QUEENSLAND COURTS

AUDAX AT FIDELIS

Office of the State Coroner

Annual report 2014–2015

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1 February 2016

The Honourable Yvette D'Ath MP
Attorney-General and Minister for Justice
Minister for Training and Skills
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

I enclose a report on the operation of the *Coroners Act 2003* for the period 1 July 2014 to 30 June 2015.

As required by section 77 of the Act, the report contains a summary of each death in custody investigation finalised during the reporting period.

The report also contains the names of persons given access to coronial investigation documents as genuine researchers.

The guidelines issued under section 14 of the Act were reviewed and updated during the reporting period. Guidelines were included in relation to domestic and family violence and child death reviews to guide the investigation of these deaths. The Guidelines are publicly available and can be accessed at http://www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications.

No directions were given under section 14 of the Act during the reporting period.

Yours sincerely

Terry Ryan
State Coroner

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State Coroner's Overview

This Annual Report gives an overview of the operation of the *Coroners Act 2003* during 2014–15.

As the outset, I acknowledge the contributions made by all of my colleagues in the Office of the State Coroner, who respond each working day to sudden and unexpected deaths in a timely and sensitive way.

While there was a slight fall in the number of deaths reported in 2013–14, this financial year saw the continuation of previous trends with an increase in deaths reported State wide. Overall, there was a 5.98% increase in deaths reported (4962 up from 4682).

The major increase in deaths reported was in the Southeastern region. The 13.7% increase in that region reflects strong population growth in the Gold Coast and Logan areas. Steady growth was also seen in the Brisbane (7.01%) and Central (5.2%) catchments, offset by a decrease in the Northern region (-6.1%).

Of particular concern, 716 of the 4962 reported deaths (14.4%) were identified as suspected suicides, increasing from 661 in 2013-14. This Office has participated in the development of the Suicide Prevention Action Plan, which presents an opportunity for the community to consider how suicide rates might be reduced. Systemic reviews of the data held by this Office in relation to suicide deaths would assist in that process.

In 2014–15, coroners finalised 4638 matters, achieving a clearance rate of 93.47 per cent. This represents 271 fewer cases than in 2013–14. The reporting period also saw an 17.2% increase in the number of pending cases.

These outcomes will need to be closely monitored. A range of factors affect the timely finalisation of coronial investigations. The increased rigour applied to deaths at the time of reporting has led to more deaths resulting from natural causes being finalised by doctors issuing a cause of death certificate. A corollary of this is that cases that proceed to further investigation are increasing in complexity. Other relevant factors include a reduction in the capacity of Queensland Health Forensic and Scientific Services following the loss of several long-serving pathologists, coroner and registrar leave, and the fact that coroners await the finalisation of criminal proceedings and other investigative processes before concluding their investigations.

The work of this Office's Domestic and Family Violence Death Review Unit was acknowledged in the report of the Special Taskforce on Domestic and Family Violence, *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland*. That Report recommended that the domestic and family violence death review process be enhanced by increasing the capacity of the Domestic and Family Violence Death Review Unit, and establishing a Queensland Domestic and Family Violence Death Review and Advisory Board. The Government has accepted those recommendations, together with all the Special Taskforce's 140 recommendations. Work is progressing to implement these important reforms.

Coroner Jane Bentley completed a two year term as Northern Coroner at the end of 2014, when she resumed her appointment as a Magistrate in Cairns. As the Northern Coroner, Magistrate Bentley presided over 19 inquests and managed a busy workload very effectively. Her coronial recommendations resulted in significant changes, including

changes to the way the Queensland Police Service manages missing person files, and enhancements to safety for persons engaging in wilderness activities in far north Queensland. Magistrate Kevin Priestly returned to the position of Northern Coroner at the start of 2015.

The coronial registrar, a position established permanently in July 2013, managed over 50% of the deaths reported to coroners in the greater Brisbane, Sunshine Coast and South West Queensland reporting catchments during 2014–15. Understandably, the position is unable to absorb further increases in workload. The appointment of a second registrar is required to enable the efficiencies achieved by the role in triaging natural causes and health care related deaths to be extended to the Southeastern, Central and Northern regions.

Once again, I extend my thanks to our partners within Queensland Health Forensic and Scientific Services for their support during the reporting period. Sadly, forensic pathologist Roger Guard and his wife were among the 298 people who lost their lives on 17 July 2014 when Malaysian Airlines flight MH17 was shot down. Dr Guard was director of the Pathology Queensland laboratory at Toowoomba Hospital for over 30 years. His contribution will be missed.

The Queensland Police Service Coronial Support Unit, and members of the QPS assist coroners in responding to reportable deaths across the State each day. I acknowledge in particular the leadership of Detective Inspector Roger Lowe, whose tenure as the officer in charge of the Coronial Support Unit finished at the end of June 2015. Detective Inspector Lowe led significant reforms and provided invaluable support to the Office during his two years in this role.

The Office trialled revised administrative processes in the Northern Region during the reporting period. This saw tasks associated with the registration of deaths and the release of bodies being managed from Brisbane. The outcomes of this pilot were generally positive and I thank the Northern Coroner, stakeholders in the Northern Region and staff within the Office for their contribution to these changes.

It is now over 12 years since the *Coroners Act 2003* commenced. Demand for coronial services is likely to continue to increase as the Queensland population both increases and ages.

In an environment of ongoing fiscal restraint it will be necessary to explore a range of options to ensure that the Queensland coronial system retains the capacity to meet its dual mandate of death investigation and prevention. Options could include a review of the Coroners Act, and other operational and policy changes referred to in this Report. The innovative use of technology to enable information held by partners within the coronial system to be shared will also contribute to efficiencies. Meeting increasing demand will also require the ongoing sustainability of forensic pathology services across the State to be addressed.

It is important that steps are taken now to develop robust governance, legislative and service delivery frameworks that will continue to support a modern and responsive coronial system.

The Queensland coronial system - a brief overview

Scope of the Queensland coronial jurisdiction

Queensland's coronial jurisdiction is established and governed by the *Coroners Act 2003*. It is focussed on the investigation of 'reportable deaths', these being certain categories of death considered to warrant independent scrutiny by virtue of the nature of the incident that precipitated the death or the deceased person's particular vulnerability. In general terms, the concept of reportable deaths compromises:

- violent or otherwise unnatural deaths
- deaths that happened in suspicious circumstances
- health care related deaths
- deaths of unknown cause
- deaths 'in custody' i.e. police-related deaths, prisoner deaths, immigration detention deaths
- deaths occurring in the course of or because of a police operation
- deaths 'in care' i.e. deaths of supported disability accommodation residents, deaths of involuntary mental health patients and deaths of children subject to formal child protection intervention
- deaths where the deceased person's identity is unknown.

The Coroners Act also confers jurisdiction in respect of suspected deaths.

Recent years have seen a significant increase in demand for coronial services state-wide with reported deaths increasing from 3,514 in 2007–08 to 4,962 in 2014–15 – a 41.2% increase in deaths reported. This increase is a result of a number of factors including increased awareness of coronial reporting obligations and legislative changes to the types of deaths that are required to be reported to a coroner over the past seven years. Even so, deaths investigated by coroners make up only a small percentage (between 10 and 20 per cent) of all deaths in a community. The 4,962 deaths reported to Queensland coroners represent only 16.4 percent of the 30,207 deaths registered in Queensland in 2014–15.

The coroner's role is to establish the identity of the deceased, when and where they died, the medical cause of death and the circumstances in which the death occurred. In doing do, coroners also consider whether the death may have been preventable and if so, whether systemic or policy or procedural changes could contribute to improvements in public health and safety, or the administration of justice, or reduce the likelihood of other deaths occurring in similar circumstances.

The coroner's investigation is an independent, impartial, open and transparent inquisitorial process. Its primary focus is not whether someone should be held criminally or civilly liable for a death; the Coroners Act expressly prohibits the coroner from making any such finding. As such, the coronial process operates alongside, informs and can be informed by, other investigative and review processes, including criminal, regulatory and administrative processes that may be triggered by the particular circumstances of a death.

Key components of the Queensland coronial system – coroners and their support staff

Since October 2012, all deaths reported under the Coroners Act have been managed by seven specialist full-time coroners and one coronial registrar, with legal and administrative assistance provided by the staff of the Office of the State Coroner (OSC) within the Department of Justice and Attorney-General.

State Coroner

The State Coroner, Mr Terry Ryan, was appointed on 1 July 2013 for a period of five years ending on 30 June 2018. The State Coroner is responsible for coordinating and overseeing the coronial system to ensure it is administered efficiently, and that investigations into reportable deaths are conducted appropriately.

As part of this coordinating role, the State Coroner may issue guidelines under s. 14 of the Coroners Act to coroners and to persons carrying out functions under the Act. The State Coroner also provides 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.

Only the State Coroner or Deputy State Coroner can investigate deaths in custody and deaths happening in the course of or because of police operations. The State Coroner also conducts inquests into more complex deaths when deemed necessary.

During 2014–15, 83 deaths were reported to the State Coroner. The State Coroner conducted inquests into 20 deaths and finalised 49 investigations without proceeding to inquest.

The State Coroner also has a review function under the Coroners Act in respect of decisions about whether a death is reportable, whether an inquest should be held an whether an inquest or non-inquest investigation should be reopened. During 2014–15, the State Coroner received 21 applications for review and finalised 18 matters of this nature.

Brisbane based coroners and coronial registrar

The Deputy State Coroner, Mr John Lock, two Brisbane Coroners, Ms Christine Clements and Mr John Hutton, and one Coronial Registrar, Ms Ainslie Kirkegaard are based in Brisbane. Their reporting catchment encompasses the greater Brisbane area including Caboolture-Redcliffe, the Sunshine Coast region north to Gympie and the South West Queensland region.

In 2014–15, 2,991 deaths were reported to the Brisbane based coroners including the State Coroner and the registrar. 2,793 investigations were finalised, including 46 deaths finalised by inquest. This represents a 7 per cent increase in the number of deaths reported to Brisbane based coroners, the State Coroner and the coronial registrar (up from 2795 deaths in 2013–14).

Northern Coroner

Deaths in the region from Thursday Island to Proserpine, north to the Papua New Guinea border and west to the Mt Isa district are reported to the Northern Coroner who is based in Cairns. In 2014–15, the Northern Coroner role was performed by Ms

Jane Bentley until December 2014 when she returned to the general magistracy, and Mr Kevin Priestly who returned to the role from the general magistracy from January 2015.

