



QUEENSLAND
COURTS



OFFICE OF THE STATE CORONER
FINDINGS OF INQUEST

Inquest into the death of Nannette FIELD

CITATION: Coroners Court
TITLE OF COURT: Brisbane
JURISDICTION: 10 October 2007
DELIVERED ON: Mt Isa
DELIVERED AT: 6 – 9 October 2007
HEARING DATE(s): Mr Michael Barnes, State Coroner
FINDINGS OF: CORONERS: Inquest – exsanguinations following surgery, serious surgery in remote locations
CATCHWORDS: Ms Jennifer Jensen
Mr Geoffrey Davis, in
Hickson Knox Law
REPRESENTATION:
Counsel Assisting:
Mt Isa Health District and staff.

Courts

Office of the State Coroner
Annual Report 2006-2007





Letter of transmission



**QUEENSLAND
MAGISTRATES COURT**
Office of the State Coroner

17 November 2008

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Dear Attorney,

Section 77 of the *Coroners Act 2003*, requires that at the end of each financial year the State Coroner is to provide to the Attorney-General a report for the year on the operation of the Act. In accordance with that provision I enclose the report for the period ended 30 June 2007.

I advise that the report contains a summary of the investigation into each death in custody finalised during the period in accordance with section 77(2)(b) of the Act.

In accordance with section 77(2) I attach a CD-Rom containing a digital copy of the guidelines I have issued pursuant to section 14 of the Act. I have not issued any directions under section 14 of the Act.

Michael Barnes
State Coroner

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State Coroner's year in review



Michael Barnes
State Coroner

The modernisation of the coronial system which commenced with the introduction of the *Coroners Act 2003* continued throughout 2006–07. This has led to a number of significant changes to the way coroners operate compared to the system that prevailed under the *Coroners Act 1958*.

As the tables and text in this report demonstrate, the number of matters dealt with by coroners continues to increase. However those raw figures do not adequately measure the increased workload of coroners. Two further factors need to be considered: namely, the added complexity of many matters referred to coroners; and the increasingly prevalent public expectation that coroners will exhaustively address all issues raised by the deaths they investigate.

Both factors are regularly exemplified by deaths that occur in a medical setting. Until recently, there was a high degree of public confidence in the opinion and actions of medical practitioners. It was widely believed if a patient died it was because their condition was irretrievable. Of late however, as a result of scandals in Australia and abroad, the public has become more questioning of medical professionals and indeed it could be argued, even mistrustful. This frequently results in demands from family members that the coroner more exhaustively examine such deaths; many of which in the past would not even have been reported. While it is appropriate this under reporting of hospital deaths is addressed, the consequences of redressing it need to be recognised.

Generally, the investigation of these deaths is more resource intensive than any other category of reportable deaths. They are more time consuming and expensive because:

- hospitals and doctors are frequently less cooperative with requests for records and statements
- police are ill-equipped to interview medical witnesses
- the coroner or those assisting are regularly required to peruse difficult to read and extensive medical records
- the briefing of busy, independent medical experts for reports adds to cost and delay.

Deaths in a medical setting also raise challenging prevention issues. Clinicians almost never intentionally harm their patients and so an explanation for substandard performance must be sought by analysing complex systemic issues such as the training and credentialing of medical staff, etc.

It is widely accepted that unexpected deaths in hospitals have been under reported in all states. In his report on the Commission of Inquiry into Public Hospitals, The Honourable Geoff Davies QC recommended changes to the *Coroners Act* to increase compliance with these obligations. A response to these recommendations was not finalised during the reporting period. However other factors, such as the promulgation of a death review standard by the Queensland Health Quality and Complaints Commission and the proactive involvement of the Patient Safety Centre of Queensland Health has seen a marked increase in the reports of these types of deaths.

While this is undoubtedly desirable, it is unavoidable that by encouraging hospitals to comply with their statutory obligations, the number of these deaths reported will increase, further driving up the workload of the coroners and their staff.

Suicides, the largest category of non natural deaths reported to coroners, also exemplify these trends. In most of these cases there is no suggestion of any direct third party involvement and until relatively recently they would be finalised 'on the papers' with a finding of 'hanging' or 'drug toxicity' or 'carbon monoxide poisoning'. However, if coroners are to diligently discharge their prevention function they need to investigate the psycho-social circumstances in which mental health patients and others commit suicide. Indeed, families and the public are demanding coroners investigate, for example, the circumstances in which such deceased persons were denied admission to a mental health ward, were discharged from such a ward or were allowed to regulate their own medication. Again such inquiries are complex, time consuming and resource intensive.

A third example of the increased workload faced by coroners is the expectation the coroner will review the performance of industry regulators. So, for example, not only will the inquest into an air crash seek to assess the contribution of pilot error, equipment failure, or bad weather but in addition the coroner will be expected to examine the training of the pilot and the oversight of the aviation operator by the regulator, the Civil Aviation Safety Authority.



It is also pertinent to note that hospitals, mental health institutions, airline companies and Commonwealth Government regulators do not benignly acquiesce to a coroner's inquisition. They frequently 'lawyer up' and vociferously contest the right of the coroner to undertake such wide ranging inquiries and/or the outcome of those inquiries.

I believe these changes have allowed coroners to make a greater contribution to public health and safety, as was intended when the 2003 Act was introduced. Coroners across the state have risen to the challenges of the new role, albeit some in small or particularly busy courts have difficulty interweaving the coronial work with general court work.

These improvements have only been possible because of the collaboration of the various disciplines that contribute to coronial investigations.

The Queensland Police Service continues to undertake most coronial investigations. While there have been problems with delays in some cases, overall the standard of the investigation is high. I am particularly grateful to Commissioner Atkinson for his continued willingness to adequately staff the Coronial Support Unit and to second an Inspector to the Office of the State Coroner (the office).

Since its inception, that officer has been Detective Inspector Gilbert Aspinall who retired at the end of the reporting period after a distinguished police career. I wish to pay testament to the very significant assistance Inspector Aspinall provided to me personally and the coronial system generally during his period in the office. We could not have implemented the new system as seamlessly as we did, or make the myriad of changes and adjustment that are always necessary when such far reaching reforms are introduced, without Inspector Aspinall's dedication and commitment. He will be sorely missed.

I also wish to acknowledge the assistance provided by Queensland Health. The Chief Executive Officer, Ms Uschi Schreiber, the Chief Health Officer, Dr Jeanette Young and the Executive Director, Clinical and Statewide Services, Dr Peter Lewis-Hughes all effectively contributed to the effective interface between the coronial system and the public health system.

The forensic pathologists and forensic scientists at the John Tonge Centre, in particular Dr Charles Naylor and Ms Deborah Whelan deserve special recognition for the high level of service they have provided to coroners. I am also grateful for the assistance provided by the Clinical Forensic Medicine Unit, in particular its director, Dr Bob Hoskins and the government medical officers around the state who assist local coroners so effectively.

I also wish to acknowledge the sterling effort of the staff of the office. Their generous and tireless application to ever growing caseloads and the professional manner in which they deal with the stressful and demanding work of the office is commendable.

And finally, I wish to express my appreciation for the support and advice of the Deputy State Coroner, Ms Christine Clements. There is no doubt that without her bearing the huge burden of dealing with the Brisbane deaths the system would founder. Further, were it not for her acumen and encouragement, I could not attend to the policy and administrative matters essential to the continued development of the jurisdiction.



Our people

Registrar's report

The 2006–07 year has been an exciting and challenging one for the office.

The year has seen a number of changes and has been one of considerable achievement across a range of areas.

The office received an additional \$1.153 million in response to a significant increase in the office's workload since the commencement of the *Coroners Act 2003*.

This additional funding was for increases in the costs of inquests and salaries for the employment of additional staff required to manage the increased workload of the office and maintain current levels of efficiency. The increase in workload is largely attributable to:

- increased interaction between the health sector and coroners since the publication of the Queensland Public Hospitals Commission of Inquiry Final Report e.g. doctors seeking advice as to whether a death is reportable and coronial permission to issue death certificates



- the more resource intensive investigations necessary since the introduction of the new legislative framework in the *Coroners Act 2003*. There are more steps in the progression of a coronial file and the pre-inquest stage of a coronial investigation has become much more rigorous, particularly in medical matters
- a dramatic increase in inquest costs due to the engagement of private counsel rather than police prosecutors as counsel assisting the coroner
- the additional court time and office support required to facilitate the widened scope of inquests to reflect the general death prevention function of the coronial system.

As a result of this funding the staff establishment was increased by four positions. A registrar was permanently appointed on 7 June 2007.

As at 30 June 2007, there were 19 officers employed by the office to provide legal and administrative support.

Last year's annual report set out the intention of the office to custom design an appropriate digital data base to provide a more effective case management system. The system currently in use across Queensland Courts does not adequately meet the technical or operational needs of the coronial system. It also does not capture useful and reliable information about coronial matters in Queensland and does not interface with the National Coroners Information System. The Information Management Committee of the Department of Justice and Attorney-General allocated funding of \$310 000 for the system design, development and testing of a coronial case management system. On 21 June 2007 a Coroner's Panel Workshop was held with staff attending from around the state. This workshop brainstormed the draft functional requirements specification.

The progress of this new case management system will be largely realised during the 2007–08 year. It will assist in delivering the strategic priorities of the department to implement systems that better support the needs of the community by improving system functionality and more efficient use of registry resources. This will significantly improve the management of coronial matters and will greatly assist in improving the quality of coronial service to the community.

State Coroner

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

In order to discharge the coordination function, the State Coroner has issued guidelines of general application which inform the way coroners manage coronial matters across the state.

Those guidelines can be accessed at www.justice.qld.gov.au/courts/coroner/publications.htm.

The State Coroner also provides daily advice and guidance to coroners in relation to specific cases. The State Coroner also liaises with other professions and organisations involved in the coronial process, such as police, pathologists and counsellors.

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

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

During the reporting period, the State Coroner sat in Brisbane, Bundaberg, Normanton and Childers. During 2006–07, the State Coroner presided over 17 inquests and finalised 74 other matters without inquest.

Deputy State Coroner

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

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

It was another extremely busy year for the Deputy State Coroner. During 2006–07 there were 1039 deaths reported in Brisbane. A large percentage of these deaths were medically related as the major hospitals of Queensland are located in Brisbane.

The Deputy State Coroner finalised over 1061 investigations including six matters that went to inquest.

Local coroners

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

Unless the file is transferred to the State Coroner, the local coroner is responsible for investigating the death. There are many steps involved in a coronial investigation some of which can be very time consuming. The coroner must consider the initial police report (Form One) and consider any family concerns before ordering an internal autopsy.

