Partridge died on 1 September 2004 after he was involved in a siege with police officers at his home at Boonah. After police finally entered Mr Partridge's premises he was found dead with apparently self-inflicted wounds.

The State Coroner found that police did not cause or contribute to the death and that nothing could have been done to save Mr Partridge when police finally gained entry to the house. He was of the view that the police involved in this incident rightly determined to attempt to resolve the situation by containing and negotiating with Mr Partridge. However, due to his mental state, this was unable to be achieved and Mr Partridge died from self-inflicted wounds

#### **Troy Crossman**

On 17 March 2004 Troy Crossman was found hanging in his cell at Borallon Correctional Centre.

The State Coroner found that prison authorities responded quickly to the advice that someone was hanging and that the first aid given was appropriate. However, the State Coroner considered there was a basis for concern about the way the authorities responded to the information about Mr Crossman's risk of self harm and the prevalence of hanging points in the cells.

The State Coroner recommended that:

- the Department of Corrective Services (DCS) investigate adding an auditing function to the Integrated Offender Management System to facilitate the assessment of compliance with the policy concerning the accessing of 'at risk' information
- DCS consider introducing a suicide awareness program in all prisons

## Notable inquests continued

### State Coroner Investigations

#### John Walter Hedges

On 23 March 2002 76 year old Mr Hedges was a patient of the Greenslopes Private Hospital. He had advanced cancer and was receiving only palliative care. Mr Hedges' pain was so severe that he was receiving up 70mg of morphine subcutaneously a day. A nurse accidentally injected a lethal dose of morphine and Mr Hedges died shortly after.

The circumstances of this case suggested systemic failings contributed to the death. However, the evidence indicated that those issues had been addressed by the hospital. The State Coroner considered that hospital management had accurately identified the systemic issues that may have contributed to the death and did not believe that he was in a position to recommend any further changes. The State Coroner found that the carelessness of the nurse did not amount to criminal negligence.

#### Malcolm Robert Bell

On 11 October 2002 two police officers confronted Mr Bell in a lane in Brisbane city. They suspected that he was wanted in connection with a number of armed robberies conducted in the city. One of the officers told Mr Bell he was under arrest. Mr Bell did not comply with instructions given by that officer and produced a weapon. Soon after, he was shot dead.

The State Coroner did not consider that this death was reasonably foreseeable and therefore there was nothing, in his view, the authorities could have done to prevent it. There were, therefore, no riders or recommendations he could make.

#### Peter Whitoria Marshall

On 9 February 2004, Peter Marshall was removing the wheel from a giant dump truck at the Zinifex Century open-cut zinc mine. Suddenly, the highly compressed air in the inner wheel was released, throwing the 3.5-ton outer wheel some 13 metres. Mr Marshall had been standing in the wheel's path and was pinned under it. He died shortly afterwards.

The State Coroner recommended that:

- an analysis of the safety culture at the mine be undertaken
- the Mines Inspectorate investigate how meaningful supervision can be delivered to a heterogeneous workforce of skilled autonomous workers
- The Mines Inspectorate, SIMTARS and industry participants continue with the revision of AS 4457 and that special attention be given to tyre handling, lock ring retention and rim maintenance.

#### Rodney John Baker

On 29 January 2004, Rodney Baker and his brother-in-law were trawling off Cape Moreton when one of their nets snagged. The men commenced to haul their nets aboard to free the obstruction but the boat rolled over and soon sank. Mr Baker has never been seen again.

The State Coroner made the following recommendations:

- that Maritime Safety Queensland liaise with the Queensland Seafood Industry Association and other relevant representative bodies with a view to curtailing concessions that exclude the application of safety design requirements to commercial fishing boats
- the installation of quick release mechanisms on trawl cables be mandated for commercial trawlers

- the mandatory carrying of inflatable life rafts, personal floatation devices (PFDs) and emergency position-indicating radis beacons (EPIRBs).

#### **Daniel Cory Rhodes**

On 7 October 2002, Daniel Rhodes was driving with friends in Bundaberg when police commenced following the car. Mr Rhodes became agitated and alighted from the vehicle when it slowed at an intersection. This further aroused the suspicion of the police officers. A struggle ensued when officers tried to apprehend Mr Rhodes and Mr Rhodes was shot dead.

