QUEENSLAND COURTS

AUDAX AT FIDELIS

Coroners Court of Queensland

Annual report 2015–2016

QUEENSLAND COURTS

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20 January 2017

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

Dear Attorney-General

I enclose a report on the operation of the *Coroners Act 2003* for the period 1 July 2015 to 30 June 2016.

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

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

The Guidelines issued under section 14 of the Act are publicly available and can be accessed at coroners-court/fact-sheets-and-publications.

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

Yours sincerely

Terry Ryan
State Coroner

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State Coroner's Overview

I am pleased to present the Annual Report of the Coroners Court of Queensland, which provides an overview of the operation of the *Coroners Act 2003* during 2015–16.

At the outset I would like to extend my appreciation to all the dedicated individuals who provide quality services in the coronial system. Those who work within the Coroners Court of Queensland and in our partner agencies, particularly the Queensland Police Service and Queensland Health Forensic and Scientific Services, have all contributed to the success of the coronial system over the past 12 months. I particularly acknowledge those who work at the front line responding directly to families during times of crisis and bereavement, and keeping them informed of the coronial process.

The number of deaths reported to the Coroners Court continued to increase during the reporting period. There was a 6.55 per cent increase in the total number of deaths reported (5287 up from 4962). This is the highest number of deaths reported since the Coroners Act commenced. It represents an 11 per cent increase in the number of deaths reported since the Coroners Court last received additional judicial resources with the appointment of the Central Coroner on 9 August 2012.

Notwithstanding the increase in the number of deaths reported in 2015–16, coroners and the coronial registrar have worked diligently to achieve a clearance rate of 100.49 per cent.

The coronial registrar managed over 60 per cent of the deaths reported to coroners in the greater Brisbane, Sunshine Coast and South West Queensland reporting catchments. With the increasing number of deaths reported across the State, consideration should again be given to appointing a second registrar to extend the benefits achieved by the role in ensuring that deaths do not unnecessarily enter the coronial system, and less complex deaths are dealt with expeditiously.

Following the 2015 report of Special Taskforce on Domestic and Family Violence, the Queensland Government allocated additional funding to the CCoQ to enhance the Domestic and Family Violence Death Review Unit, and to support the establishment during 2016 of the Domestic and Family Violence Death Review and Advisory Board. Coroners have appreciated the very detailed analysis undertaken by the Unit in their investigations of domestic violence and child protection deaths.

In March 2016, the Public Advocate released the 'Upholding the right to life and health: a review of the deaths in care of people with disability in Queensland' report. Further to that report I have agreed to report annually on deaths in care, and agreed to establish an expert panel to review a sample of deaths of persons with intellectual and cognitive impairment to enable advice to be provided to coroners in relation to the particular health and support issues for this group.

Coroners continue to be concerned about the number of suicide deaths in Queensland. Our rate of suicide remains above the national average. The Queensland Suicide Prevention Action Plan 2015–17 was released in September 2015. An ambitious target of reducing suicide by 50 per cent within a decade has been established. As noted in last year's Annual Report, the Coroners Court remains committed to working with Government to identify strategies to systemically review suicide deaths in order to enhance coronial investigations and identify opportunities to prevent these deaths.

Demand for coronial services will continue to increase as the Queensland population increases and ages, and with greater awareness of reporting obligations under the *Coroners Act*. There is a pressing need to for all agencies involved in the coronial system to continue to identify options to meet the challenges posed by the increased demand for services, while at the same time ensuring that reportable deaths are appropriately investigated. I look forward to working with our partner agencies in ensuring the coronial system continues to operate efficiently and effectively.

The Queensland coronial system - a brief overview

Scope of the Queensland coronial jurisdiction

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

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

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

Recent years have seen a significant increase in demand for coronial services state-wide with reported deaths increasing from 3,514 in 2007–08 to 5,287 in 2015–16 – a 50.45 per cent increase in deaths reported. This increase is a result of a number of factors including increased awareness of coronial reporting obligations and legislative changes to the types of deaths that are required to be reported to a coroner. Even so, deaths investigated by coroners make up only a small percentage of all deaths in the community.