The coroner is in control of and directs the coronial investigation. Police and other investigative agencies and experts engaged by the coroner prepare often lengthy and complex reports.

These reports must be considered before making a decision as to whether an inquest should be held and making findings in relation to the death.

Family members are consulted before it is decided whether an inquest is needed. Because of the many steps involved in the process, coronial work makes demands that do not mesh easily with the workload and schedule of a busy magistrate.

Office of the State Coroner

The role of the office is to support the State Coroner in delivering a more consistent and efficient coronial system across the state.

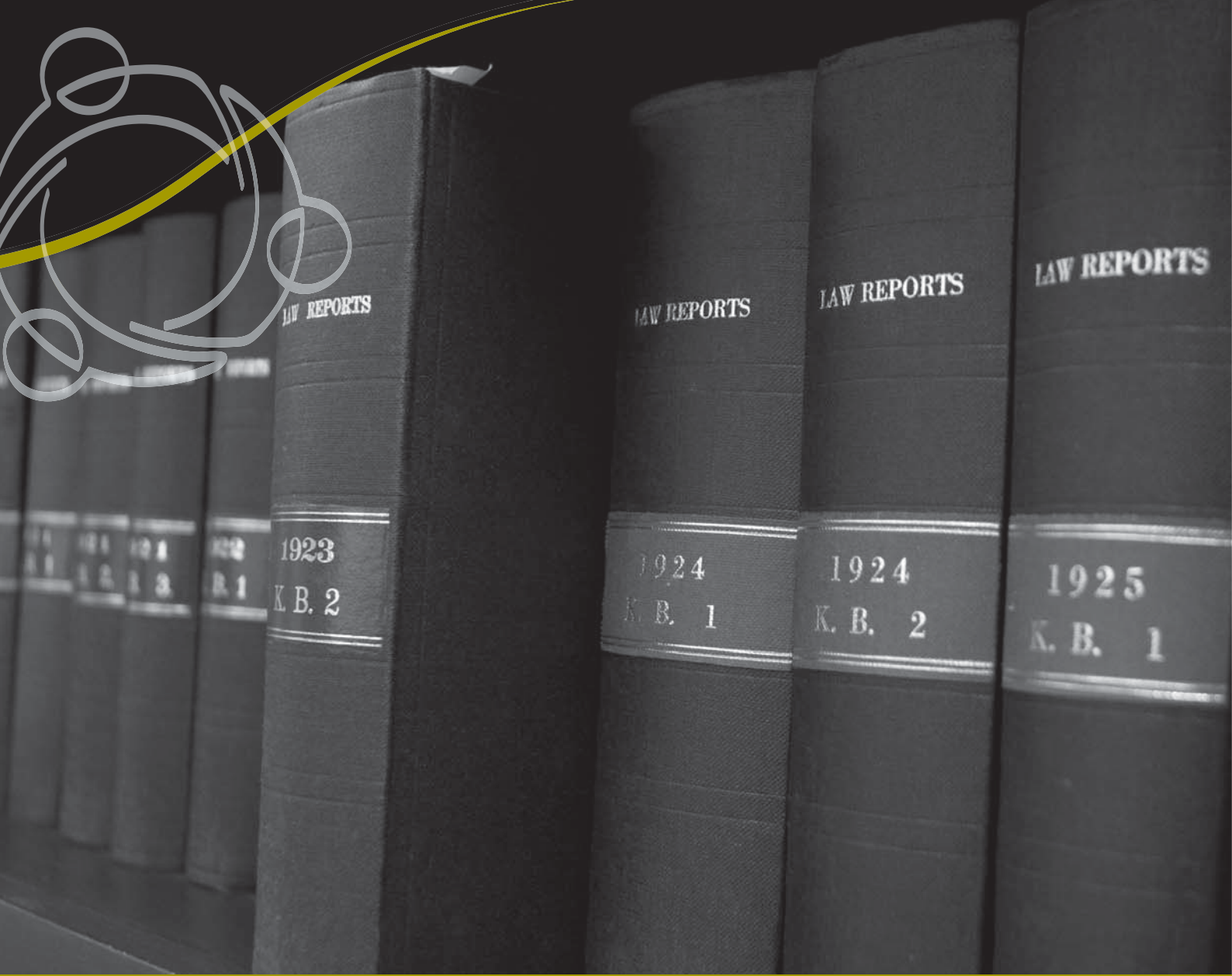
The office:

- maintains a register of reportable deaths
- supports the state involvement in the National Coroners Information System (NCIS)
- provides ongoing legal and administrative support to the State Coroner, Deputy State Coroner, local coroners and court registry staff in Magistrates Courts across the state.

The office also ensures there is publicly accessible information available for families and others regarding the coronial system and provides a central point of contact for coronial matters.

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

At the end of the reporting period, there were 19 officers employed by the office to provide legal and administrative support to coroners, court staff and coronial clients throughout the state.



Coronial investigations

Reportable deaths

Under the *Coroners Act 2003* reportable deaths, as defined in s. 8 of the Act, must be reported to a coroner. Section 7 of the Act requires anyone becoming aware of an apparently reportable death to report it to the police or a coroner.

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

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

Unidentified bodies

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

Violent or unnatural

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

Suspicious circumstances

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

Not reasonably expected to be the outcome of a health procedure

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

Deciding whether a death that occurs in a medical setting should be reported and determining how it should be investigated poses considerable challenges for a coroner.

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

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

Deaths in care

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

During the reporting period, 56 deaths in care were reported. The deaths comprise less than two per cent (1.74 per cent) of the total deaths reported during 2006–07. It is doubtful this figure accurately reflects the total number of deaths in this category.

The office is concerned about under-reporting of this category, largely attributable to the following reasons:

- the section, particularly as it relates to people with a disability living in one of the facilities listed in section 9(1)(a), is difficult for some coroners, police, medical staff and court staff to interpret and apply



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

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

Deaths in custody

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

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

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

During the reporting period, nine deaths in custody were reported. However, findings in relation to 12 deaths in custody were finalised during the reporting period. It is mandatory for an inquest to be held for deaths in custody.

Indigenous remains

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

Once a coroner has established the remains are in fact Indigenous burial remains, s. 12 of the Act precludes a coroner from investigating further, unless the Minister directs.

During the reporting period, 21 matters were investigated by coroners where the remains were confirmed as Indigenous burial remains.

Purpose of coronial investigations

The purpose of a coronial investigation is to establish, the identity of the deceased, when and where they died, the medical cause of death and the circumstances of the death. Coroners also consider whether changes to policies or procedures 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. Inquests are held so that coroners can receive expert evidence on which to base such recommendations.

Autopsies

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

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

Although family members may not prevent an autopsy being undertaken if a coroner considers it necessary, a coroner who wishes to override a family's concerns must give the family reasons for this which enlivens a right to have the coroner's decision judicially reviewed. No such review applications were lodged during 2006–07 and family concerns have been able to be resolved with the assistance of coronial counsellors from Queensland Health Scientific Services.

While precise figures are not available, a sample analysis (see Table 1) indicates during the reporting period, full internal autopsies were conducted in 67.6 per cent of cases, partial internal autopsies were conducted in 22.5 per cent of cases and external examinations were undertaken in 9.8 per cent of cases.



Table 1

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

Type of autopsy	1/12/03 to 30/06/2004	2004-05	2005-06	2006-07
Order for external autopsy	11.7%	6.3%	7.12%	9.84%
Order for internal autopsy—partial	16.3%	25.2%	27.73%	22.51%
Order for internal autopsy—full	71.4%	68.3%	65.11%	67.62%
Order on cremated remains	0.5%	0.2%	0.04%	00.03%

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

Type of autopsy	1/12/03 to 30/06/2004	2004-05	2005-06	2006-07
Order for external autopsy	107	145	198	296
Order for internal autopsy—Partial	149	575	771	677
Order for internal autopsy—full	653	1559	1810	2034
Order on cremated remains	5	5	1	1
Total	914	2284	2780	3008

Measuring outcomes

Finalisation of coronial cases

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

In many cases however, closure of coronial files is delayed by the police investigation or the involvement of other agencies that also have responsibility to review the circumstances of the death. For example, the Department of Child Safety reviews the deaths of children who have had contact with the department. The Division of Workplace Health and Safety investigates many industrial accidents.

In most cases, it is appropriate for coronial findings to await the deliberations of these other agencies so the coroner can reflect upon not only the issue of causation but also whether any preventative measures should be recommended. In many cases, the specialist agencies are best placed to devise such reforms. The coroner need then only note the changes that have been mooted and if appropriate, add their voice to the call for improvement. Of course, if criminal charges are preferred an inquest can not proceed until those charges have been dealt with.

Appendix 2 shows the finalisation rates achieved during the reporting period.



Coronial investigators and collaborators

The Coronial Support Unit– Queensland Police Service

The Coronial Support Unit (the CSU) coordinates the management of coronial processes on a statewide basis within the Queensland Police Service (QPS). The three police officers located within the office provide direct support to the State Coroner and Deputy State Coroner as well as assisting regional coroners as required.

The four police officers at the John Tonge Centre assist in the identification of deceased persons, preparation of documents for autopsy and attend autopsies. This unit also liaises with coroners, investigators, forensic pathologists, mortuary staff and counsellors. These officers bring a wealth of experience and relevant knowledge to the office. They are actively involved in various research projects and proactively review policies and procedures as part of a continuous improvement approach.



The officers of the CSU play an essential role in the effective operation of the coronial system. They:

- assist coroners to obtain vital information in a timely fashion
- institute quality control measures for police coronial processes
- ensure police investigators attend to matters as required
- coordinate the release of information from coronial files to other officers for use in criminal investigations.

Their expertise and location in the office enables these functions to be undertaken far more efficiently than if officers in police districts external to the office were required to do these tasks. As a result of these arrangements, the CSU achieves a substantial net saving of resources for the QPS and provides a high level of service to coroners.

Coronial counsellors

The Coronial Counselling Service based at the John Tonge Centre provides information and counselling services to relatives of deceased persons. This service is staffed by experienced professional counsellors who assist with negotiating autopsy objections, arranging body viewings and explaining autopsy findings. Throughout the year, efforts to extend the service beyond the south-east corner of the state have continued, but more still needs to be done in this regard.

Forensic pathology and scientific services

The coronial system is well served by the forensic pathologists, toxicologists and forensic biologists employed by the Division of Clinical and Statewide Services within Queensland Health.