The State Coroner found that no one should be charged with any offence in connection with the death. He did not consider the death was reasonably foreseeable and therefore there was nothing the authorities could have done to prevent it. There were no riders or recommendations he could make.

#### **Lex Robert Bismark**

On Friday 12 July 2002, a large group gathered at the Barkly Hotel in Mt Isa for a NAIDOC Week function. Lex Bismark was among the group. When a fight broke out at about 2.30am, the manager decided to close the hotel and staff ushered everyone outside. The fight continued outside and spilled onto the Barkly Highway. Shortly afterwards, a car travelling along the highway drove into the crowd and struck three people including Mr Bismark, killing him. The driver of the car suffered from poor eyesight rendering her unfit to drive.

The State Coroner recommended that legislation be amended to require medical practitioners to advise the Department of Transport if they conclude that a person they believe is licensed to drive is incapable of doing so safely because of any physical or psychological impairment.

#### **David Jones Muckan**

David Muckan had a lengthy history of mental illness. On 21 April 1998 he was admitted to the Winston Noble Unit, a mental health facility attached to the Prince Charles Hospital. He was given a number of sedatives and four days later he was found dead. The State Coroner found Mr Muckan died of obstructive sleep apnoea which was contributed to by the sedating effects of therapeutic drugs. The State Coroner made the following recommendations:

- that the rapid tranquilisation guidelines be reviewed to ascertain whether they inform clinicians of the added risk posed by benzodiazepines to sufferers of obstructive sleep apnoea
- that either the Chief Health Officer or the Director of Mental Health take steps to ensure the guidelines are adopted in all health care facilities where the drugs in question are used.

#### **Perry James Irwin and Damien Lawrence Coates**

On 22 August 2003, Damien Coates, took a rifle into a small area of bushland near where he lived. He told people he met there that he was going to kill himself and any police officers who tried to intervene. This information was conveyed to police at the Caboolture Police Station. A short time later, Senior Sergeant Perry Irwin went with two other officers to the bushland where Coates had initially been seen, hoping to find the firearm they assumed he had secreted in the bush. When the first group of officers were unable to locate Mr Coates they told their shift supervisor. He told one of the officers with Senior Sergeant Irwin that Coates might be returning to the original location and recommended that those officers leave the bushland area immediately. They didn't follow this advice. Soon after, Senior Sergeant Irwin was shot dead. Mr Coates then also fatally shot himself.

## Notable inquests continued

The State Coroner recommended that the Queensland Police Service:

- in conjunction with the Explosives Inspectorate of the Department of Natural Resources and Mines review the regulations governing the sale and possession of ammunition
  - undertake a training needs analysis to determine whether the Incident Command System has been adequately implemented
  - review the adequacy of the number of handheld radios issued to the Caboolture Station
  - review the adequacy of the radio channel available for use in the Redcliffe District
  - undertake an audit of all body armour in service to determine whether the inspections and replacements recommended by the manufacturers have been complied with.
- that the Medical Board of Queensland consider and determine allegations made against Dr Maree
  - that Queensland Health and the Queensland Police Service amend their policies and procedures governing the immediate response to deaths in a medical setting to reflect the need to urgently take blood samples if the death may be due to anaphylaxis.

### **Kathryn Marnie Sabadina**

On 17 December 2000 Kathryn Sabadina died at the Charters Towers Hospital after having been admitted to have an infected eye tooth removed by her dentist. When general anaesthetic was administered the patient lost consciousness. Difficulty was experienced with ventilating the patient and it became apparent that an emergency was developing. After some time, assistance was summoned and a senior anaesthetist was consulted via the telephone. Ms Sabadina died despite numerous attempts to resuscitate her.

The State Coroner made the following recommendations.

- that the Chief Health Officer with the assistance of the State Coroner develop a policy and process for the independent and expert investigation of all deaths that are “not reasonably expected to be an outcome of a health care procedure”

### **Scott Karajic**

Scott Karajic died on 28 February 2003 when he was crushed by a drilling rig while drilling a coal seam gas well. The inquest established that this occurred as a result of the drilling pipes being inappropriately stacked on old and unsafe matting not designed to bear such loads.

The State Coroner recommended that the Petroleum and Gas Inspectorate consult with participants in the gas drilling and extraction industry to design an education package to be mandated by regulation. This package should address the training needs of rig workers, supervisors and senior drilling company personnel. In the case of rig managers and supervisors, the education package should mandate a tertiary education course as a component of the required qualifications.