The 5,287 deaths reported to Queensland coroners represent only 17.46 percent of the 30,264 deaths registered in Queensland in 2015–16.

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

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

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

On 1 July 2016, the Office of the State Coroner was retitled the Coroners Court of Queensland (CCoQ) to better reflect the core business of the office, being the entirety of the business of the coronial jurisdiction. This name is in line with the majority of the other Australian states.

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

State Coroner

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

As part of this coordinating role, the State Coroner may issue guidelines under s. 14 of the Coroners Act to coroners and to persons carrying out functions under the Act. The State Coroner also provides advice and guidance to coroners in relation to specific cases and liaises with other professions and organisations involved in the coronial process, for example, police, pathologists and counsellors.

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

During 2015–16, 93 deaths were reported to the State Coroner. The State Coroner conducted inquests into 20 deaths and finalised 107 investigations without proceeding to inquest.

The State Coroner also has a review function under the Coroners Act in respect of decisions about whether a death is reportable, whether an inquest should be held and whether an inquest or non-inquest investigation should be reopened. During 2015–16, the State Coroner received 25 applications for review and finalised 14 matters of this nature.

Brisbane based coroners and coronial registrar

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

In 2015–16, 3,247 deaths were reported to the Brisbane based coroners including the State Coroner and the registrar. 3,214 investigations were finalised, including 37 deaths finalised by inquest. This represents an 8.56 per cent increase in the number of deaths reported to Brisbane based coroners, the State Coroner and the coronial registrar (up from 2991 deaths in 2014–15).

Northern Coroner

Deaths in the region from Thursday Island to Proserpine, north to the Papua New Guinea border and west to the Mt Isa district are reported to the Northern Coroner, Mr Kevin Priestly, who is based in Cairns.

In 2015–16, 605 deaths were reported in the region and 507 matters were finalised, including three deaths finalised by inquest. This represents a 1.65 per cent decrease in the number of deaths reported to the Northern Coroner (down from 615 deaths reported in 2014–15).

Southeastern Coroner

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

In 2015–16, 802 deaths were reported in the region and 943 matters were finalised including five deaths finalised by inquest. This represents a 4 per cent increase in the number of deaths reported to the Southeastern Coroner (up from 771 deaths in 2014–15).

Central Coroner

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

In 2015–16, 633 deaths were reported in the region and 649 matters were finalised including three following an inquest. This represents an 8.2 per cent increase in the number of deaths reported to the Central Coroner (up from 585 deaths reported in 2014–15).

Coroners Court of Queensland

The CCoQ supports the State Coroner to administer and manage a coordinated state-wide coronial system in Queensland. The court is also responsible for providing a central point of contact and publicly accessible information to families and the community about coronial matters.

As at 30 June 2016, the CCoQ under the leadership of A/Director Paul Ramage comprised of 48 staff members with 41 based in Brisbane, two in the Northern Coroner's office in Cairns, two in the Southeastern Coroner's office in Southport and three in the Central Coroner's office in Mackay.

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

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

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

Queensland Police Service Coronial Support Unit (QPS CSU)

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

QPS CSU officers are also located at the Queensland Health Forensic and Scientific Services (QHFSS) mortuary at Coopers Plains. They attend autopsies and assist in the identification of deceased persons and preparation of documents for autopsy.

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

The Disaster Victim Identification Squad (DVIS) is also part of the CSU. Their main role is to ensure there is ongoing capability to remove and identify the

remains of deceased victims of mass fatality incidents, air disasters and natural disasters.

During the year there were a number of changes to CSU key personnel. Mr Simon Palmer transitioned to the Detective Inspector role in July 2015. Detective Senior Sergeant Andy Cowie commenced in the Central Coroner investigator position in January 2016 and Detective Senior Sergeant Jim Bryant commenced in the Northern Coroner investigator position in June 2016.