In 2014–15, 615 deaths were reported in the region and 575 matters were finalised, including 12 deaths finalised by inquest. This represents a 6.1 per cent decrease in the number of deaths reported to the Northern Coroner (down from 653 deaths reported in 2013–14).

Southeastern Coroner
The Southeastern Coroner based in Southport, Mr James McDougall, investigates deaths in the area covering Rochedale South to the border of New South Wales, Beenleigh and Logan.

In 2014–15, 771 deaths were reported in the region and 716 matters were finalised including 15 deaths finalised by inquest. This represents a significant 13.7% per cent increase in the number of deaths reported to the Southeastern Coroner (up from 678 deaths in 2013–14).

Central Coroner
The Central Coroner based in Mackay, Mr David O'Connell, investigates deaths reported in the Central Queensland region which covers an area from Proserpine to Gayndah.

In 2014–15, 585 deaths were reported in the region and 553 matters were finalised including four following an inquest. This represents a 5.2 per cent increase in the number of deaths reported to the Central Coroner (up from 556 deaths reported in 2013–14).

Regional Coroners
Prior to the implementation of the full-time coroner model in October 2012, deaths were reported to local magistrate coroners at 16 magistrates courts across the State.

In 2014–15, the last remaining regional coronial investigation was finalised following an inquest, meaning all pending coronial investigations are now being managed under the full-time specialist coroner model.

Office of the State Coroner
The OSC supports the State Coroner to administer and manage a coordinated state-wide coronial system in Queensland. The office is also responsible for providing a central point of contact and publicly accessible information to families and the community about coronial matters. The OSC manages and maintains a register of reported deaths and supports the State's involvement in the National Coronial Information System (NCIS). Data provided to the NCIS is used to inform death and injury prevention activities for a wide range of stakeholders, including coroners, government agencies and researchers.

As at 30 June 2015, the OSC comprised 41 staff members with 30 based in Brisbane, three in the Northern Coroner's office in Cairns, four in the Southeastern Coroner's office in Southport and four in the Central Coroner's office in Mackay.

Towards the end of 2014–15, the OSC commenced implementation of recommendations made by the 2013 Operational Review of the OSC's staffing structure and method of regional service delivery. These efforts focussed on a trial of the Review's primary recommendation that the administrative work associated with supporting regional coroners to process daily reported deaths should be reallocated to Brisbane, allowing regional administrative resources to focus on supporting regional coroners in more complex investigation and inquest matters.

The initial trial transitioned the processing of daily reported deaths in the Northern Coroner's region to the Brisbane-based Daily Orders Team. The Northern Coroner's pre-existing practice of maintaining electronic rather than paper files was integral to the trial's success as it facilitated more efficient use of the Coroners Case Management System (CCMS) and Outlook by Brisbane-based staff to generate and communicate orders and coronial information, particularly during the preliminary investigation stage from the initial report of the death to release of the body and receipt of autopsy findings. The trial was complemented by the Brisbane-based coroners and coronial registrar also adopting the practice of issuing electronic rather than paper orders (though the creation of both paper and electronic files was maintained for deaths reported in their reporting catchment).

The Northern region trial was evaluated by OSC in 2014–15, in consultation with trial participants and coronial stakeholders, and found to have successfully achieved its operational objectives. The new administrative structure has been fully implemented for the Northern region, resulting in the replacement of the Cairns-based AO4 Case Coordinator and AO2 Coronial Administration Officer with a new AO3 Coronial Support Officer in the Brisbane-based Daily Orders Team. The staff whose positions were moved to Brisbane were transferred to other positions in Cairns within the Department of Justice and Attorney-General. The Northern Coroner's office now comprises one PO5 Counsel Assisting and one AO3 Coronial Investigations Officer who provide legal and administrative support to the Northern Coroner's management of complex investigation and inquest matters.

The Northern region trial evaluation recommended that OSC proceed to implement the new regional office structure in the Southeastern and Central regions after an appropriate level of stakeholder engagement and consultation in preparation for the transition.

As at 30 June 2015, OSC was preparing to implement the new regional model in the Southeastern region from 1 July 2015, with a decision about the timing of implementation in the Central region to be considered after the Southeastern transition was fully bedded down in 2015–16.

Successful implementation of the new regional office structures in both the Northern and Southeastern regions would not have been possible without the valuable experience, energy, enthusiasm and goodwill of the staff of the Cairns, Southport and Brisbane offices who worked productively together and with coronial stakeholders to prepare for and transition to the new arrangements.

It must be acknowledged that the transition process has substantially increased the volume of email correspondence received by the Brisbane office. OSC is working through business process changes to manage this emerging operational issue. This will be further informed by externally facilitated business process mapping scheduled for early 2016, and exploring options to go "paperless" in the Brisbane office.

During the reporting period, OSC also implemented other Review recommendations concerning team structures, position designations and the re-classification of the position of Coordinator (State Investigation Team) from AO4 to AO5 Manager, Inquest and Investigation Team. Mr Daniel Grice, a long serving and highly valued member of OSC who has worked closely with both the former and current State Coroner for many years, was appointed to this position on 13 November 2014.

Recommendations regarding review of the name of the Office and its Mission Statement are yet to be progressed.

Key components of Queensland coronial system – a multi-agency approach

Queensland coroners are supported by a multidisciplinary system in which the Queensland Police Service, whose officers assist coronial investigations and the Department of Health, which provides coronial autopsy and clinical advisory services, have long participated as key coronial partner agencies.

Each of these agencies is represented on the State Coroner's Interdepartmental Working Group (IWG), which meets to review and discuss state-wide policy and operational issues. The IWG met three times during the reporting period.

Queensland Police Service Coronial Support Unit (QPS CSU)

The QPS CSU coordinates the management of coronial processes on a state-wide basis within the Queensland Police Service. Four police officers co-located with the OSC in Brisbane provide direct support to the State Coroner, Brisbane based coroners and the Southeastern Coroner as required. Permanent Detective Senior Sergeant positions have been established in both Cairns and Mackay to assist the Northern Coroner and the Central Coroner respectively.

QPS CSU officers are also located at the coronial mortuary at Coopers Plains. They attend autopsies and assist in the identification of deceased persons and preparation of documents for autopsy.

QPS CSU also liaises with investigators, forensic pathologists, mortuary staff and counsellors. The CSU officers bring a wealth of experience and knowledge to the coronial process and are actively involved in reviewing policies and procedures as part of a continuous improvement approach.

The Disaster Victim Identification Squad (DVIS) is also part of the CSU. Their main role is to remove and identify the remains of deceased victims of mass fatality incidents, air disasters and natural disasters.

Key initiatives undertaken by QPS CSU during 2014-15, under the leadership of Detective Inspector Roger Lowe, include:

- state wide rollout of the sealed body bag process
- state-wide standardisation of reportable death notifications to the coroner
- expanding of coronial investigation training to regional areas
- implementing the Coronial Hub permanently staffed by a dedicated coronial officer at the Gold Coast University Hospital mortuary
- introducing a proactive approach to instigating case management meetings for matters identified as prolonged or complex investigations
- in consultation with OSC, implementing targeted follow up procedures to significantly reduce outstanding coronial investigations
- commencing initial consultation and drafting of policy to facilitate closer cooperation and support from stakeholders at international and domestic airports in relation to deaths on inbound flights
- coordinating investigation and/or preparation of coronial reports for significant incidents such as the deaths of Queensland residents on MH17 (including the involvement of DVIS in the identification and repatriation phase of this incident), suspected deaths of Queensland residents on MH370, the immigration detention death in custody of a Manus Island detainee and high profile overseas deaths
- stakeholder engagement to introduce fatal traffic incident interim reporting to the coroner; and
- contributing to improvements in the whole of government approach to responding to fatalities involving Queensland Rail Rolling Stock on the City Network.

Department of Health, Queensland Health Forensic and Scientific Services (QHFSS)

QHFSS provides coronial mortuary, forensic pathology, forensic toxicology, clinical forensic medicine and coronial counselling services to Queensland coroners.

Coronial autopsies are performed in coronial mortuaries located at Coopers Plains, Gold Coast University Hospital, Nambour General Hospital, Rockhampton Base Hospital, Townsville Hospital and Cairns Base Hospital.

Forensic toxicology and associated scientific services, specialist neuropathology and odontology, coronial nurse and coronial counselling support for all coronial cases are delivered out of the QHFSS complex in Brisbane.

Coronial Family Services based at QHFSS in Brisbane provides information and crisis counselling services to relatives of the deceased. This service is staffed by a small number of experienced counsellors who play a vital role in explaining the coronial process to bereaved families, working through families' objections to autopsy and organ/tissue retention and informing families of autopsy findings.

Independent clinical advice and when required, additional toxicology interpretation, for all coronial cases is provided by Forensic Medicine Officers (formerly known as Government Medical Officers) from the Clinical Forensic Medicine Unit within QHFSS. This unit comprises a small number of clinicians based in Brisbane, Southport and Cairns who provide coroners with preliminary clinical advice about any clinical issues requiring further investigation or independent clinical expert opinion. The invaluable assistance provided by CFMU is integral to the investigation of health care related deaths in Queensland.

The dedication, commitment and professionalism of these agencies are greatly appreciated by the coroners and the OSC, as well as the families of the deceased.

Relationships with other agencies

A coronial investigation is often but one of a range of investigative or system responses to a reportable death. The circumstances of a death may also invoke scrutiny by Commonwealth and State entities including the Australian Transport Safety Bureau, Civil Aviation Safety Authority, Australian Defence Force, police, Ombudsman, aged care and health regulatory agencies or workplace health and safety or specific industry regulators. While the focus of each entity's investigation will differ, there is often some overlap between the coroner's role and that of other investigative agencies. The State Coroner has entered into arrangements with a range of government entities to clarify their respective roles and responsibilities when investigating a reportable death. More information about these arrangements is available from the State Coroner's Guidelines, Chapter 11, *Memoranda of Understanding.*

Queensland Advisory Group on Suicide (QAGS)

As the primary custodian of suicide mortality data and information in Queensland, the State Coroner and the OSC maintained representation on the Queensland Advisory Group on Suicide and contributed to a range of other relevant projects and initiatives during the reporting period. The Queensland Advisory Group on Suicide brings together the key data custodians of suicide mortality and attempt data in Queensland, and aims to improve the strategic monitoring and coordination of this type of data in Queensland.

As part of a longstanding commitment to suicide prevention, the State Coroner continues to support the provision of data and information to maintain the internationally recognised Queensland Suicide Register (QSR) by the Australian Institute of Suicide Research and Prevention, as well as maintaining representation on relevant project reference groups including the Australian Research Council Linkage Project *Influences on Farmer Suicide in Queensland and New South Wales*. Research projects such as these are invaluable in developing the evidence base in relation to suicide risk and mortality with a view to preventing future deaths in similar circumstances.