## Deputy State Coroner

### Deaths in Custody investigations

#### Mark Anthony Waldon

Mr Waldon came into police custody on 26 December 2001 and into the Arthur Gorrie Correctional Centre on 28 December 2001. He died six days later on 3 January 2002. On entry to Arthur Gorrie he weighed 69 kilograms but at the autopsy he weighed only 63 kilograms. As Mr Waldon admitted to the daily use of heroin and cannabis he received the standard withdrawal treatment of diazepam, clonidine, quinine, maxolan and ibuprofen. The cause of death was aspiration due to acute gastric dilatation.

The Deputy State Coroner made recommendations that:

- prison and medical and nursing staff from prisons be alerted to the possibility that use of clonidine to assist a person withdrawing from heroin may have a rare side effect of inducing acute gastric pseudo obstruction
- there be a review of the suitability of the prescription of clonidine to the prison population as part of the standard drug detoxification regime
- the operator of the prison review the process of response to after hours calls for medical issues or when prisoners are locked in their cells
- there be a review of procedures for nurses attending cell in response to a possible medical problem with a prisoner
- the operator of the prison require and insist on contemporaneous and adequate notes of all requests for medical assistance by or on behalf of prisoners to correctional officers, nurses or any other staff members.

#### Adam Anthony Fernandez

On 4 December 2001, Adam Anthony Fernandez telephoned emergency services from his home. The operator thought that he was intoxicated. The operator understood from his call that he was injured and bleeding and that he was threatening further self harm. Police attended and administered capsicum spray in order to transport Mr Fernandez to hospital for medical attention. His condition was assessed and sedation was required to provide him with proper care. After he was stabilised he suddenly began vomiting so profusely that his airways were obstructed. Attempts to save him were prompt and appropriate. The cause of death was aspiration, due to alcoholic intoxication. Coronary atherosclerosis contributed to the cause of death.

Mr Fernandez' death was tragic but the Deputy State Coroner could not see that there were any matters which would warrant coronial comment aimed at preventing deaths occurring in similar circumstances.

## Deputy State Coroner

### Investigations

#### Jet Paul Rowland

On 28 February 2004 Anita Rowland was driving home with her two children, Jet, aged 22 months, and Bailey aged seven. Jet Rowland was killed when the car was hit by another car. The accident occurred when a car driven by Ian McLeod crossed the vegetated median strip of the Logan Motorway onto the opposite carriageway. Ian McLeod suffered an epileptic fit at the time or immediately before travelling onto the incorrect carriageway. In July 2003 general practitioner, Dr Torbey had given him medical clearance to renew his licence for five years on the basis of stable epilepsy with no seizure activity.

## Notable inquests continued

The Deputy State Coroner recommended:

- a review of practices concerning the forwarding of discharge summaries from Queensland hospitals to a patient's general practitioner
- a review of legislation to require doctors becoming aware of a patient suffering any epileptic event which would adversely impact on the patient's ability to drive, to discuss the issue with the patient at the consultation
- a review of legislation to consider whether a driver, and/or treating doctor should be required to inform the Department of Transport of a medical condition (such as epilepsy) or a change in the medical condition of a person impacting on their ability to drive
- a review of legislation to consider a panel of independent doctors for referrals for assessment of suitability to drive in the context of epilepsy
- the Guidelines for Fitness to Drive be publicised to the public and the medical profession
- a review of current Australian standards of child safety restraint mechanisms taking into consideration world best practice standards.

### **Pryde Michael Robe**

Pryde Robe suffered clinical depression. He had been admitted to hospital but was discharged with the Redlands Community Access team following up on his care. When a visit by team members discovered that Mr Robe was suicidal he was brought back to hospital for assessment. On 4 June 2003 Dr Paul Pun, a psychiatrist, ordered he be subject to an involuntary treatment order under the Mental Health Act. That order was revoked the following day by another doctor. Mr Robe continued to be monitored by the community based team but his condition was variable. Mr Robe committed suicide on 20 June 2003.

The Deputy State Coroner made recommendations that:

- the Mental Health Act be reviewed to require consultation between treating psychiatrists or other health professionals if revocation of an indefinite involuntary treatment order is being considered by a second authorised practitioner who was not the initial practitioner making the order. A protocol be developed, especially where the reviewing practitioner is less experienced than the practitioner making the original order
- the Access team structure be reviewed to ensure sufficiently experienced clinicians are involved to assist patients, as well as continuity of make up of team members to ensure that optimal patient care is available from suitably experienced practitioners, especially in "high risk" potential suicide patients
- that home visits be considered the appropriate communication whenever there is a strong indicator that a person's mental health is declining and that the risk of suicide has increased.