Key initiatives undertaken by QPS CSU during 2015–16, include:

- creation of a temporary Detective Senior Sergeant position to support the Domestic and Family Violence Death Review Unit located in the Coroners Court of Queensland
- commencement of trial response through development of policies and closer cooperation and support from stakeholders at international and domestic airports in relation to deaths on inbound flights
- membership on the Serious Workplace Incidents Interagency Group
- stakeholder engagement to introduce interim reporting to the Coroner by statutory investigatory bodies
- commencing initial consultation to facilitate the creation of an 'application' to allow police officers to create a form 1 on a mobile device
- consultation with stakeholders and implementation of policy allowing for a more efficient response to hospital calls for service
- involvement of the DVIS in the recovery and identification of persons involved in an explosion at Mt. Isa
- commitment to the implementation of the National Missing Persons Victim System (NMPVS) to facilitate the improved opportunities for early identification in the DVI process
- thirty additional QPS DVI officers trained in all phases of the DVI process.

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

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

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

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

Coronial Family Services based at QHFSS in Brisbane provide information and crisis counselling services to relatives of the deceased. This service is

staffed by a small number of experienced counsellors who play a vital role in explaining the coronial process to bereaved families, working through families' objections to autopsy and organ/tissue retention and informing families of autopsy findings.

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

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

Media Enquiries

The media plays a vital role in informing the public about the functions of the CCoQ and the role the coroner plays in making recommendations aimed at reducing preventable deaths.

The Department's Communication Services Branch assists journalists and media representatives seeking to prepare balanced reports about coronial matters and CCoQ's activities. CCoQ responds to information requests and media enquiries in order to promote fair and accurate reporting. In the 2015–16 reporting period, the Communication Services Branch received 142 media enquiries. These enquiries included requests for witness lists, inquest dates, access to files, inquest findings and investigation updates.

Relationships with other agencies

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

Coronial innovation

The first decade of the operation of the Coroners Act saw Queensland establish a modern, coordinated and accountable coronial system now

regarded as one of the more progressive coronial jurisdictions in Australasia. This system features a range of innovations implemented over this time to manage the steady growth in demand for coronial services. In 2015–16, the CCoQ, QPS and QHFSS continued to work proactively and collaboratively to identify opportunities to refine and develop the system to manage future demand.

The ongoing role of the Coronial Registrar

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

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

The registrar finalised 1931 matters within the reporting period. This represents 60 per cent of the total 3214 deaths finalised within the registrar's current reporting catchment and an increase of 32 per cent from the previous year.

The table below shows the steadily increasing demand on the registrar since the role was established in January 2012 and how it has come to manage approximately 60 per cent of the deaths reported in the greater Brisbane-Sunshine Coast-South West Queensland region (representing over one-third of the deaths reported state wide).

Table 1: Deaths managed by Coronial Registrar

	Total deaths reported state wide	Total deaths reported into Brisbane	Total deaths finalised by Registrar
2012-13	4762	2708	1265
2013-14	4682	2795	1537
2014-15	4962	2991	1466
2015-16	5287	3247	1931

Deaths reported by Form 1A or funeral directors

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

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

Table 2: Number of Form 1A's by region

Coronial reporting catchment	Deaths reported via Form 1A
Brisbane	877
Northern Coroner	92
Central Coroner	61
Southeastern Coroner	210
	1,240

Form 1A reviews represent another triage process which involves collating and reviewing all relevant medical records with the assistance of a forensic medicine officer and liaising with family members with the assistance of a coronial counsellor, where required. If satisfied there is no need for further coronial involvement, the death certificate will be authorised and the coronial process ends. In most cases, the Form 1A investigation can be completed within 24-48 hours of the death being reported and without the deceased person's body having to be moved from the hospital mortuary
The table below shows the significant increase in the health sector's use of the form 1A process for potentially reportable deaths since 2007–08 – effectively almost quadrupling the state-wide usage of this process over the past seven years.

Table 3: Number of Form 1A's state-wide and in Brisbane

Financial year	Form 1As State-wide	Form 1As Brisbane
2007–08	314	223
2008–09	423	295
2009–10	732	482
2010–11	880	514
2011–12	1,043	571
2012–13	1,044	699
2013–14	1,003	721
2014–15	1,101	767
2015–16	1,240	877

The registrar role continues to be an important element in improving the efficiency of Queensland's coronial system, both by diverting cases from

unnecessary autopsy and full investigation and contributing to the timely completion of full coronial investigations by the system as a whole.