The State Coroner and Deputy State Coroner also informed the development of the recently released *Queensland Suicide Prevention Action Plan*[1] which aims to reduce suicide and its impact on Queenslanders, and they look forward to exploring opportunities for enhancing coronial investigations into these types of deaths with relevant partner agencies.

Serious Workplace Incidents Interagency Group (SWIIG)

In Queensland, a number of agencies are responsible for investigating serious or fatal workplace incidents and for providing support to people affected by these incidents. On 2 June 2015, the Deputy State Coroner and OSC representatives attended in a public forum convened by the Queensland Government to discuss feedback from

[1] http://www.qmhc.qld.gov.au/work/promotion-awareness/suicide-prevention-action-plan/

affected families about the impact of the inconsistent and sometimes poor response by government agencies. The Office of Industrial Relations subsequently announced the establishment of a Serious Workplace Incidents Interagency Group as a mechanism by which to clarify the roles and responsibilities of all agencies involved in responding to serious workplace incidents; to identify opportunities to improve and enhance coordinated and effective agency responses; to improve the availability of information and support to affected families and to consult with representatives of affected families to identify emerging issues and in monitoring whole of government responses to these incidents. The group comprises representatives from the Office of Industrial Relations, QPS, OSC, Department of Transport & Main Roads and the Department of Natural Resources & Mines. It commenced operation in 2015–16.

Coronial innovation – work in progress and future directions

The first decade of the operation of the Coroners Act saw Queensland establish a modern, coordinated and accountable coronial system now regarded as one of the more progressive coronial jurisdictions in Australasia. This system features a range of innovations implemented over this time to manage the steady growth in demand for coronial services. In 2014–15, the OSC, QPS and QHFSS continued to work proactively and collaboratively to identify opportunities to refine and develop the system to manage future demand.

Triage processes – the ongoing role of the Coronial Registrar

The registrar holds appointment under the Coroners Act and operates under a delegation from the State Coroner to investigate apparent natural causes deaths reported to police under section 8(1)(e) of the Act; to authorise the issue of cause of death certificates for reportable deaths under s. 12(2)(b) of the Act and to determine whether a death referred to the coroner under s. 26(5) of the Act is reportable. In practice, this involves directing the investigation of apparent natural causes deaths reported to police because a death certificate has not been issued; reviewing deaths reported directly by medical practitioners (using the 'Form 1A' process) or funeral directors; and providing telephone advice to clinicians during business hours about whether or not a death is reportable. These deaths represent the high volume, less complex range of matters routinely reported to coroners.

The registrar proactively triages these matters using a multidisciplinary approach that engages clinical (forensic pathologists, clinical nurses, forensic medicine officers) and non-clinical (coronial counsellors) resources provided by QHFSS to divert matters from the unnecessary application of full coronial resources.

The registrar dealt with 1602 of the total 4962 deaths reported in Queensland in 2014–15 (32.3 per cent) and finalised 1466 matters within the reporting period. This represents 53.6 per cent of the total 2991 deaths reported within the registrar's current reporting catchment.

The table below shows the steadily increasing demand on the registrar since the role was established in January 2012 and how it has come to manage over 50% of the deaths reported in the greater Brisbane-Sunshine Coast-South West Queensland region (representing nearly one-third of the deaths reported state wide):

	Total deaths reported state wide	Total deaths reported into Brisbane	Total deaths managed by Registrar	Total deaths finalised by Registrar
2012-13	4762	2708	1352	1265
2013-14	4682	2795	1463	1537
2014-15	4962	2991	1602	1466

Apparent natural causes deaths

During 2014–15, 706 police reports of apparent natural causes deaths were received within the registrar's reporting catchment (up from 693 reports in 2013–14). This category of reported death accounted for almost one-third of the registrar's workload. Proactive triaging of these deaths, with input from forensic pathologists, coronial nurses, forensic medicine officers and coronial counsellors, resulted in 339 (48 per cent) of these deaths being appropriately diverted from the coronial system with the issue of a cause of death certificate.

The table below shows the positive impact of the triage process for apparent natural causes deaths in the greater Brisbane-Sunshine Coast-South West Queensland region since 2012–13:

	Total apparent natural causes death police reports into Brisbane	Certificates issued
2012–13	744	256 (34.4%)
2013–14	693	287 (41.4%)
2014–15	706	339 (48%)

Obtaining cause of death certificates for apparent natural cause cases reduces costs to the Queensland coronial system in a number of ways, including:

- cost per autopsy not performed (mortuary, forensic pathology, toxicology and associated scientific costs)
- cost per transportation not required of bodies located in regions where further transportation from a local mortuary to a coronial mortuary would be necessary if an autopsy was required
- administrative costs when further coronial investigation is not required, including registry and coroner costs.

In practice, these cost savings have helped offset increasing demand on the system.

Deaths reported by Form 1A or funeral directors

The registrar also receives and reviews deaths reported directly by a medical practitioner via Form 1A within the registrar' reporting catchment. This process is used in circumstances where the doctor is either seeking advice about whether a death is reportable or seeking authority to issue a death certificate for a reportable death because the cause of death is known and no coronial investigation appears necessary. It is used to report potentially health care related deaths, mechanical fall related deaths and apparent natural causes deaths in care.

Not surprisingly given the location of the State's major tertiary hospitals, the bulk of the deaths reported by Form 1A occur within the registrar's reporting catchment:

Coronial reporting catchment	Deaths reported via Form 1A
Brisbane	767
Northern Coroner	78
Central Coroner	71
Southeastern Coroner	185
	1,101

Form 1A reviews represent another triage process which involves collating and reviewing all relevant medical records with the assistance of a forensic medicine officer and liaising with family members with the assistance of a coronial counsellor, where required. If satisfied there is no need for further coronial involvement, the death certificate will be authorised and the coronial process ends. In most cases, the Form 1A investigation can be completed within 24-48 hours of the death being reported and without the deceased person's body having to be moved from the hospital mortuary. During 2014–15, the Form 1A process diverted all but 20 deaths reported via Form 1A in the registrar's reporting catchment from full coronial investigation.

The table below shows the significant increase in the health sector's use of the form 1A process for potentially reportable deaths since 2007–08 – effectively trebling the state-wide usage of this process over the past seven years.

Financial year	Form 1As State-wide	Form 1As Brisbane
2007–08	314	223
2008–09	423	295
2009–10	732	482
2010–11	880	514
2011–12	1,043	571
2012–13	1,044	699
2013–14	1,003	721
2014–15	1,101	767

The registrar continues to work proactively with the Queensland health sector in a variety of clinical forums including hospital grand rounds to help educate clinicians about their death certification and coronial reporting obligations.

In 2014–15, the registrar contributed significantly to the development by QPS CSU of a resource for police officers attending a death at a hospital. This resource has been provided to all hospitals for use by hospital staff when dealing with police officers who attend coronial cases. It is designed to help streamline the police attendance and minimise the distress and disruption that can arise as the result of the presence of police in the hospital setting.

A future priority for the registrar role will be to explore options for more innovative use of information technology to support the transmission of and access to hospital

records required to inform coronial investigations. This work has been prioritised by the State Coroner's Interdepartmental Working Group for commencement in 2016.

The registrar role continues to be an important element in improving the efficiency of Queensland's coronial system, both by diverting cases from unnecessary autopsy and full investigation and contributing to the timely completion of full coronial investigations by the system as a whole.

However, the registrar is at capacity and a second registrar is needed if the efficiencies that this role brings are to be realised across the Southeastern, Central and Northern regions. While the existing registrar role was established within existing resources, additional funding will be required to support an additional registrar.

Forensic pathology services

During 2014–15, the State Coroner and the OSC contributed to work being progressed by QHFSS to examine the future sustainability of its forensic pathology service.

Coronial autopsies are performed by QHFSS-employed forensic pathologists in Brisbane, Gold Coast, Nambour and Cairns only, with coronial autopsies undertaken in Toowoomba, Rockhampton and Townsville (and some at the Gold Coast and occasionally Cairns) performed by fee-for-service forensic pathologists approved under the Coroners Act. A fee structure for the performance of fee-for-service autopsies is prescribed by regulation under the Coroners Act. The prescribed fee structure underwent comprehensive review during 2014–15 to move away from a flat-fee to an hourly-rate model. For historical reasons (largely reflecting the antiquated forensic services delivery model in place prior to the commencement of the Coroners Act in December 2003 which involved the performance of coronial autopsies by regional Government Medical Officers and a much smaller team of qualified forensic pathologists), the OSC continues to manage the budget for fee-for-service autopsies. In 2014–15, the OSC expended $416,846 on fee-for-service autopsies (representing 5.6% of its overall budget). The revised fee structure took effect with the commencement of the *Coroners Regulation 2015* on 1 September 2015.

Autopsies are a vitally important aspect of coronial investigations. However, they are invasive, distressing to bereaved families and costly and should only be undertaken if and to the extent necessary to enable the coroner to make findings about the death.

Data from 2010–11 to 2014–15 about autopsies is provided in Tables 1, 2 and 3.

Table 1: Percentage of orders for autopsy issued to number of reportable deaths

	2010–11	2011–12	2012–13	2013–14	2014–15
No. of deaths reported	4,416	4,461	4,762	4,682	4,962
No. of autopsies	2,880	2,742	2,733	2,475	2,542
Percentage	65.22%	61.47%	57.39%	52.86%	51.23%

Table 2: Percentage of orders for autopsy issued by type of autopsy to be performed

Type of autopsy ordered	2010–11	2011–12	2012–13	2013–14	2014–15
External autopsy	16.42%	20%	23.01%	28.97%	26.71%
Partial internal autopsy	19.83%	23%	29.09%	24.16%	23.49%
Full internal autopsy	63.75%	57%	47.90%	46.87%	49.8%

Table 3: Number of orders for autopsy issued by type of autopsy to be performed

Type of autopsy ordered	2010–11	2011–12	2012–13	2013–14	2014–15
External autopsy	473	544	629	717	679
Partial internal autopsy	571	639	795	598	597
Full internal autopsy	1,836	1,559	1,309	1,160	1,266
Total	2,880	2,742	2,733	2,475	2,542

During 2014–15, there was again a reduction in the percentage of autopsies performed relative to the number of reported deaths overall. This is attributable to proactive triaging of apparent natural causes deaths and increasing use of the Form 1A process, as discussed earlier in this report.