The workload of those professionals continues to increase, creating challenges for the timely finalisation of some matters. During the reporting period, the recommendations of the Ministerial Taskforce that reviewed the operations of the John Tonge Centre were progressively responded to and the service level agreement between the office and Clinical and Statewide Services was reviewed.

The mortuary staff at the John Tonge Centre work closely with the police officers of the CSU to manage lodgements of bodies, viewings and releases for burial. They work effectively in a fraught environment.

It is apparent that the managers and professional leaders within the division are conscientiously applying themselves to the challenges of providing a high quality and timely service to the coronial system. However, delays continue to cause problems in some cases. This is an issue that will require ongoing monitoring.

Coronial investigators

The majority of coronial investigations are undertaken by officers of the Queensland Police Service. Generally, the standard of those investigations is high.

Specialist agencies operate in some fields. For example the Australian Transport Safety Bureau investigates aviation deaths, the Mines Inspectorate looks at deaths in the extractive industries and the Division of Workplace Health and Safety inquires into industrial accidents.

Without the assistance of these agencies the coronial system could not operate. From time to time delays are occasioned by the workload of these agencies and on occasions their investigative focus does not coincide with the coroner's. These difficulties are resolved through negotiation.

Genuine researchers

The coronial system is an important source of information for researchers and the analyses of researchers assist are an invaluable resource for other coronial systems in their preventative role.

The following genuine researchers were approved in the reportable period:

Dr Nathan Milne and Dr Beng Beng Ong *(approved 7 July 2006)*

Dr Milne and Dr Ong are forensic pathologists with Queensland Health Forensic and Scientific Services who perform autopsies to assist in investigation of deaths reported to the coroner.

The results of the research project is intended for publication in a peer reviewed journal and is aimed at providing coroners with evidence to support decision making regarding the extent of autopsy required.

National Marine Safety Committee *(approved 25 May 2007)*

The National Marine Safety Committee is an intergovernmental committee formed in 1997 by the Council of Australian Governments, to lead reform in the marine sector and achieve national consistency in legislation and administration.

The National Marine Safety Committee reports through the Australian Maritime Group to the Australian Transport Council and is investigating all water transport deaths in Australia registered in the period 1999–2004. This investigation will provide an update on a previous study covering the period 1992–1998. The study will be used to develop programs to prevent boating deaths and therefore has a significant benefit to the community. The information provided by the office will assist in furthering the National Marine Safety Committee's goals of improving safety on Australian waters.



Inquests

Deaths in custody

Calvin Wayne BEE

On 18 August 2003, Mr Bee, a 42 year old Aboriginal man, was sentenced by the Magistrates Court at Normanton to six months imprisonment. He was taken into custody and held at the watch house at Normanton. At that time he appeared to be in good health and did not appear to be affected by liquor. He did not complain to police of any illness or injury, nor was any apparent.

The next morning at about 7am, Mr Bee was lying on a bench in a communal cell when he was seen to convulse, fall to the ground, continue to fit, and lapse into unconsciousness.

Despite attempts by an ambulance officer who soon arrived, Mr Bee was unable to be resuscitated.

The State Coroner recommended a review of the assessment and treatment of alcohol withdrawal risk among watch house detainees.

Lenard John CASEY

At about 1pm on Friday 19 November 2004, Lenard Casey, a 39 year old Aboriginal man, was arrested on a charge of unlawful wounding of his partner. As he was being charged at the Normanton police watch house he complained of chest pains and was taken by ambulance to the Normanton Hospital. Shortly after midnight that evening, an attempt was made to transport Mr Casey by aircraft to the Mount Isa Hospital. However, as result of his violent behaviour the pilot refused to transport him and Mr Casey was returned to the Normanton hospital where he died about an hour later.

The State Coroner was satisfied that the investigation established the cause and circumstances of Mr Casey's death.

The State Coroner considered the performance of the police officers in this matter to have been exemplary. They moved quickly to take into custody a suspect for a serious, violent crime. They acted equally expeditiously when it became apparent Mr Casey needed medical attention.

He also noted the effective cooperation between the police, the ambulance and the hospital staff.

Mark Walter DAY

On 3 October 2003, Mark Walter Day an inmate at the Sir David Longland Correctional Centre died as a result of a violent prolonged attack by a prisoner who had previously been convicted of murdering another prisoner. The attacker has since been convicted of Mr Day's murder.

Disciplinary action was taken against the officers who failed to search the prisoners, adequately monitor the prisoners in the exercise yard, and who made false entries in the search logs.

One officer was dismissed, one retired before the action could be resolved and one was formally reprimanded.

An external audit of the management, staffing and operations of the maximum security units at the Arthur Gorrie Correctional Centre and the Sir David Longland Correctional Centre was undertaken. This also included consideration of the maximum security units' operational procedures and the practices concerning prisoner association in this environment.

The State Coroner was satisfied the Department of Corrective Services had moved to address the issues and recommendations arising from the internal investigation undertaken by the independent inspectors. No further recommendations concerning this matter were proposed.

Darren Michael FITZGERALD

At the time of his death Mr Fitzgerald was an inmate of the Woodford Correctional Centre where he was serving a sentence of life imprisonment for murder. At about 2am on 13 June 2004, correctional staff were conducting a routine head count of the unit in which Mr Fitzgerald was housed when they noticed him slumped at his desk. A nurse was called and she and the correctional officers entered the cell. It was immediately ascertained that Mr Fitzgerald was dead.

On initial assessment, at the commencement of his life sentence, Mr Fitzgerald disclosed a history of drug abuse. Thereafter, while in prison he returned positive results to urine drug screening tests on 15 occasions. He was breached for drug related offences on nine occasions.

Autopsy results revealed Mr Fitzgerald died from heroin toxicity with a possible contribution from coronary atherosclerosis.



The State Coroner considered that no action of any prison officer or other prisoner caused or directly contributed to the death. He was satisfied the prison authorities had no information to alert them to the likelihood that Mr Fitzgerald was in imminent risk of harm and they responded expeditiously and appropriately when they became aware that Mr Fitzgerald may be in need of assistance.

The State Coroner recommended:

- the resources of the intelligence section of the Woodford Correctional Centre be increased
- as a matter of urgency, the Department of Corrective Services establish opioid dependence pharmacotherapy programs utilising methadone and buprenorphine.
- in view of the inability of the Department of Corrective Services to keep prisons drug free, and in recognition of its obligation to minimise the spread of blood born viruses among the prison population and those who prisoners will come in contact with after release, prisoners be given access to clean syringes.

Leon Mark CARROLL

On the morning of 1 December 2003, Mr Carroll was found by correctional staff to be hanging in the cell he occupied alone at the Arthur Gorrie Correctional Centre. He was immediately cut down and first aid was provided. He did not have a pulse and was not breathing. He was not able to be resuscitated and was pronounced dead at the scene.

On 4 November 2003, Mr Carroll was transported to the Arthur Gorrie Correctional Centre. As part of the usual initial assessment of his health needs, Mr Carroll was interviewed by a social worker. The counsellor considered he was at risk of self harm or suicide. Accordingly, she completed the necessary paper work to cause Mr Carroll to be reviewed by a psychologist.

In the meantime, the social worker ordered he be placed on 15 minute observations and detained in the medical centre where he could be watched.

On 7 November 2003, Mr Carroll was interviewed by a prison psychologist who had been assigned to conduct an interim risk plan assessment. She did not have access to the notes made by the social worker who had ordered the assessment or the prisoner's medical file when she was interviewing Mr Carroll.

Mr Carroll expressly denied any history of suicide attempts or deliberate self harm. He also denied current ideation, intent or plan of suicide or deliberate self harm. It was on this basis the psychologist completed a recommendation that Mr Carroll be taken off observations and returned to the protection unit where he was to be housed as a result of the nature of his charges.

Later that day she relayed her opinion to the High Risk Assessment Team (HRAT). The psychologist's recommendation that Mr Carroll be taken off observations was accepted.

When Mr Carroll was returned to the protection unit, he ceased to be under official observation. At 6:42am on 1 December 2003 the officer conducting the morning head count approached the cell occupied by Mr Carroll. He saw him apparently standing against the wall to the right of the cell door. On closer inspection he saw that Mr Carroll was not moving and his chin was resting on his chest. Queensland Ambulance officers arrived at 7:09am and applied a cardiac monitor which confirmed that Mr Carroll was dead. Resuscitation attempts were then abandoned.

The State Coroner recommended:

- authorities at the Arthur Gorrie Correctional Centre review the mechanisms and procedures used to reassess prisoners who have previously been assessed to be at risk before the person is removed from close observation to ensure the decision has a sufficient evidence base
- the operators of the Arthur Gorrie Correctional Centre review the resources of the HRAT to enable a more careful and extensive consideration of each of the matters that come before the team
- as a matter of urgency the Department of Corrective Services cause the cells at the Arthur Gorrie Correctional Centre to be modified to remove hanging points.

Mario Emmy TYSSSEN

Mario Emmy Tyssen was 45 years of age when he died at 147 Staiers Road, Mungar via Maryborough while gardening on Friday 3 December 2004. At the time, he was in the custody of the Department of Corrective Services however he was on a 72 hour leave of absence order as part of his re-integration program to return to the general community.

An autopsy was conducted on Mr Tyssen's body at the Maryborough Hospital Mortuary by Doctor Paul Anderson. He advised that, in his opinion, Mr Tyssen died as a result of natural causes namely coronary artery disease due to or as a consequence of severe atherosclerosis. In other words, Mr Tyssen died as a result of heart failure.

There is no record of Mr Tyssen reporting cardiac disease symptoms to anyone while he was in the custody of the Department of Corrective Services, although he had many opportunities to do so. It may well be that he suffered no detectable symptoms prior to the day of his death.

There was no evidence of any suspicious circumstances or third party involvement in the death detected at autopsy.

The State Coroner found that no one in the Department of Corrective Services or any of the Visiting Medical Officers contributed to the death and that, under the circumstances, nothing could have been done to save Mr Tyssen.

Michael John EDDY

In the early hours of the morning on 20 February 2004, four police officers went to a home unit in Dutton Park, Brisbane. They were looking for Michael Eddy, believing him to be the person who had fled from a traffic interception earlier in the evening.