### **Robert Edward Cook**

On 21 December 2003, Mr Cook died of injuries received in a traffic accident occurring at the roundabout intersection of Scarborough and Griffith Road at Scarborough.

The Deputy State Coroner commended the suggested remedies set out in the Road Safety Audit and Risk Assessment Report from the Redcliffe City Council which were aimed at reducing the speed of traffic approaching the intersection and increasing visibility of the intersection by removing overhanging vegetation.

## Local Coroners

### Coroner Previtiera

#### Thomas Creegan

Thomas Creegan died during a dive on the Great Barrier Reef on 30 November 2003. Mr Creegan was holidaying in Australia and had never dived before. He became separated from other divers who were free swimming behind the instructor. He ascended unsupervised to the surface from a depth of five minutes after a period of four minutes and after calling out for help, became unconscious. The medical cause of his death was myocardial ischaemia as a result of undiagnosed coronary artery disease, although the possibility of CAGE (cerebral arterial gas embolism) as the precipitating event could not be excluded.

The Coroner recommended that:

- persons undertaking recreational diving or snorkelling ensure an automatic electronic defibrillator with a non-conducting mat is immediately available at each dive and snorkelling site and is checked daily
- the Queensland recreational diving and snorkelling industry consult and review the adequacy of training programs for its members
- the Queensland recreational diving and snorkelling industry sponsor adequate research to provide a sound basis for the consultation, review and possible further development of additional risk management strategies
- the Office of the State Coroner provide assistance to such projects by ensuring appropriate access to records of all diving and snorkelling matters reported to the Coroner.

## Coroner Daly

#### Karl Peter Sperling

Cadet Karl Sperling drowned during an orienteering exercise held during a camp with the South Burnett Army Cadet Group. A Military Board of Enquiry was held in relation to the death. A copy of the *Report of the Board of Inquiry into the Death of Cadet KP Sperling arising from an incident at Bjelke-Petersen Dam on 18 November 2000* and documentation showing the implementation of the report recommendations were considered by the coroner.

In view of the Australian Army's implementation of the Board's findings and the Army's additional action to improve cadet safety further recommendations were not made.

### Coroner Rinaudo

#### Penelope Ann Croft

Penelope Croft was an experienced bike rider and tri-athlete. On the 2 March 2004, a white Austral bus was travelling on Mt Cotton Road when it passed Ms Croft riding her racing bike. The right rear engine compartment door of the bus was open. As the bus passed the open door struck the rider inflicting fatal injuries.

The Coroner made the following recommendations:

- all exterior doors on buses should be fitted with a safety locking system with a special key and alarms to alert the driver that a door is open and should be regularly maintained and inspected and at least each month
- drivers should be properly instructed to undertake a physical inspection of all outer doors and should be given a list of things to check on the bus at least twice per day
- inner doors on engine compartments should be locked by an adequate locking device and a safety system should be installed
- a maintenance log must be kept by the company/owner of the bus which lists defects detected by the driver during routine inspections before departure each day. This log must be available for service mechanics and the Department of Transport for inspection.

### Coroner Hennessy

#### Jye Conrad Perry

Jye Conrad Perry was born on 2 February 1999 and died on 26 December 2002 as a result of fatal stab wounds at the hands of his aunt during an apparent episode of his aunt's mental illness diagnosed as schizophrenia.

The Coroner recommended:

- that Queensland Health progress as soon as possible a Mental Health information system that interfaces with the Emergency Department information system as well as adopting a statewide uniform practice for forensic patient files to be flagged
- the continuation of the improvement and standardisation of processes of management of forensic patients and persons of special notification
- that the risk assessment and management strategies to ensure the safety of children presently in place for persons of special notification be extended to cases where children reside with the person receiving treatment
- that Queensland Health review and implement changes to the present confidentiality provisions to ensure that confidentiality of the person receiving treatment is balanced with the rights of the public to protection against the risk of harm
- it would assist Coronial inquiries for the Queensland Police Service to have direct access to medical staff for the purposes of taking statements or obtaining information for the purpose of such inquiry.