This is in keeping with the tenor of the State Coroner's Guidelines, *Chapter 5 Preliminary investigations, autopsies and retained tissue* which encourages coroners to order the least invasive post-mortem examination necessary to inform the coroner's investigation,

While these figures show that current triaging processes are diverting a significant number of cases away from unnecessary autopsy, the steady increase in reporting is still placing a substantial burden on Queensland forensic pathology services. This is compounded by the perennial challenges faced by QHFSS in recruiting to such a small niche speciality. The dearth of specialist neuropathology expertise in Queensland has also been a difficult issue, protracting complex autopsy reports in cases where brain examination is required.

The State Coroner has identified that this situation is fast becoming a critical vulnerability for the Queensland coronial system. The State Coroner has acknowledged the work being undertaken by QHFSS to explore and conceptualise future service delivery models has the potential to place Queensland at the forefront of innovative coronial autopsy practice. This work is expected to gain significant momentum in 2016.

Integrated coronial information system

Presently, coronial information generated or obtained by each key coronial agency (QPS, OSC and QHFSS) is kept in each agency's internal information system:

- deaths reported to and investigated by police generate information including the initial police report, supplementary police reports, witness statements etc

in the QPS information system, Queensland Police Records Information Management Exchange (QPRIME)
- deaths reported to coroners (whether by police, hospitals, other agencies e.g. Health Ombudsman) are registered in and generate/upload information including autopsy orders, release orders, directions to police, formal requirements for information, reports, findings, inquest-related documents such as inquest notices, summons to appear and general correspondence from the OSC Coroners Case Management System (CCMS)
- autopsy notices/certificates/reports and toxicology reports are generated in the Queensland Health clinical database, AUSLAB.

Currently none of these systems 'talk' to each other, so information generated by each system is transmitted by email from the initiating agency to the other agencies as documents are generated at each stage of the coronial investigation. This creates a high volume of business transactions over the course of a coronial investigation, particularly in the preliminary investigation phase (from the initial report of the death to the release of the body for burial).

During 2014–15, the State Coroner identified the concept of a shared information system for coronial death investigations as the logical progression of interagency work into the future. An existing QPS software application has been identified as having potential to meet the coronial system's information storage and sharing needs and enhance business efficiencies across the system. The State Coroner's Interdepartmental Working Group has identified this as a priority project to commence in 2016.

Achieving system efficiencies – rethinking and refocussing the application of coronial resources through policy and legislative change

There has been a significant growth in demand for coronial services since the enactment of the Coroners Act in 2003. From 2004–05 (the first full financial year of reporting under the new legislation) to 2014–15 reported deaths have increased by 63 per cent (4,962 up from 3,043 deaths).

While current proactive initiatives such as the active triaging of reported deaths and ongoing efforts to educate clinicians about their death certification and coronial reporting obligations are showing results, it is timely to reassess some of the policy underlying the Coroners Act and perhaps rethink the extent of the coroner's involvement in some types of reportable death in order to manage future demand for coronial services.

In 2014, the OSC developed a discussion paper for the Department of Justice and Attorney-General outlining a range of possible policy and legislative changes to assist in achieving system efficiencies including whether:
- coroners should continue to have a role in investigating all mechanical fall-related deaths resulting from age or infirmity
- coroners should be required to make findings (other than relating to the medical cause of death) in all apparent natural case deaths that proceed to coronial autopsy
- a mandatory inquest is necessary for all natural causes prisoner deaths in custody where there are no issues of concern

- to limit the current prohibition on holding an inquest once a person has been charged with an offence in respect of the death to indictable offences only.

As at 30 June 2015, these proposals were still under consideration.

Domestic and Family Violence Death Review

The Domestic and Family Violence Death Review Unit (DFVDRU) underwent significant change during this reporting period, resulting in an expansion of its scope and function with respect to the review of domestic and family violence related deaths, as well as those child deaths where there had been prior contact with the child protection system.

In July 2014, the unit acquired a dedicated resource responsible for providing specialist advice and assistance to coroners in relation to child protection systems, policies and practices for relevant child deaths. This role was developed as part of the whole of government response to recommendations made by the *Queensland Child Protection Commission of Inquiry* (2013) that resulted in new child death review processes being implemented from 1 July 2014.

During this time period the unit provided assistance to the Inquest into the death of Noelene Beutel who was killed by her former partner Wayne McClutchie, in which Coroner Hutton examined the systemic circumstances of Ms Beutel's death. In making his findings Coroner Hutton made the following recommendations in relation to the Queensland Police Service, general practitioners and the broader service system response to victims of domestic and family violence, with a view to preventing future deaths in similar circumstances:

- that the medical profession, along with government, consider issues facing general practitioners who are treating both the perpetrator and victim of domestic violence, with a view to establishing simple guidelines for General Practitioners
- General Practitioners be allowed to report their concerns about domestic violence to the police, even in circumstances where there is no immediate and severe threat to the patient's life, so that police involved in supporting the victim, or involved in the interagency support model, can be more fully informed
- that the appropriate government agencies develop an inter-agency model to support victims of domestic violence similar to the Suspected Child Abuse and Neglect teams in Queensland
- that the relevant government departments should establish an interdepartmental process, with engagement from appropriate community organisations, to establish a pilot 'domestic violence centre' in an appropriate part of Queensland, where victims can access support from multiple relevant agencies
- that a common risk assessment tool be implemented in Queensland, with the effect that when agencies cooperate with one another in relation to a vulnerable person, they are 'speaking the same language' and communication difficulties are reduced

- for police to establish additional Domestic and Family Violence Coordinator positions in areas of Queensland where domestic violence is prevalent and to re-implement a state-wide coordinator for these positions
- to ensure police address potential vulnerabilities with the identification of domestic violence incidents to ensure they are not misclassified as non-domestic assaults.

The DFVDRU also provided input and advice to the Special Taskforce on Domestic and Family Violence, which was established in late 2014 to examine Queensland's domestic and family violence support systems. Chaired by Dame Quentin Bryce, the Taskforce was also required to make recommendations to the Premier of Queensland to improve support systems and prevent future incidents of domestic and family violence.

In February 2015 the Taskforce released their Final Report *'Not Now, Not Ever: Ending Domestic and Family Violence in Queensland*[2] which made a range of recommendations to the Premier that aim to reduce the incidence and prevalence of domestic and family violence in Queensland. In their Final Report, the Taskforce recognised the important work of the coronial jurisdiction, and the DFVDRU, in providing assistance to Coroners in their investigations of these types of deaths. They also incorporated Coroner Hutton's findings and recommendations into their Final Report which has led to Government committing to adopting and implementing all of his relevant recommendations.

The Final Report also made a number of additional recommendations to improve the domestic and family violence death review process in Queensland, specifically:

- a more appropriate resourcing model for the DFVDRU, to ensure it can best perform its functions
- the development of information sharing protocols to ensure government departments with relevant policy development responsibilities have access to the research and resources available from the unit
- the establishment of an independent multidisciplinary Domestic and Family Violence Death Review and Advisory Board to identify systemic failures, gaps or issues and make recommendations to improve systems, practices and procedures.

The Office of the State Coroner contributed to the development of the Queensland Government response to this report, with all 140 recommendations being supported. As of 30 June 2015, implementation rapidly became a priority for OSC upon receipt of additional funding to enhance the DFVDRU and to support the establishment of the new Domestic and Family Violence Death Review and Advisory Board, chaired by the State Coroner.

The DFVDRU also collates data and information in relation to homicides that have occurred within a domestic or family relationship.

The unit adopts the Australian Domestic and Family Violence Death Review Network (the National Network) definition of a domestic and family violence related homicide.

[2] http://www.qld.gov.au/community/getting-support-health-social-issue/dfv-read-report-recommendation/index.html

The definition of 'homicide' adopted by the Network is broader than the legal definition of the term. 'Homicide', as used by the Network, includes all circumstances in which an individual's intentional act, or failure to act, resulted in the death of another person, regardless of whether the circumstances were such as to contravene provisions of the criminal law.

During this financial year, as part of a national commitment to improve the available data in relation to these types of deaths, the unit assisted in the development of data protocols to establish a national minimum dataset of domestic and family violence related homicides.

This work, in collaboration with other jurisdictional domestic and family violence death review mechanisms, will add significant value to our collective understanding of these deaths, including the precipitating events leading up to the death.

Based on the current dataset, from 1 January 2006 to 30 June 2015, 223 women, men and children have been killed by a family member, or by a person in which they were, or had been, in an intimate partner relationship with, in Queensland.

In the 2014-15 financial year, 12 homicides occurred within an intimate partner relationship and 16 within a family relationship. There were also two deaths of bystanders who were killed either intervening in a domestic and family violence incident or by their current partner's former partner. This equates to a total of 30 homicides during this reporting period.[3]

Women continue to be overrepresented as victims in domestic and family violence related homicides, whilst over 80% of all offenders in these cases were male. In the majority of these deaths a previous history of violence and abuse was identifiable, as were opportunities for intervention by services and agencies prior to the death.

The DFVDRU notes that in a significant proportion of the deaths that occurred within an intimate partner relationship, in which a female deceased was killed by a male partner, the deaths occurred after the couple had separated, or when they were in the midst of a separation, and in situations where there were prior threats to kill, stalking, harassment and other non-physical controlling behaviour.

Conversely it is also the case that these behaviours, and the underlying pattern of coercive control by the perpetrator, are often not recognised as acts of domestic and family violence, despite meeting the legislative definition as outlined in the *Domestic and Family Violence Protection Act 2012* (the Act).

In these circumstances, a lack of recognition of the increased risk of harm associated with this type of behaviour means that victims who express concerns or seek support are not being provided with appropriate assistance, and perpetrators who exhibit these behaviours, are not being held accountable for their controlling tactics, by the services and agencies required to respond.

[3] This is preliminary data only and may be subject to change pending the outcomes of any further coronial investigation as the data relates to open coronial matters.

The DFVDRU has also conducted an analysis of a number of suicides that include a history of domestic violence, with the most common interrelated factors identified as: mental health issues such as depression, anxiety and post-traumatic stress disorder (PTSD), drug and/or alcohol abuse, financial crises and/or situational crises.

A substantial number of these suicides involve males with a prior history of using violence against their female partners and many of these deaths have occurred within the midst of relationship conflict and separation. Whilst further research is required, it indicates that perpetrators of domestic and family violence may be at heightened risk of harm to both themselves and others during periods of relationship breakdown and separation.

Enhancing suicide mortality review capability

Death by apparent or suspected suicide is one of the largest categories of non-natural death reported to coroners each year.