They were let into the unit but were told that Mr Eddy was not there. They forced the bedroom door and were confronted by Mr Eddy who resisted their attempts to arrest him. A violent struggle ensued. The officers all say that Mr Eddy was warned that unless he cooperated oleoresin capsicum spray (OC spray) would be used against him. They say he continued to act in a very aggressive and threatening manner and the spray was deployed. The spray had minimal impact on Mr Eddy. He fell back momentarily, appeared to wipe the spray from his eyes and then again attacked them. The OC spray was again deployed but again had minimal effect on deterring Mr Eddy from his resistance to attempts to subdue him. After Mr Eddy was restrained it was noticed that he was suffering some sort of medical emergency and an ambulance was called and first aid administered. He was not able to be revived and was pronounced dead at the scene.

The exhaustive examinations of Mr Eddy's body undertaken during two autopsies revealed numerous injuries. The three pathologists who participated in those examinations agreed that none of the injuries were serious and none were sufficient either alone or in conjunction with others to cause death.



The State Coroner made the finding that Mr Eddy died from restraint asphyxia compounded by the effects of amphetamine abuse and extreme exertion.

The State Coroner recommended:

- the QPS review the training provided to officers concerning the use of OC spray and the dangers of restraint asphyxia to ensure the risk of fatalities are appropriately emphasised
- the form mandated for autopsy reports be amended to include a requirement that the doctor who undertakes the autopsy list the sources of information other than the examination of the body and the chief forensic pathologist and the director of the clinical forensic medicine unit encourage forensic pathologists and government medical officers undertaking autopsies to include in their reports a discussion of the contextual information that is critical to their opinions as to the cause of death
- the *Births, Deaths and Marriages Act 2003* be amended to require that upon receipt of a coroner's findings the Registrar if necessary amend the details of death entered in the register so they accord with those findings.

Joseph Edwin JAMES

Joseph Edwin James was 67 years of age, when he was found deceased on the floor of his cell at the Lotus Glen Correctional Centre at Mareeba in North Queensland on Wednesday 9 June 2004.

Prior to this fatal incident, Mr James was not known to suffer from any medical problems. Mr James' body was taken to the Cairns Hospital Mortuary where, at the conclusion of the autopsy examination, Forensic Pathologist, Doctor David Williams advised that, in his opinion, Mr James died as a result of natural causes namely coronary atherosclerosis and emphysema.

Dr Williams confirmed there was no evidence to suggest the head injuries contributed to death nor was there any evidence of involvement of any third party in Mr James' death.

Doctor Anthony Brown provided an independent expert medical report into this death. He concluded that Mr James died of a completely unheralded cardiac arrest, related to coronary atherosclerosis, on a background of smoking and emphysematous lung disease. Dr Brown confirms that all the care delivered by Lotus Glen Correctional Centre staff and the Queensland Ambulance Service staff was of the highest quality and entirely appropriate.

The State Coroner found that Queensland Corrective Services staff followed death in custody and medical emergency protocols in this instance. Queensland Corrective Services staff and Queensland Ambulance Service paramedics did all within their power to provide assistance and resuscitation to Mr James upon him being located unconscious in his cell.

A comprehensive police investigation was conducted into the circumstances of this death in custody situation. The investigation, coupled with the autopsy, revealed that Mr James passed away suddenly and unexpectedly from natural causes, whilst in his cell.

Corey Allan McGEARY

At the time of his death, Corey Allan McGeary was an inmate of the Arthur Gorrie Correctional Centre. He was discovered hanging in his cell on 7 March 2005. He was not able to be revived.

Prison medical records indicate Mr McGeary had attempted suicide in the past, had been an inpatient at a psychiatric hospital and been diagnosed with schizophrenia at some stage. Mr McGeary was transported to the Arthur Gorrie Correctional Centre on 22 September 2004. He was assessed as an at risk prisoner and placed on high risk–10 minute observations. A few days later, his observations were reduced to every 15 minutes.

A psychologist reviewed Mr McGeary on 15 October 2004 and recommended Mr McGeary's observations cease. In order for this recommendation to be implemented a second assessment was required. This second assessment concluded he should remain on observations but they could be reduced to two hourly.

On 25 October 2004, Mr McGeary was assessed by another psychologist. He presented as coping well and a recommendation was made he be removed from observations altogether. A counsellor concurred with this recommendation.

At about 9am on 7 March 2005, it was determined that some inmates currently housed in Unit B5 would need to be transferred to B3, another protection unit. When a Queensland Corrective Services Officer notified Mr McGeary he was to be transferred, he expressed opposition to this proposal.

Both Mr McGeary and a second inmate were transferred from Unit B5 to B3 at approximately 1.30pm. At this stage there was nothing to indicate Mr McGeary was distressed or depressed.

At approximately 8.55pm, a head count was conducted. Mr McGeary was found hanging in his cell. Ambulance officers arrived at the unit at 9.18pm. CPR was continued by them until 9.25pm when it was clear he was dead.

An autopsy was performed by Dr Olumbe, an experienced forensic pathologist, on 8 March 2005 at the John Tonge Centre. He concluded the cause of death was neck compression. He found no injuries or other evidence any third party was involved in the incident.

The State Coroner considered the evidence established Mr McGeary was alone in his cell when it was locked shortly after 5.30pm and no one entered it until he was found hanging soon before 9.00pm by which time he was deceased. He found no one other than the deceased was directly involved in his death and the staff of the Arthur Gorrie Correctional Centre took all reasonable action when he was discovered hanging.

The State Coroner recommended:

- the Department of Corrective Services investigate whether it is feasible for counsellors or psychologists who undertake the initial assessment of all prisoners soon after incarceration to identify those who pose a chronic risk of self harm which, while not acute so as to warrant observation or other immediate intervention, should be flagged so as to require the involvement of a counsellor or psychologist whenever defined events are likely to impact such a prisoner
- the State Government immediately make available sufficient funding to enable the removal of the exposed bars in all cells at the Arthur Gorrie Correctional Centre.



Paul Allen COE and Steven John PITTAWAY

Paul Allan Coe was born on 10 December 1966. At approximately 7am on the morning of 10 June 2005, police executed a search warrant on Mr Coe's residence at 124 Mount Perry Road, Bundaberg. During a search of the residence and a detached shed, police located a quantity of equipment they believed had been used to produce methylamphetamine. While other police officers searched the residence, a Detective Senior Constable observed Mr Coe and others at the dining room table. A strip search of Mr Coe was conducted during which a small clip seal bag of methylamphetamine was found in Mr Coe's shirt pocket.

Upon arrival, Mr Coe was formally charged with two offences; namely, possessing a dangerous drug and producing a dangerous drug. A detective who had previously had a number of dealings with Mr Coe noticed nothing unusual about Mr Coe's behaviour and noted that he appeared calm. He did not consider Mr Coe was at risk of self harm.

Mr Coe was received into custody at the watch house at about 12.30pm. An intake interview and a pat down search were conducted with Mr Coe during which some of his clothing was removed and examined. A series of questions was asked relating to his physical and mental health. None of Mr Coe's answers gave the officer any cause for concern he might be at risk of self harm, nor was there anything in Mr Coe's demeanour to suggest this was likely. Mr Coe was then allocated to cell number seven.

The watch house manager was also present. He observed Mr Coe to be a compliant prisoner who displayed no indication of depression or of being drug affected.

The Queensland Police Service Operational Procedures Manual (QPSOPM) and the Bundaberg Watch House Standing Operating Procedures (SOP) stipulate that every prisoner must be personally inspected at intervals of not more than one hour. That log for the shift in which Mr Coe was first in custody indicates inspections were undertaken at the required intervals.

The next day, Mr Coe was transported to the Magistrates Court. The vehicle used to transport the prisoners was a Hi-Lux twin cab four wheel drive. The vehicle used to transport the prisoners to and from court was thoroughly searched before leaving the watch house and upon their return to the watch house from court. Nothing of interest was located.

At 1.49pm officers were collecting the lunch plates and saw Mr Coe hanging by a shirt secured in the space between the door and its jam.

Ambulance officers attended the watch house at about 1.56pm. Mr Coe was examined by the ambulance officers and found to have fixed and dilated pupils. He was unresponsive and could not be revived. He was transported to the Bundaberg Hospital where a life extinct certificate was issued.

A search of Mr Coe's cell located a suicide note on the wall written in soap in which he apologised for his actions, expressed his love of his partner and children and said a sad goodbye.

Steven John Pittaway was born on 17 December 1958. On 3 February 2004, police executed a search warrant on Mr Pittaway's residence at Gin Gin. They found a quantity of cannabis leaf, some 700 plants and numerous cannabis seeds. As a result, Mr Pittaway was charged with producing a dangerous drug and other drug offences. Police allege during the search Mr Pittaway resisted and obstructed their attempts to gain access to his motor vehicle and became violent. It was alleged he punched at least two officers to the face causing them injury. As a result he was charged with a number of simple offences and with two counts of assault occasioning bodily harm.

Several days later Mr Pittaway was again detained for questioning. During this procedure he became very distraught and invited police to shoot him. He said he was on a hunger strike and his life was over. Police took Mr Pittaway to the Bundaberg Mental Health Unit. He was assessed but deemed not in need of treatment and released. Nevertheless, as a result of this incident, a warning was placed on the QPS data base which indicated that Mr Pittaway may be suicidal.

On 6 December 2005, the charge arising from the allegation Mr Pittaway assaulted one of the officers involved in the search, went to trial in the District Court in Bundaberg. On 8 December 2005 the jury returned a verdict of guilty and Mr Pittaway was remanded in custody for sentencing later in the afternoon.

After the verdict Mr Pittaway was taken from the dock and moved to a holding cell adjacent to the courtroom. One of the two police officers acting as a court orderly gave him a pat down search and removed his shoes and belt.

At about 5pm Mr Pittaway returned to court for sentencing. A four month custodial sentence was imposed. Mr Pittaway was then taken to the Bundaberg Watch House.

The barrister who represented Mr Pittaway advised police he had no basis to suspect that Mr Pittaway was suicidal at any stage during his dealings with him.

Mr Pittaway was asked the standard questions outlined in the watch house custody register. These included questions relating to his mental health such as 'Do you suffer any mental problems?' to which Mr Pittaway answered 'Yes, depression.' He was also asked 'Are you currently seeing or have you ever seen a psychiatrist?' to which Mr Pittaway answered 'Yes, in Bundy years ago.' He denied ever attempting suicide, self harming or having suicidal thoughts in the previous three months. As a result of observing his demeanour and having regard to the answers detailed above, it was concluded no special precautions needed to be taken in relation to Mr Pittaway.