### **Craig Liddington, Stewart Eva and Andrew Carpenter**

On 17 October 2003, the CQ Rescue Bell 407 Helicopter departed Mackay on an aero medical retrieval flight to recover a patient from Hamilton Island. On board, were the pilot, Andrew Carpenter, paramedic Craig Liddington and crewman Stewart Eva. The three men were killed when the helicopter crashed into the sea near Mackay.

The Coroner made extensive recommendations including recommendations regarding the type of helicopters to be used by community helicopter providers, the qualifications, skills and training of pilots employed by community helicopter providers and emergency services officers, funding of community helicopter providers, the relationship between the Department of Emergency Services and community helicopter providers, facilities at Hamilton Island for the overnight care of patients, review of emergency assistance and medical facilities on residential and resort islands.

### **Coroner Spencer**

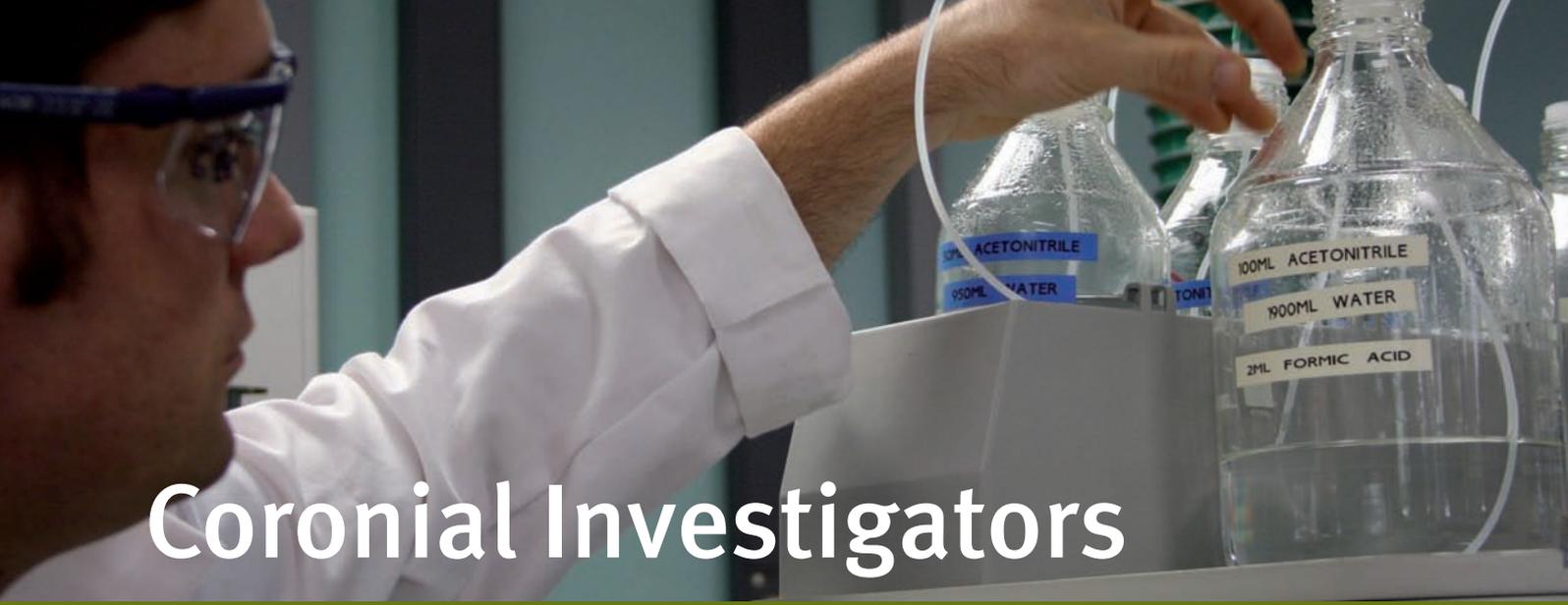
#### **Phillip Allan Walter Tognola**

Five-year-old Phillip Tognola drowned in a neighbour's pool on 19 April 2003.