Reporting period	Total deaths reported	Total suspected suicides
2011–12	4461	581 (13%)
2012–13	4762	571 (12%)
2013–14	4682	661 (14%)
2014–15	4962	716 (14.4%)

A significant proportion of these deaths, whether in the community or in the health or prison system, warrant investigation of the person's psycho-social circumstances and their access to or assessment and treatment by the mental health system. Queensland coroners have struggled for many years to access timely, cost effective and appropriate expertise to assist their investigations of these deaths.

In 2012–13, the Department of Health Mental Health, Alcohol and Other Drugs Branch (MHAODB) began providing assistance to coroners by triaging deaths where the adequacy of mental health treatment may be an issue. The purpose of this review was to help coroners to identify early on in the investigative process whether the treatment was adequate or whether further investigation or specialist review is necessary. Unfortunately this triage service was discontinued in 2014 following the Queensland Health restructure after which MHAODB was no longer about meet the demand for coronial case review.

During 2014–15, the State Coroner identified the pressing need for the Queensland coronial system to be equipped with access to a source of independent suicide mortality review expertise to better position the coronial system to inform and influence suicide prevention and mental health reform.

It is hoped this can be realised through ongoing work led by the Queensland Mental Health Commission under the *Queensland Suicide Prevention Action Plan* so that coroners can have access to specialist advice analogous to that currently available to them through existing specialist domestic and family violence and child protection death review processes.

Coronial performance – measuring outcomes

The performance measures for the coronial jurisdiction align with the national benchmarking standards outlined in the Report on Government Services.

Coronial performance is measured by reference to a clearance rate (finalisations/lodgements) and a backlog indicator (the percentage of matters more than 24 months old). The national standard for coroners' courts is that no lodgements pending completion are to be more than 24 months old.

Clearance rate

In 2014–15, 4,962 deaths were reported state wide. Compared to the total numbers of deaths reported in 2013–14, this represents an overall increase of 5.98 per cent of 'lodgements' (up from 4,682).

In 2014–15, coroners finalised 4,638 matters achieving a clearance rate of 93.47 per cent.

Many matters reported to coroners are, following review of medical records and circumstances of death, found to be not reportable or reportable but not requiring autopsy and further investigation. During 2014–15, of the 4,638 deaths finalised, 1,616 were found not to be reportable within the meaning of s. 8(3) of the Coroners Act.

These matters are included in the lodgement figures on the basis that the coroner performs work in considering whether a death certificate can be authorised. This may involve obtaining medical records using the powers under the Coroners Act, discussing the matter with treating clinicians and obtaining advice from doctors at the Clinical Forensic Medical Unit, discussing treatment with family members and liaising with funeral directors. Significant time is often involved in processing these matters.

Pending cases and backlog indicator

Coroners are aware that delays in finalising coronial matters can cause distress for family members and strive to conclude matters expeditiously. However, coroners are dependent upon other agencies completing their parts of the investigative process, and must balance the benefits of timeliness against the importance of conducting comprehensive and robust case investigations.

There has been a 17 per cent increase in the overall number of pending cases during the reporting period (2162 up from 1844 as at 30 June 2014). This increase arises mainly from increases in cases pending older than 12 months (13.78 per cent) and cases older than 24 months (11.89 per cent).

Factors impacting on the capacity of the coronial system to finalise investigations expeditiously during the reporting period have included:

- coroner and registrar leave – historically the coroners have absorbed the impact of their and the registrar's absences on leave without routinely seeking relief from the Magistrates relieving pool. The appointment of the registrar as an Acting Magistrate in April 2015 and the use of deputy registrars to perform

the registrar role in the registrar's absence from that role are expected to help manage this issue into the future
- reduced forensic pathology services – the provision of forensic pathology services was impacted significantly by the loss of several long-serving forensic pathologists during the reporting period. The challenges of recruiting to this niche specialty mean vacancies cannot be filled quickly. The flow on effect of this has been significant increasing pressure on the remaining forensic pathology workforce and delays in finalising autopsy reports which are required before the coronial investigation can be finalised
- increased inquest commitments – time spent in court coupled with the time required to prepare complex inquest findings reduces the coroner's capacity to finalise non-inquest investigations.

As at 30 June 2015, 257 or 11.89 per cent of pending matters were more than 24 months old. This figure exceeds the national benchmarking target of 0 per cent largely due to the increasing number of lodgements and the more rigorous investigation required under the Coroners Act. The finalisation of a coronial investigation also depends on the completion of autopsy, toxicology and police reports. Coroners also await the outcome of other expert investigations and criminal proceedings.

As at the end of the reporting period, of the 257 matters that were older than 24 months, 43 per cent (110 matters) were waiting for police or other expert investigations or the outcome of criminal proceedings. Excluding these cases, 147 matters i.e. 6.8 per cent of pending matters are older than 24 months.

Appendix 1 details the lodgements and finalisations during the reporting period.

Inquests

An inquest is the 'public face' of the coronial process, a public proceeding that scrutinises the events leading up to the death and provides the mechanism by which coroners can make comments and recommendations which can be powerful catalysts for broad systemic reform.

Despite the common misconception that all deaths reported to coroners will go to inquest, inquests are held only into a very small percentage of the total deaths reported each year.

Inquests into the deaths of 84 persons were opened and/or closed during 2014–15. Table 1 shows the breakdown of mandatory and discretionary inquests conducted during this period.

Inquest type	Number of inquests	Closed during 2014–15	Open as at 30 June 2015
Mandatory death in custody	13	13	0
Mandatory death in police operation	2	2	0
Mandatory death in care	1	1	0

Directed by Attorney General	0	0	0
Ordered by District Court	1	1	0
Directed by State Coroner	4 (joint inquest)	4	0
Discretionary – public interest	63	57	6

This represents a significant increase in the number of deaths finalised by inquest since 30 June 2014.

In-house counsel assisting at inquests
Each of the full time coroners is assisted by a legal officer. These legal officers are increasingly performing the role of counsel assisting and during 2014–15 assisted in inquests into the deaths of 60 persons. Having in house counsel assisting is beneficial as coroners are supported by lawyers with specialised skills and experience in the jurisdiction and inquest costs are kept to a minimum.

Deaths in custody
This section contains a summary of coronial investigations into all deaths in custody, as required by s. 77(2)(b) of the Act.

The complete inquest findings are posted on the Queensland Courts website at: http://www.courts.qld.gov.au/courts/coroners-court/findings

During the reporting period, the State Coroner conducted one inquest into a death that occurred in the context of avoiding custody.

Jamie Robert Joseph Punch

Jamie Robert Joseph Punch was a 35 year old man who died unexpectedly on 26 January 2011. His death occurred after he had initially pulled his motorbike over for the purposes of a random breath test (RBT), only then to accelerate quickly and drive away, where he subsequently crashed.

Late on the morning of Australia Day in 2011, Mr Punch approached an RBT site on Logan River Road at Edens Landing. He was unlicensed, a warrant for his arrest was in force, and he was in possession of vials of illegal steroids. It is likely he would have also tested positive for driving under the influence of a drug if the relevant test was conducted. After slowing down and appearing to comply with a police officer's direction to pull over, Mr Punch quickly accelerated away on his Honda CBR900 motorcycle. A short distance later he travelled through a red light, struck another vehicle and sustained injuries that killed him instantly. There was no attempt by the RBT police to follow, intercept or pursue Mr Punch on the motorcycle. All police officers remained at the RBT site and continued duties until becoming aware of the collision via police radio some 5-10 minutes later.

The State Coroner accepted in his findings that the actions and decisions made by the RBT police officers in the immediate lead up to Mr Punch's death were appropriate. Mr Punch's death could not have reasonably been prevented by the RBT officers. There was no attempt to pursue Mr Punch, an option which, having regard to the police pursuit policy, was open to the officers in the circumstances. It was found that Mr Punch died as a direct result of his own dangerous driving; constituted by his excess speed and failure to stop at a red light while under the influence of illicit drugs. His decision to speed away from the RBT site resulted from knowing that, by stopping, he risked being detained either due to his being affected by illicit drugs and/or due to the warrant which had been issued for his arrest.

The State Coroner made no recommendations.

The State Coroner conducted one inquest during the reporting period into a death that occurred in the course of a person being detained by police.

Mathew Richardson

Mathew Richardson was a 45 year old man who died unexpectedly on 26 October 2013. His death occurred after officers from the Special Emergency Response Team (SERT) of the QPS attempted to arrest him.

Mr Richardson lived in a makeshift campsite on an isolated property near Almaden in central far north Queensland, over 2.5 hours' drive from Cairns. He avoided contact with other people, which assisted in the management of his untreated psychiatric condition. In May 2013, he failed to attend court and a warrant was issued for his arrest. In October 2013, because of threats made by Mr Richardson to the owner of the land on which he lived, and his apparent access to a shotgun, it was decided that the QPS SERT should conduct an arrest. When SERT officers unexpectedly appeared at his campsite and he became aware of his impending arrest, Mr Richardson attempted to hang himself using rope and a chain suspended over a nearby cliff. The apparatus, which had been pre-prepared for this purpose, failed and Mr Richardson fell to rocks below where he sustained fatal injuries.

The State Coroner accepted in his findings that the actions and decisions made by the attending police officers in the immediate lead up to Mr Richardson's death were appropriate and timely. Mr Richardson's death could not have reasonably been prevented by the attending officers. It was found that the actions of Mr Richardson were pre-meditated and it was unlikely that he could have been saved no matter what approach had been taken to the arrest. The State Coroner concluded that there was a reasonable basis for SERT to be used in this case to give effect to the arrest.

The State Coroner made no recommendations.

During the reporting period, the State Coroner conducted one inquest into the death of a person in a siege situation:

Michael Shawn Sweeney

Michael Shawn Sweeney was a 42 year old man who died on 8 February 2013 from a self-inflicted gunshot wound to the head. At the time of his death, Mr Sweeney was on parole, having been released from prison a month earlier. His relationship with his partner, Ms Sand, had also deteriorated and they were no longer living together. A Domestic Violence Order was in place.

On the morning of his death Mr Sweeney attended Ms Sand's home with the purpose of seeing his 6 month old son. Ms Sands called her sister, Ms Vandenburg and she quickly attended at the home with her partner, Mr Chester. While at the residence, Ms Vandenburg called the police, staying on the line to them as events unfolded.

While Mr Sweeney was holding his son, he went over to his carry bag and retrieved a sawn-off rifle. He then gave his son back to Ms Sands, who retreated to one of the bedrooms in home. She stayed there, along with her teenage son and Ms Vandenburg. Mr Sweeney then threw the keys to Ms Sands' vehicle to Mr Chester and requested that he drive. As both men exited the residence Mr Sweeney was holding the gun to the left side of his head. Police officers were in attendance and were establishing outer and inner cordons around the property. Both men entered the vehicle. Police approached the vehicle and yelled at Mr Sweeney to "drop the gun". Police were approximately 10m from the vehicle when Mr Sweeney shot himself through the right side of his head.