The QPSOPM requires an arresting or detaining officer to search the QPS data base, POLARIS, during the process of charging a prisoner. This is to allow information about threats the prisoner may pose or risks they may face when in the watch house that have previously been identified, to be brought to the attention of the watch house staff. On this occasion, neither the officers who brought Mr Pittaway to the watch house, nor the officers on duty there interrogated the system and so they were not aware of the entry referred to earlier. Both watch house officers gave evidence that had they been aware of the entry indicating Mr Pittaway may be at risk of suicide they may have more closely questioned him in relation to this.

The prisoner inspection log indicated that inspections were undertaken at 6pm, 7pm, 7.20pm 8pm 8.15pm, 9pm and 9.50pm. However the officers concerned conceded that unless one of them had reason to visit a cell, the inspections were in fact done by looking at the prisoners over the video monitors located behind the charge counter.



Mr Pittaway was found on the floor of his cell at 10.44pm with a cord around his neck and foot. Ambulance officers arrived at the scene and after examining Mr Pittaway it was agreed further resuscitation attempts would be futile and treatment was terminated at 10.52pm.

The State Coroner found that no person other than the two deceased men were directly responsible for or involved in the deaths.

The State Coroner made the following recommendations:

A prisoner's emotional state may change very significantly as a result of decisions made as part of the criminal justice processes. I recommend watch house staff be directed to have regard to the likely impact of such decisions and to re-assess a prisoner's risk of self harm whenever a negative impact can be anticipated.

I recommend the OPM be amended to make clear the responsibility of watch house staff to check all relevant indices when a prisoner is sentenced and comes into the watch house after having been on bail.

I recommend the requirement to inspect prisoners contained in the OPM be reviewed in light of the Bundaberg Watch House Manager's concerns to determine whether they should be amended or enforced. If it is determined the policy should be maintained all other watch house managers should also be reminded of the requirements.

I recommend the QPS make the necessary modifications to eliminate the hanging points from the cell doors in the Bundaberg Watch House.

Deputy State Coroner

Mulrunji

On 19 November 2004, a man known by his tribal name, Mulrunji, was arrested and charged with the offence of public nuisance.

Mulrunji was transported to the police station and placed on the floor in a cell. At approximately 11.23am the cell was checked and he was found to have no pulse. An ambulance was called. The ambulance officer arrived and upon examination confirmed Mulrunji was in fact deceased.

The State Coroner, the Crime and Misconduct Commission and the Ethical Standards Command of the Queensland Police Service were immediately notified. A police investigation was undertaken.

The original autopsy examination of Mulrunji's body was performed by forensic pathologist, Dr Guy Lampe. This occurred on 23 November 2004 at the Cairns Base Hospital mortuary. A second autopsy was performed in Brisbane on 30 November 2004 by Associate Professor David Ranson. Professor Anthony Ansford and Dr Byron Collins were also in attendance together with Dr Guy Lampe.

Both autopsies concluded the cause of death was intra-abdominal haemorrhage, due to the ruptured liver and portal vein.

An inquest was held over 21 sitting days and 51 witnesses were heard.

The Deputy State Coroner made 40 recommendations relating to:

- arrest and policing
- diversionary centres and community patrols
- assessment and monitoring of health
- supervision, monitoring and care in custody, and
- amendments to the Operational Procedures Manual (OPM) of the Queensland Police Service regarding investigations.

Coroner Tonkin

Jodie Maree DAVIS

Jodie was born on 5 April 1977 and was aged 24 when she died.

Prior to her imprisonment in 2002, Jodie had made several attempts on her life. A psychiatrist had diagnosed her as suffering from oppositional defiant disorder and evolving borderline personality disorder.

On 21 February 2002 she was sentenced to three years imprisonment and no recommendation was made for early parole.

On admission to the watch house that day she attempted to hang herself and was admitted to Townsville Hospital. She was admitted straight to the crisis support unit at the Townsville Correctional Centre where she stayed for her first 24 days in custody. This was followed by no less than four episodes of either self-mutilation or attempted suicide involving attempted strangling and cutting her wrists.

On 30 May 2002, Jodie was discovered by another prisoner at 6.35pm hanging by a sheet from bars covering the louvres in the shower cubicle in her cell. A plastic chair had been used by her and kicked aside.

Ambulance officers arrived at 6.54pm. A pulse was restored and she was taken to hospital at 7.16pm by ambulance. She was unable to be revived and her life support was switched off in consultation with her family and life pronounced extinct at 10.45am on 1 June 2002.

Coroner Tonkin made 12 recommendations by way of rider relating to:

- accessibility of medical files and sentencing remarks to prison psychological staff
- reviewing of operational procedures at the prison in consultation with the senior psychologist
- funded training

- incentives be devised to attract and retain experienced psychological professionals at the prison
- the development of protocols with Queensland Ambulance
- increased contact by counselling professionals with next of kin and regular visitors
- nursing staff at correctional centres be provided with the opportunity to shadow emergency workers
- that obvious hanging points, including bars, be immediately retro fitted with alternative security to reduce obvious opportunities for hanging.

Coroner Tonkin noted in conclusion that section 21 of the *Corrective Services Act 2006* now compels a prisoner to submit to medical examination or treatment by a doctor if the doctor considers the prisoner requires medical attention. This appears now to provide the power to mandate the taking of medication which was a significant issue in the management of Jodie Davis.

Inquests of public interest

State Coroner

Palace Backpackers Hostel Fire

In 2000 the Palace Backpackers Hostel was operated as a working hostel rather than a holiday hostel. Most backpackers were employed as fruit pickers on various farms within the Childers district and would often stay for lengthy periods.

The hostel was mainly fitted out with bunk style bedding constructed of pine and high-density foam mattresses. The bunks were stacked double and sometimes triple.

At the time of the fire, the maximum occupancy was approximately 101 people based on 99 beds. On the evening of 22 June 2000, 88 people were accommodated at the hostel.



Shortly after midnight, several backpackers were awoken by the sounds of banging noises and breaking glass. All attempts were made to vacate the building which by this time was filled with smoke. Of the 88 occupants, 73 managed to escape the fire.

The first fire crew arrived on the scene at 12.38am.

The Disaster Victim Identification Squad was dispatched from Brisbane. The role of the squad is to attend at major incidents, accidents, air disasters and natural disasters and to remove the remains of victims of such events and coordinate the reconciliation process which is used to facilitate positive identification of the deceased people. The remains were transported to the John Tonge Centre, Kessels Road, Coopers Plains. Autopsy examinations were conducted on 28 and 29 June by Professor Ansford, Associate Professors Naylor and Williams, and Dr Sinton. Autopsy examinations indicated that the cause of death for all deceased was smoke inhalation due to fire.

Mr Long, a resident of the hostel at the time of the fire appeared in the Bundaberg Magistrates Court on 18 August 2000 charged with the murder of two of the hostel residents, sisters Kelly and Stacey Slarke, in addition to the arson of the hostel.

On 15 March 2002 Mr Long was found guilty on all charges. He was subsequently sentenced by His Honour Justice Dutney on 18 March 2002 to life imprisonment for the murders of Kelly and Stacey Slarke, with a nonparole recommendation of 20 years, and to 15 years imprisonment for the arson of the Palace Backpackers Hostel.

The State Coroner found no other person should be committed to stand trial in connection with the deaths.

Sparka Isarva HUNTINGTON aka James Philip Huntington

On 14 December 2003, Mr Huntington was an involuntary patient in the mental health unit of the Logan Hospital. As a result of being perceived to be a threat to the safety of staff and other patients, it was decided to place him in a seclusion room until the medication that was to be administered sufficiently sedated him. Mr Huntington resisted efforts to move him and a violent struggle with hospital security officers and nurses ensued. Police were called to assist. Soon after one of the officers handcuffed Mr Huntington, it became apparent he was unconscious. Efforts to revive him failed and Mr Huntington died.

An autopsy was performed by Doctor Nathan Milne on 16 December 2003. Of particular significance, he noted that Mr Huntington had 90 per cent blockage of his coronary arteries that would predispose him to a myocardial infarction or an arrhythmia. Neither would leave evidence detectable at autopsy.

Dr Milne concluded that coronary atherosclerosis leading to arrhythmia were the most likely cause of death. However, Dr Milne noted that death may have been precipitated or contributed to by the struggle where asphyxia may have been a contributing factor.

The cause of death was therefore undetermined.

The State Coroner made the following recommendations:

- as a matter of urgency Queensland Health develop an electronic database to enable clinicians to instantly access medical records of mental health patients who have been treated at any public health service throughout the state

- the Director of Mental Health mandate a policy that stipulates patients on forensic orders who abscond are automatically to be held in high-secure or medium-secure wards when they are returned to the responsible mental health facility until their risk of further flight can be assessed.
- as a matter of priority all mental health nursing staff and any security officers who may be called on to assist them undertake the aggressive behaviour management course or any other more appropriate course the department chooses to develop. I also recommend that the holding of an appropriate competency based qualification be a pre-condition to employment as a security officer in a hospital
- pending the achievement of a quality of care that enables mental health patients to be managed without resort to physical restraint, Queensland Health evaluate the use of soft ties to assist in restraining violent patients.

Deputy State Coroner

Fiona Jane DEE

Mrs Dee was 32 years old, fit and healthy when she entered Sunnybank Hospital on 7 March 2005 to deliver her second child. Mrs Dee delivered by caesarean section with a spinal block anaesthetic.

The following day she complained of headache, mainly when she was sitting up. Later, on the afternoon of 8 March 2005, Mrs Dee suffered what appeared to be a seizure and became unconscious. She was taken to intensive care and questions were asked to check whether there had been any previous traumatic injury. There was no history of such an injury or any previous incidence of seizures.

A CT scan revealed a subdural haematoma on 9 March 2005. The doctors in intensive care called on the expertise of the neurologist Dr Michael Coroneos to check the CT scan. Dr Coroneos advised that no operation was necessary. On 13 March Mrs Dee was still suffering from headaches. Mr Dee recalled that Dr Coroneos' opinion was that the bleed was not large enough to warrant an operation.

Mrs Dee continued to suffer from headaches. She was discharged home on 18 March 2005. On 24 March Mr Dee contacted Dr Coroneos concerned that his wife was still suffering from headaches. Dr Coroneos told Mr Dee to continue with the current treatment of rest and pain relief. Later that same day, at 9.59 in the evening Mr Dee rang the Sunnybank Hospital and spoke with someone from the intensive care ward. Mr Dee was concerned because the headaches were getting worse. Mr Dee was told to follow his doctor's advice.