The Coroner made the following recommendations and requested that such recommendations be provided to all Federal, State and Local Government departments responsible for swimming pool construction and fencing:

- Queensland Parliament consider enacting a single piece of legislation containing a uniform set of rules and requirements relating to the construction and fencing of pools
- local authorities institute a system to identify all properties in their local authority areas which have swimming pools

- legislation be enacted to require a compulsory inspection and issue of a certificate of compliance prior to settlement of all properties
- Queensland Law Society and the Real Estate Institute of Queensland provide a mandatory condition that a certificate of compliance and clearance be received from the local authority before any premises having a swimming pool be settled
- Australian Standards which relate to swimming pools be updated and upgraded
- local authorities be required by legislation to institute a regular system of inspection of swimming pools
- legislation be enacted giving local authorities appropriate powers to have serious defects attended to immediately and to be required to compile policies, practises and procedures and inspections regarding applications for the approval of domestic swimming pools
- local authorities implement a more proactive inspection campaign on existing swimming pools and their compliance with all legislation
- an awareness campaign be undertaken to promote training on resuscitation techniques, and an awareness to home owners of the extreme dangers of swimming pools and young children
- all local authority websites provide information or links to the relevant information relating to the swimming pool legislation and requirements
- legislation clearly set out the right of enforcement officers to enter private properties to monitor compliance
- local authorities utilise their powers to issue on the spot fines in order to create awareness by property owners of their obligations to comply with fencing legislation.

A close-up photograph of a person wearing safety glasses and a white lab coat, working in a laboratory. They are handling several glass bottles on a tray. One bottle is labeled '100ML ACETONITRILE', another '100ML WATER', and a third '2ML FORMIC ACID'. The person's hands are visible as they adjust the bottles. The background is slightly blurred, showing a laboratory setting.

# Coronial Investigators

The Coronial Support Unit coordinates the management of coronial processes on a state-wide basis within the Queensland Police Service. The officers located within the Office provide direct support to the State Coroner and Deputy State Coroner as well as assisting regional coroners as required.

The officers at the John Tonge Centre assist in the identification of deceased persons, preparation of documents for autopsy and attend autopsies. This unit also liaises with coroners, investigators, forensic pathologists, mortuary staff and counsellors.

These officers bring a wealth of experience and relevant knowledge to the Office.

They are actively involved in various research projects and proactively review policies and procedures as part of a continuous improvement approach.

The Coronial Counselling Service based at the John Tonge Centre provides information and counselling services to relatives of the deceased. This service is staffed by very experienced professional counsellors.

Forensic Pathology, QHSS is responsible for the provision of the coronial autopsy service and provides a specialist pathology investigation service to the OSC.

The Coronial Support Unit, the Coronial Counselling Service and Forensic Pathology are integral parts of the coronial process. Their dedication, commitment and professionalism are greatly appreciated by the OSC as well as the families of the deceased.

## Research into coronial investigations

### **Genuine Researchers**

The coronial system is an important source of information for researchers and the analyses of researchers are essential in the assisting other coronial system to prevent future deaths.

The following genuine researchers were approved in the reportable period:

#### **Associate Professor Robert Hoskins**

Recent advances in testing and analyses of toxicology reports for coronial investigations in which road trauma was the cause of death have shown stronger and more convincing links between illicit drug use and culpability in road accidents.

The object of Assoc. Professor Hoskins research is to undertake a comparative study between living and deceased subjects to determine whether the drugs implicated in Queensland driving fatalities were of the same types and levels. This research may progress legislative reform in identifying a reliable and cost-effective method of detecting drug impairment or drug use at the road side.

#### **Dr Benjamin Mark Reeves – Paediatric Registrar**

Sudden Infant Death Syndrome (SIDS) is the leading cause of post-neonatal death in Australia and previous studies provide good evidence that these deaths are largely preventable through avoiding known risk factors.

The object of Dr Reeves research is to analyse the SIDS deaths within the Mackay Health Service District region to identify risk factors thought to contribute to SIDS deaths (such as sleep position, parental smoking, so-sleeping, potential asphyxia etc).

Dr Reeves anticipates that as a result of this research, recommendations relating to the establishment of local multidisciplinary case reviews where police, pathologists and other clinicians can attend to present relevant information in one forum for better accuracy and diagnosis and further intervention if necessary. The research is also likely to lead to educational campaigns for the community.

#### **Dr Walker**

Dr Walker is a declared 'genuine researcher' and his research involves investigating fatal accidents occurring in underwater activities to attempt to identify 'avoidable factors'. As a result of Dr Walker's research, this information is utilised to improve preventative measures in the diving industry.