The State Coroner accepted in his findings that the actions and decisions made by the attending police officers in the immediate lead up to Mr Sweeney's death were appropriate and timely. Mr Sweeney's death could not have reasonably been prevented by the attending officers.

The State Coroner made no recommendations, however did refer his findings to the Queensland Police Commissioner and the Secretary of the Australian Bravery Decorations Council for consideration of appropriate bravery awards for the police officers involved.

During the reporting period, the State Coroner conducted three inquests into prisoner deaths in correctional facilities.

Kyle Leslie Canisi

Kyle Leslie Canisi was a 24 year old man who died at the Arthur Gorrie Correctional Centre (AGCC) Detention Unit (DU) on 27 December 2011. His death was the result of a violent and unprovoked assault inflicted on him by another DU prisoner, Scott O'Connor. Two days prior to his death, after a lengthy stand-off with correctional officers in the exercise yard of the DU, Mr O'Connor was returned to his cell. The General Manager of AGCC, Greg Howden, had personally intervened in this stand-off. Mr Howden said he gave a verbal order to the A/Area Manager, Greg Moody that Mr O'Connor was not to associate with any other prisoner until he returned from Christmas leave on 28 December 2011.

Early on the day of the death, Mr O'Connor was allowed to associate with Mr Canisi, to give Mr Canisi a haircut. Just before 8:00am Mr O'Connor began a vicious and apparently unprovoked attack that left Mr Canisi with severe brain injuries and caused

his death a short time later. Due to the threat Mr O'Connor posed to the safety of corrective services officers, 20 minutes passed before they could access the exercise yard, restrain Mr O'Connor and commence first aid.

Upon being notified of Mr Canisi's death by AGCC, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. A parallel investigation was conducted by investigators appointed by the QCS Chief Inspector. In addition to those investigation reports, the State Coroner also had also had access to reports compiled by an investigator appointed by the GEO Group Australia Pty Ltd, the private company which operates AGCC. A full internal autopsy was conducted which confirmed the cause of death as head injuries. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

The State Coroner found that none of the correctional officers or other inmates at AGCC had any direct involvement in Mr Canisi's death. Mr O'Connor was charged with Mr Canisi's murder, but died in custody in early 2013 before the charge was finalised. His death was the subject of a separate coronial inquest in 2015.

The focus of the inquest was to establish whether the direction given by Mr Howden did in fact occur, and if so why it was not followed. The State Coroner concluded that the direction was given and, owing to the stressful events of the day involving the management of the Arunta system, prisoners in the MSU, and his own health issues, Mr Moody failed to remember it. It was also clear that Mr Moody failed to document and pass on the General Manager's direction to other officers within the AGCC. The State Coroner found that Mr Canisi's death could have been prevented if Mr O'Connor was maintained in his cell in accordance with the General Manager's direction. Appropriate disciplinary action had been taken in this regard by the GEO Group.

The State Coroner adopted the majority of the findings of the Chief Inspector and found the 14 recommendations made by the Chief Inspector to be appropriate. The implementation of those recommendations was confirmed, with the effect that policies and procedures within the DU relating to communication were improved. After Mr O'Connor's death in the DU in early 2013, the DU was shut down and currently remains shut down.

Charles Kingston Hurst

Charles Kingston Hurst was a 38 year old man who died in his cell at the Maryborough Correctional Centre (MCC) in the early hours of 7 November 2012. Mr Hurst had been in custody specifically at the MCC since August 2012. In the preceding months before his death he had, at various times, been accommodated in the MCC safety unit due to self-reported suicidal ideation. He was classified as a patient at risk of suicide. Two days prior to his death, Mr Hurst's risk classification was lowered and he was returned to a regular cell. He was also a patient of the Prison Mental Health Service (PMHS), and was seen regularly by a psychiatrist from September 2012.

On the evening before his death, Mr Hurst was locked in his cell shortly prior to 6:00pm. He was checked on at 12:55am and observed to roll over on his bed. At

around 2:25am (in accordance with the observation requirement) Mr Hurst was found to be hanging and could not be revived. The drawstring on a prison laundry bag enabled Mr Hurst to fashion a noose through the otherwise inaccessible holes in an air vent.

Upon being notified of Mr Hurst's death by MCC, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. The arrival of the CSIU was after the local CIB had attended and commenced analysing the scene. An external autopsy was conducted which confirmed the cause of death as being a result of hanging. The police investigation ran parallel to an investigation by the Office of the Chief Inspector.

The State Coroner was satisfied the matter was investigated thoroughly and professionally. It was concluded that the quality of psychiatric health care provided by the PMHS was adequate and commensurate with that which Mr Hurst might expect to receive in the community. The State Coroner was satisfied that the QCS 'At Risk' procedure was applied properly and, for the most part, to a very high standard. The State Coroner was satisfied that no other prisoner or member of staff at MCC was directly involved in the death.

The State Coroner adopted the finding of the Chief Inspector relating to the laundry bag string and toggle that was used, being one that was thinner and longer than the original laundry bag design that was approved for use. This slippage in laundry bag design/production standards directly contributed to the incident. The State Coroner concluded that this was clearly a failure which ultimately contributed to the ease with which Mr Hurst was able to take his own life (and, therefore, the likelihood that he would). There was no evidence to suggest there was any malicious intent associated with the mistake in design.

The State Coroner adopted the 3 recommendations made by the Chief Inspector relating to the elimination of the type of laundry bag from prisons and further training of correctional staff relating to at-risk suicidal prisoners. The State Coroner accepted information provided to the inquest confirming the implementation of all recommendations to an adequate standard.

Farrin John Vetters

Farrin John Vetters was a 26 year old man who died in his cell at the Borallon Correctional Centre (BORCC) on 26 October 2011. Mr Vetters was a patient of the Prison Mental Health Service (PMHS) and had experienced ongoing anxiety and had a tendency towards aggressive behaviour. These traits presented some difficulties for correctional and medical staff at BORCC. In the days prior to Mr Vetters' death he had, not unusually, required intensive management and had a brief stay in the BORCC Detention Unit. He was not assessed as an at-risk prisoner, and he consistently denied suicidal ideation.

On the day of his death Mr Vetters appeared relatively content and was alone in his usual cell when it was locked at around 6:00pm. A short time after 9:00pm, during the next routine check, Mr Vetters was found to be hanging and could not be revived. Mr

Vetters was serving a four year sentence and had been in custody specifically at the BORCC since June 2011.

Upon being notified of Mr Vetters' death by BORCC, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. A parallel investigation was conducted by investigators appointed by the QCS Chief Inspector. The PMHS also conducted a clinical incident review immediately after Mr Vetters' death. An external autopsy was conducted which confirmed the cause of death as being a result of neck compression.

The State Coroner was satisfied the matter was investigated thoroughly and professionally. It was accepted that there was no causal connection between the death and Mr Vetters' contact with the PMHS, however, the PMHS provided information to the inquest about how it had improved its referral processes and workplace instructions. The inquest raised a number of issues relating to the management and administration of prisoners on Intensive Management Plans, and also Notifications of Concern. The State Coroner was satisfied that no other prisoner or member of staff at BORCC was directly involved in the death of Mr Vetters.

The State Coroner adopted the findings of the Chief Inspector. Aside from recommendation 3, the State Coroner found the 8 recommendations made by the Chief Inspector to be appropriate. The implementation of those recommendations was confirmed, with the effect that training of staff and further administrative procedures had been put in place at the prison so as to improve the overall management of Intensive Management Plans and Notifications of Concern.

The State Coroner heard evidence confirming the decommissioning of the BORCC, and was assured that if BORCC was to recommence operations the custodial operations Practice Directive entitled "Risk of Harm to Self" would be applied to all accommodation decisions for prisoners in the centre. This directive provides that prisoners with demonstrated histories of at risk behaviour would not be placed in non-hanging point resistant cells, unless extenuating circumstances exist.

The State Coroner recommended that the Queensland Government review the allocation of resources to the Prison Mental Health Service and Queensland Corrective Services to ensure that the capacity of staff in those agencies to respond to the mental health needs of prisoners is established at an appropriate level, and can then be adjusted to respond to fluctuations in the prison population.

The remaining seven deaths in custody inquests examined the adequacy of the medical and emergency treatment provided to prisoners in a custodial setting:

Mark William Proberts

Mark William Proberts was a 52 year old man who died on 6 February 2013 at the Princess Alexandra Hospital (PAH). At that time he was an inmate at the Arthur Gorrie Correctional Centre (AGCC), and had been incarcerated there since early January 2013, after his parole was revoked.

A week prior to his death, Mr Proberts had been transferred to hospital from the AGCC. Multiple chronic medical conditions had left Mr Proberts' organs in a weakened state. Although his medical condition was managed by staff at AGCC, the acute onset of more serious symptoms led to his transfer to PAH on 29 January 2013. There, the source of a severe infection was identified. However, the seriousness of Mr Proberts' co-morbidities limited treatment options when he began suffering cardiac failure.

Mr Proberts refused to have an electrocardiogram and then refused to take his prescribed medication. He was transferred to the coronary care unit on 2 February 2013 where his health remained precarious. An ultrasound of the liver was suggestive of cirrhosis. In the context of the severe endocarditis and likely cirrhosis it was agreed that Mr Proberts was not suitable for "active invasive" treatment. Despite treatment over the following 24 hours Mr Proberts' condition deteriorated. Further assessment indicated that he was unlikely to survive surgery and he died at 9:15pm on 6 February 2013.

Upon being notified of Mr Proberts' death by the PAH, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. An external autopsy was conducted which confirmed the cause of death as acute coronary syndrome, due to or as a consequence of coronary artery embolus, due to or as a consequence of infective endocarditis. Coronary atherosclerosis and chronic liver disease were listed as other significant conditions.

The adequacy of the medical care provided to Mr Proberts was independently reviewed by Dr Anne-Louise Swain of the Clinical Forensic Medicine Unit. Dr Swain provided opinion that the medical care provided at both the PAH and WCC was appropriate in the circumstances. Dr Swain noted that Mr Proberts had refused medical and nursing assistance on a number of occasions. She agreed that Mr Proberts was competent to make end of life decisions.