The next day, on 27 March Mrs Dee appeared to have a seizure and Mr Dee's sister called the ambulance. She was transported to the Wesley Hospital. Mrs Dee had suffered a seizure and was deeply unconscious with a Glasgow coma scale 3 recorded by the ambulance officers. On arrival at the Wesley Hospital she suffered an episode of ventricular tachycardia. She was deeply unconscious with large fixed dilated pupils. ACT scan showed a right parietal subdural haematoma between one and one and a half centimetres depth with midline shift. She had suffered another seizure and had stopped breathing, requiring intubation.

The previously diagnosed subdural haematoma had enlarged slightly and progressed causing midline shift. Hyponatremia was also diagnosed as well as a further episode of tachycardia. She was suffering irreversible hypoxic injury to her brain which was swollen causing raised intracranial pressure and the herniation of her brain into the spinal column.



Her condition was irretrievable and she died on 28 March 2005. The cause of death was hypoxic brain injury due to a combination of factors arising from subdural haematoma. Those factors included hyponatremia, cerebrospinal leak and epileptic seizure arising from spinal anaesthesia administered for a caesarean section procedure.

The Deputy State Coroner commented 'there are opportunities for greater knowledge sharing which may help overall to prevent other tragedies. In the course of evidence medical experts referred to "the literature" meaning articles written documenting unusual case history aimed to inform specialty practice. There have certainly been many reviews of Fiona Dee's history and opinions expressed but the opportunity may well remain for a proper review once some time has passed to enable impartial, scholarly review. With hindsight there are opportunities for reflection on whether there was an optimum holistic team involvement in Mrs Dee's care.

A review of the history might better inform the anaesthetist that this was a complex problem involving both post dural and subdural haematoma headaches. The rarity of these coalescing conditions called out for more collegiate discussion between the team at Sunnybank Hospital and also other neurological input.'

Coroner McLaughlin

Lillian Margaret SHAW

Mrs Shaw had a long history of health related problems and had been a patient of the Lowood Medical Centre since at least June 2000. She had seen a number of doctors at the medical centre over the years. She was a 67 year old woman who was 164cm in height and weighed 86kg, placing her in the severely obese range. She had been prescribed some medications to help with weight loss. She had been diagnosed as having a large hiatus hernia, which it seems, was left untreated.

She had for years also suffered from back and hip pain and as a result, over time, had been prescribed a range of non-steroidal anti-inflammatory drugs including piroxicam (Feldene), celecoxib (Celebrex) and meloxicam (Mobic), with the last prescription being written on 25 October 2004 for Celebrex. Additionally, she had been diagnosed as suffering gastroesophageal reflux disease.

On Wednesday 12 January Mrs Shaw's condition had worsened and she was vomiting. Her husband, Ian Shaw, arranged for a doctor from the Lowood Medical Centre to make a home visit and as a result Dr Jaideep Bali attended the residence that afternoon. Mrs Shaw was given an intramuscular injection of tramadol (Maxalon) to control the vomiting. Although several other doctors from the Lowood Medical Centre had previously seen Mrs Shaw, Dr Bali had only seen her once before, on 15th April 2004, in relation to back and neck pain.

Dr Jaideep Bali is a medical practitioner employed at Lowood Medical Centre. He holds the qualifications of MB BS and Master of Surgery from Punjab University in India. He is registered to practice in Queensland in an 'area of need' pursuant to s. 135 of the *Medical Practitioners Registration Act 2001*. The relevant Medical Practitioners Register kept by the Office of Health Practitioner Registration Board (Queensland Government) shows his registration category under s. 135 to be:

'Special Purpose Activity: To fill an area of need in rural general practice at Lowood Medical Centre and Fernvale Medical Centre.'

On the morning of Thursday 13 January her condition had not improved and she was vomiting, distressed and suffering abdominal pain. Dr Bali was again requested by Mr Shaw to make a home visit. He arrived late in the morning and administered a further injection of Maxalon as well as an intramuscular injection of Pethedine to alleviate pain. Later that day there was still no improvement in her condition and Dr Bali was again requested to visit her. Before attending this third time, Dr Bali issued a prescription in the name of Mr Shaw for Ranitidine in oral form and for Maxalon in ampule form for injecting, apparently because the medical centre had no stocks of either drug left. Mr Shaw collected the drugs from a chemist.

Dr Bali arrived at about 4.30pm and administered a third injection of Maxalon from the drugs obtained by Mr Shaw. He also administered an intramuscular injection of Morphine from drugs he had brought with him from the medical centre, this drug being given for pain relief from the continuing abdominal pain. The Ranitidine was intended to reduce reflux or peptic ulcer symptoms, and was to be given orally that night.

A little after 7pm that evening Mr Shaw found Mrs Shaw kneeling on the floor at the head of her bed with her head resting on the bed. Upon checking her he found her to be cold and with her eyes open and fixed. There was no sign of life and he therefore made an emergency call for an ambulance. He commenced attempts at CPR while waiting for the ambulance. The ambulance arrived about 20 minutes later and also attempted resuscitation, without success.

An autopsy was carried out on 14th January by Dr Nathan Milne, a pathologist at the John Tonge Centre. After considering his own findings along with the blood analysis, Dr Milne concluded in his report:

'In my opinion, the most likely cause of death is a perforated gastric ulcer. This is consistent with the history of abdominal pain.....Another potential cause of death is Morphine toxicity. It is difficult to interpret the significance of the blood Morphine concentration. Although it falls within the potentially fatal range, this does not mean it causes death in all cases. Although this cannot be completely excluded as a cause of death, the history and post mortem findings are more in keeping with death from a perforated gastric ulcer.'

Opinions were obtained from two independent medical specialists.

Dr Graeme Macdonald, Ph D, FRACP is registered as a Medical Specialist and is the Director of the Department of Gastroenterology and Hepatology at the Princess Alexandra Hospital, Brisbane.

The second specialist was Dr Peter Pillans, Associate Professor, registered Medical Specialist and Director of Pharmacology at Princess Alexandra Hospital, Brisbane.

Both provided a written report and also gave evidence at the inquest.

Coroner McLaughlin found there was no reason to depart from the finding of Dr Milne that the primary cause of death was a perforated gastric ulcer. Dr Macdonald specifically agreed with this proposition. Dr Pillans did not put the matter any higher than saying that the administration of Morphine was probably a "significant contributor" to Mrs Shaw's death and that it caused her condition to deteriorate more rapidly.



Coroner McLaughlin made the following comments:

- in relation to the use of Pethedine or Morphine. While there is a register kept of such drugs showing the date of removal from storage, the quantity of drug, and the patient's name, there is no record kept of what becomes of any unused portion of those drugs. Such a register should also indicate what amount of the drug was actually administered to the patient, and if there is any amount remaining, what became of that surplus
- medical practitioners registered pursuant to s. 135 of the *Medical Practitioners Registration Act 2001* need to be adequately supervised given their qualifications are from non accredited institutions. Protocols need to be put in place not only specifying in detail what level of supervision is needed, but also a system of monitoring or verifying what supervision is in fact being given. A periodic review of their performance must also be made if there is to be any assurance that the supervision is achieving what is intended
- a protocol needs to be put in place to ensure that a subsequent medical practitioner is aware of treatment recently given by a previous practitioner, particularly where the first practitioner is aware the patient is so unwell they are likely to soon be admitted to hospital, and the first practitioner has administered drugs which the hospital should be aware of
- the public is entitled to be informed as to the status of a medical practitioner's right to practice. People registered to practice under s. 135 of the *Medical Practitioners Registration Act 2001* should be required to inform patients of this fact so the patient may make an informed choice.

Recommendations from inquests examining mental health issues

During the reporting period 10 inquests were held regarding deaths which involved a range of mental health issues. Recommendations made as a result of these inquests are summarised below.

Deputy State Coroner

Matthew John LIDDELL

Matthew John Liddell was born on 18 September 1974. At about 1.05 am on Sunday 23 November 2003, he was found by a nurse in the bathroom of his room at the Toowong Private Hospital, where he was a patient receiving treatment for a mental illness, with a ligature made of a shoelace around his neck and connected to a shower tap.

Nursing staff immediately rendered medical assistance until the ambulance arrived at 1.23 am. Medical assistance then continued by ambulance officers together with nursing staff and an intensive care paramedic who arrived shortly after the ambulance officers.

Mr Liddell was transported to the Royal Brisbane Hospital and arrived there at 2.04 am on 23 November 2003. He was placed in intensive care and was ventilated until 11.15 am on Monday 24 November 2003 when life support was discontinued. A certificate was issued stating that life was extinct at 11.33 am on 24 November 2003.

The Deputy State Coroner noted:

- the review and consideration given by the Toowong Hospital after Matthew's death particularly, the improvement in communication between family carers and hospital carers. The hospital had introduced a report to be completed by family carers after a patient is returned to hospital after leave

- that open and continuing communication between the family and friends of a person suffering depression and the risk of suicide, with the doctors and nurse involved in their care is essential to achieve optimal support and treatment
- that while it might seem that hospitals could improve physical safety for patients at risk by more onerous restrictions on personal items with which they might cause themselves harm, the reality is it is impossible to remove all items and change the physical environment to eliminate all risk of suicide.

Graeme William Julian EADY

Graeme Eady was born on 9 October 1978. Although he had a history of feeling depressed, he did not have formal treatment for a psychiatric condition until July 2003 when he was diagnosed with a major depressive disorder. He was then treated as an outpatient until a suicide attempt on 24 September 2003 when he was admitted as an inpatient to G Floor of the Mental Health Unit at the Royal Brisbane and Women's Hospital. His mental state appeared to stabilise initially and then worsen. On 11 October 2003, he was transferred to H Floor of the Mental Health Unit. On 13 October 2003, a decision was made to place him under an involuntary treatment order. On the afternoon of 15 October 2003 he was found unconscious, after apparently placing a plastic bag over his head, in the bathroom of his room. After efforts were made to resuscitate him, he was transferred to the Emergency Department and later that day, to the Princess Alexandra Hospital but did not recover, and died four days later after his life support was ceased.

The Deputy State Coroner recommended:

Queensland Health consider the introduction of statewide guidelines regarding the carrying out of intermittent visual observations of patients in mental health facilities in order to establish a clear and unambiguous written procedure directing:

- the manner in which observations are to be performed
- the nurse or nurses who are responsible for carrying out the observations
- how the observations are to be documented and recorded.

Such guidelines could be tailored to meet the specific requirements of individual hospitals but should aim to increase uniformity of observation practice and compliance with it. Compliance with policy and procedures should be audited regularly.