Dr Walker has provided the OSC a prepublication copy of the provisional report he has produced on diving-related fatalities in Australian waters in 2001 for the Diving and Hypyperbaric Medicine Publication.

## National Coroners Information System

The National Coroners Information System (NCIS) is a national internet-based data storage and retrieval system for Australian coronial cases. Information about every death reported to an Australian coroner since July 2000 (January 2001 for Queensland) is stored within the system, providing a valuable hazard identification and death prevention tool for coroners and research agencies.

The NCIS has a primary role to assist coroners in their role as death investigators by providing them with the ability to review previous coronial cases that may be similar in nature to current investigations, enhancing their ability to identify and address systematic hazards within the community.

## Usage of the National Coroners Information System

Table 2 shows the total number of cases created and closed for the reporting period. The total number of cases created includes the additional cases that have been inputted onto the local case management system as a result of measures put into place to address the backlog issues for Queensland that were identified in the last reporting period.

As predicted, the NCIS usage figures increased significantly for the reporting period due to presentation and awareness sessions provided to select coroners and magistrates. As a result, NCIS usage rates increased. The usage rates during the reporting period are reflected in Table 3.

### Table 2

Total Number of created / closed cases  
01/07/05 – 30/06/06

Cases created	6600
Cases closed	3007

### Table 3

Usage figures for coroners / experts 01/07/05 – 30/06/06

Position	Count of Use	
	On line	Direct to NCIS
Senior Coronial Information Officer - NCIS Expert	390	
Data Entry Officer - NCIS Expert	217	
Coronial Information Support Officer - NCIS Expert	3	
Executive Officer		1
Coroner – Rockhampton		1
Coroner – Southport		1
<b>Total</b>	<b>610</b>	<b>3</b>



# Appendices

## Appendix 1

### Presentations by the State Coroner and Deputy State Coroner

#### **Michael Barnes—State Coroner**

Caboolture Public Hospital, “Coroners cases – how to identify them and what to do about it”, July 2005

Department of Emergency Services, command and control conference, *The role of the coroner in a mass fatality disaster*, August 2005

Australian Institute of Emergency Services, National conference & exhibition, Large scale event coordination strategies, “*Planning to include the State Coroner*”, November 2005

Royal Australian College of Medical Administrators, *Coroners cases – how to identify them and what to do about it*, November 2005

Royal Brisbane and Women’s Hospital Neonatal Unit, *Coroners cases – how to identify them and what to do about it*, January 2006

Royal Brisbane and Women’s Hospital, *A hospital doctor’s responsibility in relation to hospital deaths*, February 2006

Department of Emergency Services, command and control conference, *The role of the coroner in a mass fatality disaster*, February 2006

Queensland suicide and self harm prevention conference, *Suicide prevention and the new coronial system*, March 2006

Redcliffe Hospital, *Coroners cases – how to identify them and what to do about it*, April 2006

Community Forensic Mental Health Service, *Qld’s new coronial system*, May 2006

QUT, LLM Health law unit, *The State’s supervision of death*, May 2006

#### **Deputy State Coroner—Christine Clements**

The Deputy State Coroner delivered presentations to the Redlands Hospital, Mater Children’s Hospital Caboolture Hospital, Royal Brisbane & Women’s Hospital and the Police Accident Investigation Pacific Conference for Accident investigators.

## Appendix 2—Operating expenses

### Operating expenses

	1/12/03 to 30/6/04	1/7/04 to 30/6/05	1/7/05 to 30/6/06
Employee related expenses	\$328,159	\$717,269	\$893,499
Supplies and services	\$156,427	\$265,695	\$535,501
Burials and Cremations	\$398,633	\$660,471	\$635,620
Conveyance of human remains	\$508,437	\$1,005,216	\$1,041,267
Post Mortem fees	\$305,209	\$544,622	\$529,539
Counsel fees	\$327,946	\$173,007	\$232,175
Travel	\$25,529	\$61,075	\$80,942
Conferences		\$1,045	\$3930
<b>Total</b>	<b>\$2,050,340</b>	<b>\$3,428,400</b>	<b>\$3,952,473</b>

## Appendix 3—Coronial cases lodged and finalised in 2005–06

Number of Coronial cases Lodged and Finalised in the 2005–06 financial year and the number cases pending as at 30 June 2006