The State Coroner accepted Dr Swain's opinion, and ultimately was satisfied the matter was investigated thoroughly and professionally. The State Coroner found that none of the correctional officers or other inmates at WCC had any contribution to the death. Nothing could reasonably have been done to prevent the death.

The State Coroner made no recommendations.

Dharam Raj Chettiar

Dharam Raj Chettiar was an 82 year old man who died in the early hours of 4 July 2013. At that time he was an inmate at the Wolston Correctional Centre (WCC), and had been incarcerated there since December 2010.

Mr Chettiar was an elderly man imprisoned late in life at which time he had an already lengthy history of cardiac disease. While in custody at WCC he was regularly transported to the Princess Alexandra Hospital (PAH) for treatment. A discussion was had regarding the need for a further coronary angiography. Mr Chettiar declined the procedure and, in discussion with his nephew and hospital staff, put in place an acute resuscitation plan in June 2013.

In the early hours of 4 July 2013 a fellow inmate heard the sound of a chair being dragged across the floor. On investigation he found Mr Chettiar lying on the floor of his room, apparently unconscious. A medical alarm was raised and the Queensland Ambulance Service attended. Mr Chettiar was taken to the PAH. The acute resuscitation plan was discussed with Mr Chettiar and his family and his pain was managed with morphine. A chest x-ray confirmed acute pulmonary oedema. The acute resuscitation plan was followed and his condition rapidly deteriorated. He died at 7:10am.

Upon being notified of Mr Chettiar's death by the PAH, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. An external autopsy was conducted which confirmed the cause of death as ischaemic cardiomyopathy, due to or as a consequence of coronary atherosclerosis (previous bypass graft surgery). Type 2 diabetes mellitus and chronic kidney disease were listed as other significant conditions.

The adequacy of the medical care provided to Mr Chettiar was independently reviewed by Dr Gary Hall of the Clinical Forensic Medicine Unit. Dr Hall described the medical management of Mr Chettiar at WCC as being as good as he could expect (if not better) than if he was living within the greater community. Dr Hall considered the medical management of Mr Chettiar during his presentations at PAH in March and June 2013 as "excellent". Dr Hall had no doubts that the advanced resuscitation plan in place had been devised with appropriate explanation and within Mr Chettiar's full capacity to understand the ramifications.

The State Coroner accepted Dr Hall's opinion, and ultimately was satisfied the matter was investigated thoroughly and professionally. The State Coroner found that none of the correctional officers or other inmates at WCC had any contribution to the death. Nothing could reasonably have been done to prevent the death.

The State Coroner made no recommendations.

John Kelly Peter

John Kelly Peter was a 61 year old man who died on the morning of 26 December 2013. At that time he was an inmate at the Lotus Glen Correctional Centre (LGCC), and had been incarcerated since March 2013.

At the time of his incarceration, Mr Kelly was suffering numerous chronic health conditions, including congestive heart disease. That condition deteriorated rapidly throughout the course of 2013 despite regular treatment in hospital.

On Christmas day 2013, staff at LGCC contacted Mr Peter's treating doctor, Dr Purcell to advise that Mr Peter had collapsed and his condition was deteriorating. Dr Purcell gave advice to nursing staff about appropriate management for Mr Peter. Dr Purcell knew it was Mr Peter's preference to stay at LGCC rather than being transported to hospital. On this basis, Mr Peter remained in the palliative care of nursing staff and his nephew until Boxing Day when, at 10:30am, he passed away.

Upon being notified of Mr Peter's death by LGCC, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. An external autopsy was conducted which confirmed the cause of death as congestive cardiac failure, due to or as a consequence of ischaemic heart disease. Type 2 diabetes mellitus and chronic kidney disease were listed as other significant conditions.

In determining the adequacy of the medical care provided to Mr Peter, the State Coroner had regard to a statement from Mr Peter's treating doctor at Mareeba Hospital, which set out the history of Mr Peter's chronic conditions and the steps taken to treat them while he was in custody. The State Coroner was satisfied that the medical care provided to Mr Peter at LGCC and prior to his death was adequate and appropriate. In this respect the State Coroner also made note that Mr Peter's nephew, who had the opportunity to closely follow the course of Mr Peter's medical treatment, raised no concern about its adequacy.

The State Coroner ultimately was satisfied the matter was investigated thoroughly and professionally. The State Coroner found that none of the correctional officers or other inmates at LGCC had any contribution to the death. Nothing could reasonably have been done to prevent the death.

The State Coroner made no recommendations.

Reynold David Horace

Reynold David Horace was a 51 year old Indigenous man who died on the morning of 15 August 2012. At that time he was an inmate at the Wolston Correctional Centre (WCC). Mr Horace was last seen alive in his cell at 7:15am on 15 August 2012. By 7:38am he was unconscious and could not be revived by prison medical staff or ambulance officers.

Mr Horace had spent the last 26 years of his life in prison or secure psychiatric care. In the preceding two years Mr Horace had been treated on multiple occasions for chest pains and shortness of breath. However, he remained reluctant to accept medical treatment and continued to smoke cigarettes until close to his death.

Documentation from attendances at the PAH showed that Mr Horace was thought to have suffered heart attacks in July 2011 and again in May 2012. In June 2012, Mr Horace became unresponsive and had to be resuscitated by QAS officers before being transferred to PAH. He refused treatment at PAH and returned to WCC where he continued to suffer episodes of chest pain over the months leading to his death.

Upon being notified of Mr Horace's death by WCC, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. A full internal autopsy was conducted which confirmed the cause of death as coronary atherosclerosis.

The adequacy of the medical care provided to Mr Courtney was independently reviewed by Dr Sally Jacobs of the Clinical Forensic Medicine Unit. Dr Jacobs concluded that Mr Horace was seen regularly by nursing, medical and psychiatric staff in regard to his medical issues. The care and treatment he received seemed

appropriate, and at times Mr Horace was not willing to participate in treatment regimens advised.

The State Coroner accepted Dr Jacobs' opinion, and ultimately was satisfied the matter was investigated thoroughly and professionally. The State Coroner found that none of the correctional officers or other inmates at WCC had any contribution to the death.

The State Coroner investigated concerns put forward by Mr Horace's family relating to his capacity to make decisions at the end of his life, and the standard of medical care for ATSI persons in custody. In response to the concerns information was provided to the inquest in relation to the employment of ATSI staff and health workers within correctional centres and programs related to ensuring compliance with medication regimes, diet, exercise and general health and well-being.

The State Coroner made no recommendations, but made comment encouraging the Queensland Government to continue to invest in health services that are culturally appropriate and accessible to those in custody.

Victor Bertram Vince Courtney

Victor Bertram Vince Courtney was a 44 year old Indigenous man who died at the palliative care unit of the Princess Alexandra Hospital (PAH) on 2 November 2013. He had been imprisoned for 18 years when, in late 2012, he was diagnosed with lung cancer. After a year of palliative care his condition deteriorated suddenly and he died after being taken to hospital. He was incarcerated at the Wolston Correctional Centre (WCC) in the lead up to his death. A transfer to the Townsville Correctional Centre had been approved but not implemented at the time of his death.

Mr Courtney's doctors, in consultation with the Adult Guardian, considered that he understood his diagnosis of cancer and the nature and effect of refusing treatment, and was competent to make decisions regarding ongoing care. This later formed the basis for a "not for resuscitation" order being put in June 2013. By April 2013, Mr Courtney had increasingly refused to take his anti-psychotic medication. He was admitted to The Park. He reportedly responded well to treatment; in particular the more regular taking of his prescribed medication. It was late in this period of treatment that Mr Courtney signed his Acute Resuscitation Plan. After discharge from The Park, Mr Courtney continued to receive palliative care at WCC.

Upon being notified of Mr Courtney's death by WCC, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. An external autopsy was conducted which confirmed the cause of death as end stage non-small cell lung carcinoma, with chronic obstructive pulmonary disease and atrial fibrillation listed as other significant conditions.

The adequacy of the medical care provided to Mr Courtney was independently reviewed by Dr Nelle van Buuren of the Clinical Forensic Medicine Unit. Dr van Buuren considered Mr Courtney's many chronic health problems and found that he was provided with medications, investigations and appropriate specialist consultations

commensurate with a non-custodial environment. Dr van Buuren noted that at times appropriate medical care was not possible due to Mr Courtney's refusal to engage.

The State Coroner accepted Dr van Buuren's opinion, and ultimately was satisfied the matter was investigated thoroughly and professionally. The State Coroner found that none of the correctional officers or other inmates at WCC had any contribution to the death.

The State Coroner investigated Mr Courtney's parole request which was contingent upon his being able to access palliative care through the Townsville Correctional Centre. The State Coroner found that the transfer request was given appropriate consideration under the policies in place at the time and was treated with sufficient urgency.

The State Coroner made no recommendations.

Harold James Carpenter

Harold James Carpenter was a 66 year old man who died on 24 May 2014 from natural causes whilst in the palliative care unit at the Townsville Hospital (TTH). At the time of his death, Mr Carpenter was in custody at the Townsville Correctional Centre (TCC) on a continuing detention order pursuant to the *Dangerous Prisoners (Sexual Offenders) Act 2003*. He had been incarcerated specifically at TCC since 8 May 2013. Mr Carpenter was also awaiting extradition to NSW for outstanding offences.

On 28 April 2014, Mr Carpenter started displaying symptoms including shortness of breath, chest pain, pain in his hips and clamminess. He was subsequently transferred to TTH that same day. Mr Carpenter was initially admitted to the orthopaedic ward as it was thought he had problems with his hips. Blood tests confirmed a raised white cell count, supporting an infection of some sort. A subsequent CT scan detected an aneurysm in the iliac artery on the right hand side that was blocking the kidney from draining properly. A number of surgeries were performed but Mr Carpenter continued to have poor kidney function. The infection spread and Mr Carpenter eventually refused further blood transfusions. A referral to the palliative care unit was made on 22 May 2014 and Mr Carpenter was pronounced deceased on 24 May 2014.

Upon being notified of Mr Carpenter's death by TTH, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. The investigation obtained Mr Carpenter's correctional records and his most recent hospital records. The investigation was informed by statements from all QPS personnel, relevant custodial officers and Queensland Health staff at TCC and information from Mr Carpenter's partner, Ms Biancha Esson. An external autopsy was conducted which showed the cause of death to be coronary atherosclerosis, with emphysema listed as a secondary cause. The Deputy State Coroner was satisfied the matter was investigated thoroughly and professionally.

Evidence from the Director of the Clinical Forensic Medicine Unit was heard surrounding the adequacy of Mr Carpenter's medical care and treatment whilst in custody at TCC. The Deputy State Coroner accepted that the health care provided to

Mr Carpenter during this time was adequate and appropriate. The Deputy State Coroner accepted that there were no concerning factors contributing to Mr Carpenter's demise. No third party caused or contributed to his death.