Mental Health Patient

The patient was a self employed farmer. He was born in 1934 and died on 23 July 2005 at the age of 71 years. The patient was suffering severe depression and had been admitted to Belmont Hospital from Greenslopes Hospital on 18 July 2005. These admissions followed an episode of overdose of medication. It was not definitively clarified whether or not the overdose was inadvertent or an attempt at suicide. It was for this reason that he was admitted to Belmont Hospital under the care of his existing psychiatrist, Dr Dodds for assessment and treatment.

At about 5.10am on 22 July 2005, the patient was discovered unconscious hanging from the shower rail in the ensuite. A rope that had been in his possession on his admission to hospital had been used by him. The rope was for the purpose of physiotherapy rehabilitation after shoulder surgery. He was resuscitated and transferred to Princess Alexandra Hospital. He died the next day.



The Deputy State Coroner recommended:

- feedback for reflection and learning be provided to all who were involved in the patient's admission
- changes to the Belmont Hospital policies and procedures be considered
- training and resources be provided and compliance measured via audit. These measures should alert administration of any need for further discussion or training to ensure that checklists have been completed
- that a further audit for any hanging points be considered, and
- hospital records be maintained in a timely, detailed and accurate manner to enable proper care to be provided.

Coroner Previtera

Barlow, Lusk and Baggott

Charles Barlow was a 36 year old Indigenous man who had lived a troubled life in the Indigenous community of Yarrabah in Far North Queensland. He had significant mental health and other admissions since he was a child of four years of age. He had previously attempted suicide. He died in Yarrabah in February 2004.

Patrick Douglas Lusk was a 66 year old father of two young boys at the time of his death by suicide in Cooktown in April 2005. He had been referred to the Cooktown Hospital by his general practitioner specifically for admission, treatment and opinion. He had also previously attempted suicide.

Emily Jane Baggott was 16 years old at the time of her death in Kuranda in October 2005. She had only been released from a mental health unit in Kempsey in late August 2005, where she had been an inpatient for a significant period as a result of self-harming behaviour, against a background of mental illness and her significant life issues.

In none of the three cases was the mental health system able to contain their respective suicide ideations.

Coroner Previtera made the recommendations detailed below.

Implementation of mental health policy and service reform

1. Queensland Health, as a matter of priority, to actively implement the strategies for reducing suicide and deliberate self-harm in mental health services and related health service settings; as outlined in the National Safety Priorities in Mental Health: A National Plan for Reducing Harm, October 2005.
2. Queensland Health, as a matter of priority, to actively implement the National Practice Standards for the Mental Health Workforce and the National Practice Standards for Mental Health Services.
3. Queensland Health, as a matter of priority, to actively implement the reforms of the National and Queensland Action Plans on Mental Health 2006-2011.
4. Queensland Health to actively implement the recommendations from the Public Advocate's annual reports to the Queensland Parliament 2003-04 and 2004-05 and give consideration to the involvement of the Office of the Public Advocate in relation to such implementation.
5. Queensland Health, as a matter of priority, to actively implement the Queensland Health Guidelines for the management of patients with suicidal behaviour or risk

6. Queensland Health to accelerate the implementation of key recommendations one, two, four, five and eight of the *Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events*.
7. The Director of Mental Health and the corporate office of the Mental Health Branch, consistent with the Director's functions under the *Mental Health Act 2000* to be given both the mandate and the resources to:
 - provide the necessary leadership and guidance to support district mental health services in implementing the national safety priorities, the National Practice Standards, the national and Queensland action plans and the recommendations of the Public Advocate's annual reports; and in accelerating implementation of key recommendations one, two, four, five and eight of the *Achieving Balance: Report of the Queensland Review of Fatal Mental health Sentinel Events* and the recommendations from the Public Advocate's reports referred to above
 - develop and implement statewide policy and frameworks in relation to the implementation of the recommendations raised in the Issues Paper of the Public Advocate in relation to assessments, access to information, carers and network support, liaison with general practitioners, discharge planning, supports in the community, indigenous mental health and broader systemic issues; and consider the involvement of the Public Advocate
 - develop and implement statewide policy and frameworks in relation to other recommendations made as a result of this inquest
 - monitor, review and report on the districts' implementation of each of these reforms, or create an independent mechanism for this review to occur.
8. With respect to district mental health services:
 - local policies to be developed to implement the above-mentioned strategies, national practice standards, action plans and recommendations, taking into account local circumstances, service demand and capacity
 - operational procedures and clinical guidelines to be developed to enable staff to put these policies into practice
 - a strategy for the active and ongoing implementation of these policies, procedures and guidelines to be created, to include a training regime which will target all staff, whether new or existing, (including psychiatrists, nurses and allied health) and whether fulltime, part-time, temporary, casual or relieving staff. Area and district management should demonstrate their active support for this process
 - executive directors of district mental health services to be accountable to their area directors for the implementation of (a)-(c) above
 - area directors to actively monitor their districts' implementation of (a)-(c) above
 - area general managers to be accountable for implementation of policy and service reform as well as assessment of the knowledge of, and competency in, mental health procedures/policies of their staff in their areas; and consideration be given to the involvement of the Director of Mental Health, with the Director-General of Health, in any process ensuring that area general managers deliver on their accountability



9. With respect to implementing the reform agenda of the 2005 Queensland Health Systems Review (i.e. the 'Forster' review):

- consideration to be given to the importance of flexibility in the progress of policy and service reform at the local level by Queensland Health area general managers, district executive directors and clinical directors
- the impact of the current Queensland Health reform process on patient outcomes in mental health to be closely scrutinised over a period of time, to ensure that an appropriate balance has been reached between central office control and regional independence in decision-making.

Mental health/suicide risk assessment

10. In addition to the recommendations contained within the Issues Paper of the Office of the Public Advocate:

- the statewide Clinical Risk Assessment and Management Training Project Training package to be made available to all mental health professionals, including life promotion officers, throughout Queensland, whether new or existing, full-time, part-time, temporary, casual or relieving; and that Queensland Health provide the necessary funding, to include funding for performance management of staff which will identify and correct gaps in competencies; and recurrent funding for ongoing training.

11. Where there is no mental health unit attached to a health service at which patients are likely to present for mental health problems:

- if the health service has a mental health team/worker, patients should be properly assessed by this team/worker at the earliest opportunity, and particularly before they are discharged; or

- if there is no mental health team/worker at the health service, the health service should establish a formal protocol with the nearest mental health service/team/worker to ensure the proper assessment and treatment of such patients.
- wherever possible, two mental health workers are to complete a mental health risk assessment, and in the event of any difference of opinion, a consultant psychiatrist is to review the assessment.

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

13. Queensland Health to develop and implement a guideline for use by mental health workers, of the National Institute for Health and Clinical Excellence Quick Reference Guide for Depression in Children and Young People; Identification and Management in Primary, Community and Secondary Care.

14. Queensland Health to develop and implement guidelines in relation to the use of Selective Serotonin Reuptake Inhibitors for young people with a mental illness.

15. The Queensland Government Suicide Prevention Strategy 2003–08 to be revised to include reference to the need for frameworks/guidelines to assess suicide risk.

Access to information

16. In addition to the recommendations contained in the Issues Paper of the Office of the Public Advocate:
- the Director of Mental Health to accelerate the implementation of a statewide electronic network of patient information that allows treating health professionals, including both inpatient and community staff, to rapidly access patient data throughout the state; and that Queensland Health provide the necessary funding as a matter of priority
 - Queensland Health to review the provisions of the *Health Services Act 1991* Queensland as they relate to the disclosure of confidential information. Queensland Health implement such changes as will remove any doubt that the confidentiality of information relating to a person receiving a health service is balanced with the duty of care to that person, the rights of the public to protection against the risk of harm, the rights of carers and support networks to meet their responsibilities to the person and other members of the household
 - Queensland Health to develop, implement and provide training in, statewide guidelines defining the issues of confidentiality of mental health as they affect clients and their families and making clear to all mental health workers the circumstances in which it is appropriate for mental health staff to share information regarding the person
 - the requirement in s. 62I *Health Services Act* to have the authority of the chief executive in writing for a disclosure to be made of confidential information that is necessary to assist in averting a serious risk to the life, health or safety of a person, including a person to whom the confidential information relates; or public safety, should be removed.

General practitioner liaison/support

17. In addition to the recommendations contained in the Issues Paper of the Office of the Public Advocate:
- consideration to be given to establishing a regular formal minuted meeting between the public and private sector medical staff that facilitates frank discussion of problems experienced from both perspectives and generates workable action plans to resolve identified difficulties.

Supports in the community

18. In addition to the recommendations contained in the Issues Paper of the Office of the Public Advocate:
- the Queensland Government to increase funding to a range of community-based services to assist both adults and children with mental health problems, in Yarrabah, Cooktown and the Cairns Integrated Mental Health Service Clinical Network. This should include both clinical and non-clinical services, and both generic and mental health-specific services, in addition to nurses, allied health workers, psychiatrists, psychiatry registrars and Indigenous mental health workers and life promotion officers.
19. The Queensland Government to ensure that:
- priorities include both clinical and non-clinical support (given that many people with a mental illness also require support with housing, substance abuse and employment) and specific high-needs sub-groups receive equitable access to support (in particular, Indigenous people and people living in rural/remote areas)



- Queensland Health to identify, develop and fund community-based and culturally-appropriate alternatives to acute inpatient admission in the Cairns District Health Service area, specifically for those patients for whom inpatient care is unnecessary or contraindicated, but who still require some support
- Queensland Health to invest in programs of intensive post-discharge support for patients in the Cairns District Health Service Area who have presented with suicide ideation or who have been assessed at risk of suicide or self harm.

Indigenous mental health

20. In addition to the recommendations contained within the Issues Paper of the Office of the Public Advocate:
- Queensland Health, as a matter of priority, to implement the Protocols for the Delivery of Mental Health Services in Far North Queensland Indigenous Communities: Guidelines for Health Workers, Clinicians, Consumers and Carers
 - Queensland Health, in conducting ongoing research into Indigenous peoples' understanding of behaviour generally, particularly mental illness and suicide, to give consideration to the involvement of Dr Ernest Hunter in the formulation and implementation of policy guided by such research.

Recommendations specific to the Yarrabah community

21. Queensland Health to provide funding for the extension of the Dual Diagnosis Mental Health/Substance Abuse Program in Cairns to Yarrabah to facilitate the entry of dual diagnosis Indigenous clients into existing Substance Rehabilitation Programs at Yarrabah and the Cairns District.