Court location	Number of deaths reported to the Coroner	Number of Coronial Cases finalised			Number of Coronial Cases pending			
		Reported deaths			< or = to 12 months old	> 12 and < or equal to 24 months old	> 24 months old	TOTAL
		Inquest held	Inquest held	TOTAL				
Atherton	23	-	21	21	10	-	1	11
Aurukun	-	-	1	1	-	2	-	2
Ayr	-	-	6	6	-	-	-	-
Beenleigh	152	2	174	176	84	24	19	127
Bowen	14	1	11	12	5	-	1	6
Brisbane	1,010	11	828	839	574	67	86	727
Bundaberg	64	1	54	55	47	3	4	54
Caboolture	79	-	76	76	32	4	1	37
Cairns	147	-	167	167	61	10	7	78
Caloundra	34	-	27	27	19	-	-	19
Charleville	11	-	9	9	3	1	3	7
Charters Towers	-	-	1	1	-	-	2	2
Chinchilla	3	-	5	5	1	1	-	2
Cloncurry	-	-	-	-	-	-	1	1
Coen	-	-	1	1	-	-	-	-
Cooktown	5	-	12	12	1	3	1	5
Cunnamulla	4	-	1	1	3	-	-	3
Dalby	26	1	19	20	15	3	1	19
Emerald	40	-	47	47	16	5	1	22
Gatton	-	-	1	1	-	-	-	-
Gayndah	9	-	7	7	4	1	-	5
Gladstone	44	3	38	41	22	7	-	29
Goondiwindi	1	-	3	3	-	-	-	-
Gympie	27	-	42	42	9	3	-	12
Hervey Bay	48	1	42	43	15	-	2	17
Innisfail	21	-	20	20	11	2	5	18
Ipswich	140	4	134	138	59	6	4	69
Kingaroy	12	-	24	24	8	1	1	10
Kowanyama	-	-	3	3	-	1	-	1
Lockhart River	1	-	2	2	-	-	-	-
Mackay	98	2	104	106	27	3	-	30
Mareeba	14	5	13	18	8	-	-	8
Maroochydore	131	5	142	147	51	15	4	70
Maryborough	24	-	29	29	7	2	-	9
Mitchell	4	-	1	1	4	-	-	4
Mossman	14	1	9	10	7	-	-	7
Mount Isa	44	-	38	38	26	3	2	31

continued

Appendix 3—Coronial cases lodged and finalised in 2005–06 continued

Court location	Number of deaths reported to the Coroner	Number of Coronial Cases finalised			Number of Coronial Cases pending			
		Reported deaths			< or = to 12 months old	> 12 and < or equal to 24 months old	> 24 months old	TOTAL
		Inquest held	Inquest held	TOTAL				
Murgon	2	1	19	20	-	2	2	4
Nambour	-	-	-	-	-	-	1	1
Nanango	7	-	7	7	4	1	-	5
Noosa	-	-	1	1	-	-	-	-
Oakey	1	-	4	4	-	-	-	-
Petrie	-	-	1	1	-	-	-	-
Pittsworth	4	-	-	-	5	-	-	5
Proserpine	15	-	19	19	4	1	2	7
Redcliffe	54	-	50	50	24	2	2	28
Rockhampton	101	4	92	96	45	5	2	52
Roma	7	-	7	7	2	3	-	5
Southport	315	-	91	91	273	96	32	401
St.George	3	-	8	8	-	1	-	1
Stanthorpe	-	-	3	3	-	-	-	-
State Coroner	40	23	27	50	30	44	23	97
Taroom	3	-	3	3	-	-	-	-
Thursday Island	6	-	7	7	5	-	-	5
Toogoolawah	-	-	2	2	-	-	1	1
Toowoomba	99	5	84	89	29	6	-	35
Townsville	202	8	151	159	105	9	5	119
Warwick	40	-	40	40	16	-	-	16
Weipa	1	-	5	5	-	-	-	-
<b>Total</b>	<b>3,144</b>	<b>78</b>	<b>2,733</b>	<b>2,811</b>	<b>1,671</b>	<b>337</b>	<b>216</b>	<b>2,224</b>

Source: Queensland Wide Interlinked Courts (QWIC) system and 2005-06 manual survey for the Report on Government Services (RoGS)

## Appendix 4—State Coroners Guidelines

[www.justice.qld.gov.au/courts/coroner/publications.htm](http://www.justice.qld.gov.au/courts/coroner/publications.htm)