The Deputy State Coroner made no recommendations.

Robert Dennis McIntosh

Robert Dennis McIntosh was a 55 year old man who died on 29 May 2013 from natural causes whilst in the palliative care unit at the Princess Alexandra Hospital (PAH). At the time of his death, Mr McIntosh was remanded in custody at the Arthur Gorrie Correctional Centre (AGCC) on a break and enter offence. He had been incarcerated there since 9 May 2012. Mr McIntosh had a history of illicit drug use and hepatitis C, making him more susceptible to diseases relating to the liver.

As part of the reception process into AGCC, blood tests were ordered and became available on 14 May 2012. These tests showed no indication of liver disease or cirrhosis of the liver. On 15 May 2013, a liver function test showed similar derangement to previous tests, and he was not displaying any symptoms of chronic liver disease. Mr McIntosh's final admission to the PAH began on 25 May 2013, and came about after a week long history of abdominal distension. On admission, Mr McIntosh was noted to have clinical features of chronic liver disease. A CT scan showed a small liver with a nodular surface in keeping with cirrhosis. Mr McIntosh subsequently suffered episodes of haematemesis (vomiting of blood) and his overall prognosis was assessed as poor. He was assessed for palliative care and pronounced deceased on 29 May 2013.

Upon being notified of Mr McIntosh's death by PAH, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. The investigation obtained Mr McIntosh's correctional records and his most recent hospital records. The investigation was informed by statements from all QPS personnel, relevant custodial officers and Queensland Health staff at PAH. An external autopsy was conducted which showed the cause of death as:

1(a) gastrointestinal haemorrhage; due to or as a consequence of
1(b) oesophageal varices; due to or as a consequence of
1(c) hepatocellular carcinoma with portal vein thrombosis; due to or as a consequence of
1(d) cirrhosis of the liver.

The State Coroner was satisfied the matter was investigated thoroughly and professionally. Specialist evidence was heard surrounding the standard of care for patients with cirrhosis of the liver in the community, and how this might be applied to the custodial setting. Whilst the State Coroner accepted that the overall standard of health care provided to Mr McIntosh was adequate and appropriate, there was also evidence presented by AGCC with respect to a number of enhancements made at the prison since Mr McIntosh's death so as to improve the identification of cirrhosis in prisoners, of whom the prominence of hepatitis C is high.

The State Coroner recommended that the Queensland Government convene a working party comprised of representatives from Queensland Health, Queensland Corrective Services, the West Moreton Hospital and Health Service, the Metro South Hospital and Health Service, AGCC and other correctional facilities to:

1. Examine how the identification and management of patients with hepatitis and cirrhosis in correctional settings could be improved; and
2. Review the former "Protocol for the management of viral hepatitis in offender health services" in consultation with appropriate experts, for distribution to all Hospital and Health Services.

Monitoring responses to coronial recommendations
When a matter proceeds to inquest, a coroner may make recommendations aimed at preventing similar deaths in the future. This is one of the most important objectives of a modern coronial system.

In 2006, the Ombudsman reported that the capacity of the coronial system to prevent deaths would be improved if public sector agencies were required to report on responses to coronial recommendations. In 2008, the Queensland Government introduced an administrative process for monitoring responses to recommendations involving government agencies reporting to the Attorney-General about implementation of recommendations and compilation of an annual report.

The first report considering recommendations made during the 2008 calendar year was released in August 2009. The most recent report in relation to 2012 recommendations was published in March 2014. No reports were published during 2014–15.

Publishing responses to coronial recommendations enhances the death prevention role of the coronial jurisdiction by increasing the likelihood that public sector agencies will give them due consideration. It also provides an important feedback mechanism to coroners. The report can be accessed at the Department of Justice and Attorney-General website: https://publications.qld.gov.au/dataset/the-queensland-government-s-response-to-coronial-recommendations.

Higher courts decisions relating to the coronial jurisdiction

There were no decisions of significance to coronial jurisprudence during the reporting period.

State Coroner's Guidelines

One of the State Coroner's functions is to issue guidelines about the investigation of deaths and other matters under the Coroners Act. Guidelines are issued under s.14 with the objective of ensuring best practice in the coronial system. The State Coroner must consult with the Chief Magistrate before issuing any directions or guidelines.

The guidelines issued under section 14 of the Act were reviewed and updated during the reporting period. Guidelines were included in relation to domestic and family violence and child death reviews to guide the investigation of these deaths.

The State Coroner's Guidelines can be accessed at: http://www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications.

Access to coronial information

Genuine researchers

The coronial system is an important source of information for researchers who in turn provide an invaluable resource for coroners in their preventative role. Section 53 of the Coroners Act facilitates access to coronial documents by researchers.

Generally, researchers may only access coronial documents once the investigation is finalised. However, the State Coroner may give access to documents on open files if the State Coroner considers it appropriate having regard to the importance of the research and the public interest in allowing access before the investigation has finished.

The Coroners Act requires the names of persons given access to documents as genuine researchers to be noted in the annual report. The following genuine researcher was approved under s. 53 of the Coroners Act during the reporting period:

- Professor Robert (Robin) A Cooke, Independent Researcher

The full list of researchers can be found at Appendix 2.

Appendix 1: Number of Coronial cases Lodged and Finalised in the 2014–15 financial year and the number cases pending as at 30 June 2015

Court Location	Number of Deaths reported to the Coroner	Number of Coronial Cases finalised			Number of Coronial Cases pending			
		Inquest held	No inquest held	Total	Less than or equal to 12 months old	Greater than 12 and less than or equal to 24 months old	Greater than 24 months old	Total
Brisbane	**2991**	46	2747	**2793**	828	158	134	**1120**
Cairns	**615**	12	563	**575**	251	45	31	**327**
Gympie	**0**	1	0	**1**	0	0	0	**0**
Mackay	**585**	4	549	**553**	173	33	38	**244**
Southport	**771**	15	701	**716**	355	62	54	**471**
	4962	**78**	**4560**	**4638**	**1607**	**298**	**257**	**2162**

Appendix 2: Register of approved genuine researchers 2014–15

Person/position	***Organisation***
Chairperson	Queensland Maternal and Peri-natal Quality Council - Queensland Health
Chairperson	Queensland Paediatric Quality Council - Queensland Health
Chairperson	Committee to Enquire into Peri-operative Deaths - Queensland Health
Director (Rob Pitt)	Queensland Injury Surveillance Unit
Director (Prof Diego De Leo)	Australian Institute for Suicide Research and Prevention
Director (Prof Nicholas Bellamy)	Centre of National Research on Disability and Research Medicine
Director (Assoc Prof David Cliff)	Minerals Industry Safety and Health Centre
Dr Douglas Walker	Not applicable
Deputy Team Leader Safety and Education Branch	Australia Transport Safety Bureau
Director (Prof Mary Sheehan)	Centre for Accident Research and Road Safety – Queensland
Dr Charles Naylor Chief Forensic Pathologist	Queensland Health Forensic and Scientific Services (QHFSS) funded by Australian Research Council (ARC)
Dr Belinda Carpenter Criminologist	QUT School of Justice Studies funded by ARC
Dr Glenda Adkins Criminologist	QUT School of Justice Studies funded by ARC
Director (Assoc Prof Robert Hoskins)	Clinical Forensic Medicine Unit – Queensland Health
Dr Ben Reeves	Paediatric Registrar Mackay Base Hospital
Dr Beng Beng Ong	QHFSS
Dr Nathan Milne	QHFSS
Dr Peter O'Connor / Ms Natalie Shymko / Mr Chris Mylka	National Marine Safety Committee
Dr Nathan Milne	QHFSS
Dr Beng Beng Ong	QHFSS
Manager (Strategy & Planning)	Maritime Safety Queensland
Dr Luke Jardine	Royal Brisbane & Women's Hospital
Dr Yvonne Zurynski	Australian Paediatric Surveillance Unit -The Children's Hospital at Westmead

Director of Neonatology - Dr John Whitehall & Dr Yoga Kandasamy	Department of Neonatology - Townsville Health Service District
Professor Ian Thomas - Director of CESARE	Centre for Environmental Safety and Risk Engineering
Dr Margot Legosz	Crime & Misconduct Commission
National Manager for Research & Health Promotion (Dr Richard Charles Franklin)	Royal Life Saving
Lance Glare (Manager BCQD Building Legislation & Standards Branch)	Building Codes Queensland Division
Michelle Johnston masters student	School of Pharmacy, University of Queensland
Dr Damian Clarke	Paediatric Neurology Department Mater & Royal Children's Hospital
Professor Grzebieta, Hussein Jama & Rena Friswell	NSW Injury Risk Management Research Centre
Director - John Lippmann OAM	Divers Alert Network Asia Pacific (DAN AP)
Dr Michelle Hayes	Department of Communities
Associate Professor Alexander Forrest	QHFSS
Professor Tim Prenzler, Doctor Louise Porter, Kirsty Martin & Alice Hutchings	ARC Centre of Excellence in Policing & Security
Professor Christopher Semsarian	Centenary Institute - Molecular Cardiology Group
Ms Donna McGregor, Dr Laura Gregory, Mr Matt Meredith, Miss Nicolene Lottering	QUT / QHFSS
Mark Stephenson - Team Leader / Glen Buchanan - Snr. Chemist	QHFSS
Julian Farrell - Research Officer	Agri- Science Queensland
Professor Belinda Carpenter & Associate Professor Gordon Tait	QUT
Adjunct Professor Peter Ellis, Associate Professor Alexander Stewart & Professor Craig Valli	QHFSS, Griffith University and Edith Cowan University
Keith Loft	QUT / QHFSS
John Drayton, Senior Counsellor	QHFSS
A/Professor Alex Forrest & Professor Peter Ellis & Dr Nathan Milne & Brittany Wong	QHFSS
Director	Department of Veterans' Affairs - Family Studies
Ms Donna McGregor, Dr Laura Gregory, Mr Matt Meredith, Miss Nicolene Lottering & Miss Kaitlyn Gilmour	QUT / QHFSS
Sean Hogan & Professor Richie Poulton	DMHDRU, Dunedin School of Medicine - University of Otago - NZ

Adjunct A/Prof. George Rechnitzer, Adjunct A/Prof Andrew McIntosh and Mr Declan Patton	Transport & Road Safety - University of New South Wales
Dr Susan Ballantyne	Director, Drugs of Dependence Unit
Professor Robert (Robin) A Cooke	Independent Researcher