22. Queensland Health to provide funding for the provision of a detoxification program in Yarrabah to accommodate the needs of chronically dependent and relapsing heavy drinkers.
23. Alternatively, that Queensland Health to restore in-patient capacity to the Yarrabah Hospital to allow for brief periods of observation, management of detoxification, short-term management of patients at risk of harm to self or others, or until safe transport to Cairns Hospital is available.
24. Queensland Health to provide funding to the culturally specific mental health programs outlined in the Queensland Mental Health Plan. In the interim, urgent consideration should be given to funding non-clinical support and housing for Indigenous Australians with mental illness in the Cairns Mental Health District.
25. Resources to be made available for the establishment within the Cairns Mental Health Network of an Indigenous Specific Community Mental Health Rehabilitation and Recovery Service (modelled on the new Cairns FIRRST—Far North Queensland Intensive Rehabilitation and Recovery Support Service).
26. Queensland Health to develop a job description for life promotion officers and include life promotion officers in all training and assessment provided to mental health workers throughout Queensland.

Recommendations specific to the Cooktown community

27. Queensland Health to establish a formal protocol between Cooktown Mental Health Service and the Cairns District Mental Health Service to ensure that any patient admitted to the Cooktown Hospital for mental health assessment and treatment, unless transferred to Cairns for ongoing treatment, should be discussed with the psychiatrist on-call for rural and remote mental health prior to discharge.

28. The executive of Cooktown Hospital, together with the executive of the Cairns Health District Service to:
- identify and reduce barriers to onsite training
 - support both nursing staff and medical officers to attend local training opportunities
 - facilitate the attendance of all mental health staff at Cairns Base Hospital medical and nursing in-services, either personally, by video link or by pre-recording
 - implement processes to enable staff to access relevant protocols during work time, and
 - set up a system of peer supervision/ support.
29. The Memorandum of Understanding being developed by the Cairns District Health Service Remote Team, which details the service delivery interaction between the district mental health teams and the Remote Area Mental Health Team based in Cairns, to be completed and signed off by the district and remote team.
30. Position descriptions for rural and remote practitioners need to indicate that competency in mental health is essential and needs to be of the standard demanded by the Australian Medical Council and Australian Medical Schools. Position descriptions should indicate that extension training in mental health is desirable. Practitioners should be encouraged to complete the Royal Australian College of General Practitioners Level One Mental Health Skills Training or an equivalent qualification prior to taking up a position in a rural or remote Queensland Health Service.
31. The Cairns District Health Service and the executive of the Cooktown Hospital to develop and implement a policy guideline to ensure that patients of the Cooktown Inpatient Unit need to be able to identify a primary nurse assigned to their care. That nurse needs to be fully appraised of their responsibilities towards an individual patient.
32. The Cooktown Hospital staff to review their complaints procedure to ensure complaints are advanced to the relevant parties as soon as possible and actioned in a timely manner.
33. Remote Area Nursing Incentive Package (RANIP) conditions to be available to nursing staff in Cooktown in an attempt to attract permanent staff, through providing increased remuneration, accommodation and other education benefits.
34. Alternatively, Queensland Health to consider funding nursing positions in Cooktown on a basis which would offer nursing staff the alternative to fly in and out from Cairns so as to increase the chances of obtaining more permanent positions in Cooktown.
35. Cairns District Mental Health Service to review its partnerships with Queensland Ambulance, Queensland Police and the Royal Flying Doctor Service to establish protocols for the safe transport of mentally ill people from remote and rural locations such as Cooktown who need specialist services in Cairns.
36. The Cairns District Mental Health Service to review any real or perceived barriers to providing inpatient beds for patients from Cooktown and surrounding districts.



37. Consideration to be given to increasing the number of acute mental health inpatient beds at the Cairns Base Hospital to five to meet existing and projected needs.
 38. Queensland Health to provide funding for adequate nursing staff numbers at the Cooktown Hospital and community mental health worker positions at the Cooktown Community Health Centre.
 39. The hospital at Cooktown to be urgently refurbished or redeveloped so as to provide one room within it that is properly configured to adequately house patients at risk and contain those at risk of harming others.
 40. Consideration to be given to creating one or more medical positions to be managed by a large regional service (e.g. Cairns) and to provide a fly in, fly out service to relieve medical staff.
 41. The Queensland Medical Board and the Royal Australian and New Zealand College of Psychiatrists should consider streamlining their processes of assessments of competency and recognition of overseas trained psychiatrists to ensure that such applications can be processed in a timely manner.
 42. The Cooktown Hospital administration to review the process for the collection and dissemination to important stakeholders of Queensland Health statewide initiatives, particularly those that relate to clinical practice and patient safety.
 43. Formal lines of reporting responsibility to be established between mental health district staff and psychiatrists/team leaders in Cairns Integrated Mental Health.
 44. The Cooktown Hospital administration to review the process for the distribution of the recommendations of Sentinel Event Reviews and other relevant Queensland Health initiatives to those responsible for the implementation of the recommendations.
 45. The executive of the Cooktown Hospital to formulate and publish to all staff, whether new or existing, full-time, part-time, casual, temporary or relieving, an orientation manual that identifies local issues and procedures; and provide formal orientation and induction training for all staff.
 46. Queensland Health and the executive of the Cooktown Hospital to develop and implement policies /guidelines to give immediate effect to the recommendations of the Sentinel Event Team Report dated 25 May 2005, in the matter of Patrick Douglas Lusk.
 47. Queensland Health to provide funding, including recurrent funding, for the training and education referred to in that report, such training to be provided to all health staff, whether full-time, part-time, casual temporary or relieving.
- ### Coronial inquiries—dissemination of recommendations
48. The Queensland Health Patient Safety Centre to remain the point of contact for the receipt of all coronial findings and recommendations.
 49. The Queensland Health Patient Safety Centre to be mandated to consistently provide all coronial findings and recommendations to Area Health Service Clinical Governance Units in each of the health districts so that relevant systemic improvements can be made.
 50. Area Health Service Clinical Governance Units in each of the health districts to effectively communicate coronial findings and recommendations to all mental health professionals within the particular area; and provide information and reasons to clinical directors about what recommendations are to be actioned and what recommendations are not to be actioned.



Appendices

Appendix 1

Operating expenses	1/7/06 to 30/6/07
Employee related expenses	\$ 1,087,051.16
Supplies and services	\$ 911,107.30
Burials and cremations	\$ 862,439.05
Conveyance of human remains	\$ 1,173,650.09
Post mortem fees	\$ 738,065.59
Counsel fees	\$ 215,478.04
Travel	\$ 69,458.74
Conferences	\$ 931.75
Total	\$ 5,058,181.72



Appendix 2

Number of coronial cases lodged and finalised in the 2006-07 financial year and the number of cases pending as at 30 June 2007

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 to months old	Greater than 24 months old	Total
Atherton	26	-	23	23	12	2	1	15
Aurukun	-	-	1	1	-	-	1	1
Beenleigh	179	2	146	148	122	21	12	155
Bowen	9	-	4	4	8	2	-	10
Brisbane	1,039	14	1,047	1,061	504	106	63	673
Bundaberg	68	-	45	45	51	25	3	79
Caboolture	80	-	77	77	33	8	1	42
Cairns	180	3	144	147	98	9	4	111
Caloundra	55	-	52	52	20	5	-	25
Charleville	3	1	2	3	3	1	3	7
Chinchilla	-	-	1	1	-	-	-	-
Cloncurry	-	-	-	-	-	-	2	2
Cooktown	-	-	1	1	-	-	-	-
Cunnamulla	4	-	3	3	3	1	-	4
Dalby	32	1	30	31	16	5	3	24
Emerald	33	1	30	31	21	-	1	22
Gayndah	6	1	5	6	5	-	-	5
Gladstone	60	-	47	47	26	-	-	26
Gympie	35	3	20	23	19	4	2	25
Hervey Bay	40	-	38	38	14	4	-	18
Innisfail	29	4	20	24	17	2	3	22
Ipswich	118	3	106	109	62	12	2	76
Kingaroy	24	-	25	25	7	2	-	9
Kowanyama	-	-	-	-	-	-	1	1
Mackay	71	-	64	64	34	5	-	39
Mareeba	15	-	18	18	3	2	-	5
Maroochydore	123	8	121	129	47	7	7	61
Maryborough	23	-	21	21	10	-	1	11
Mitchell	2	-	-	-	2	4	-	6
Mossman	13	-	16	16	4	1	-	5
Mount Isa	51	-	38	38	32	9	2	43
Murgon	6	-	3	3	5	-	2	7
Nanango	2	-	6	6	1	-	-	1

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 to months old	Greater than 24 months old	Total
Oakey	1	-	-	-	1	-	-	1
Pittsworth	3	-	-	-	1	4	-	5
Proserpine	23	-	11	11	14	1	2	17
Redcliffe	39	-	53	53	12	2	2	16
Rockhampton	101	9	93	102	56	9	3	68
Roma	7	1	5	6	3	1	1	5
Southport	329	6	380	386	265	44	35	344
State Coroner	52	36	38	74	34	35	53	122
Thursday Island	-	-	5	5	-	1	-	1
Toogoolawah	3	-	-	-	3	-	1	4
Toowoomba	118	9	94	103	49	1	5	55
Townsville	184	6	170	176	97	28	7	132
Warwick	33	1	37	38	11	-	-	11
Total	3,219	109	3,040	3,149	1,725	363	223	2,311



Appendix 3

Presentations

State Coroner

Department of Emergency Services,
Command and Control Conference, *The Role
of the Coroner in a Mass Fatality Disaster*,
August 2006

Wesley Hospital ground rounds, *A Drug
Overdose Scenario—the Role of the Coroner*,
August 2006

HQCC, interaction between the Office and
the HQCC, *Identifying unsafe practices*,
December 2006

UQ graduate medicine course in pathology,
*The Role and Function of the Coroner
Autopsy in Sudden Death Investigation*,
January 2007

Department of Emergency Services,
Command and Control Conference, *The Role
of the Coroner in a Mass Fatality Disaster*,
February 2007

Mater Hospital Neonate Mortality Group,
*The Coroner's Role in Investigating
Peri-natal Deaths*, February 2007

Department of Emergency Services,
Command and Control Seminar, *The Role
of the State Coroner in a Mass Disaster*,
February 2007

Queensland Health Mental Health planning
workshop, *Lessons from Inquests for Mental
Health Services*, April 2007

QUT LWN151 Health Law, *The State's
Supervision of Death*, May 2007

Deputy State Coroner

The Deputy State Coroner made several
presentations to the major teaching
hospitals in the Brisbane area through this
reporting period.



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