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

Forensic pathology services

During 2015–16, the State Coroner and the CCoQ contributed to work being progressed by QHFSS to examine the future sustainability of its forensic pathology service.

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

In 2015–16, the CCoQ expended $531,538 on fee-for-service autopsies (representing 6.58 per cent of its overall budget, a substantial increase from 5.6 per cent in 2014–15). The revised fee structure took effect with the commencement of the *Coroners Regulation 2015* on 1 September 2015.

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

Data from 2010–11 to 2015–16 about autopsies is provided in Tables 4, 5 and 6.

Table 4: Percentage of orders for autopsy issued to number of reportable deaths

	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
deaths reported	4,416	4,461	4,762	4,682	4,962	5,287
autopsies	2,880	2,742	2,733	2,475	2,542	2,550
Percentage	65.22	61.47	57.39	52.86	51.23	48.23

Table 5: Percentage of orders for autopsy issued by type of autopsy to be performed

	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
External	16.42	20	23.01	28.97	26.71	30.2
Partial internal	19.83	23	29.09	24.16	23.49	20.9
Full internal	63.75	57	47.90	46.87	49.8	48.9

Table 6: Number of orders for autopsy issued by type of autopsy to be performed

	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16
External	473	544	629	717	679	769
Partial internal	571	639	795	598	597	533
Full internal	1,836	1,559	1,309	1,160	1,266	1,248
Total	2,880	2,742	2,733	2,475	2,542	2,550

During 2015–16, there was again a reduction in the percentage of autopsies performed relative to the number of reported deaths overall. This is attributable to proactive triaging of apparent natural causes deaths and increasing use of the Form 1A process, as discussed earlier in this report.

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

These figures demonstrate that triaging processes continue to divert a significant number of cases away from unnecessary autopsy.

The CCoQ will continue to work with QHFSS to plan future service delivery models to ensure that Queensland continues to have access to timely and quality forensic pathology services.

Integrated coronial information system

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

- deaths reported to and investigated by police generate information including the initial police report, supplementary police reports, witness statements, etc., in the QPS information system, Queensland Police Records Information Management Exchange (QPRIME)
- deaths reported to coroners (whether by police, hospitals, other agencies e.g. Health Ombudsman) are registered in and generate/upload information including autopsy orders, release orders,

directions to police, formal requirements for information, reports, findings, inquest-related documents such as inquest notices, summons to appear and general correspondence from the CCoQ Coroners Case Management System (CCMS)
- autopsy notices/certificates/reports and toxicology reports are generated in the Queensland Health clinical database, AUSLAB.

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

The capacity to achieve efficiencies through a shared information system for coronial death investigations has been identified previously. Options to implement such a system will continue to be explored in 2016–17.

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

There has been a significant growth in demand for coronial services since the enactment of the Coroners Act in 2003. From 2004–05 (the first full financial year of reporting under the new legislation) to 2015–16 reported deaths have increased by 73.7 per cent (5,287 up from 3,043 deaths).

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

In 2014, the CCoQ developed a discussion paper for the Department of Justice and Attorney-General outlining a range of possible policy and legislative changes to assist in achieving system efficiencies including whether:
- coroners should continue to have a role in investigating all mechanical fall-related deaths resulting from age or infirmity
- coroners should be required to make findings (other than relating to the medical cause of death) in all apparent natural case deaths that proceed to coronial autopsy
- a mandatory inquest is necessary for all natural causes prisoner deaths in custody where there are no issues of concern
- to limit the current prohibition on holding an inquest once a person has been charged with an offence in respect of the death to indictable offences only.

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

Enhancing the coronial prevention role

With the legislative authority to make recommendations that aim to prevent or reduce deaths in similar circumstances from occurring in the future, coroners are in a unique position to be able to influence policy, service and practice change, and to drive systemic reform.

In addition to preventative recommendations made with respect to individual deaths, or clusters of similar deaths, for those matters that proceed to inquest, coronial data and information has proven invaluable in informing research and projects that aim to better understand the context and circumstances in which certain types of deaths occur.

The CCoQ manages and maintains a register of reported deaths and supports the State's involvement in the National Coronial Information System (NCIS). Data provided to the NCIS is used to inform death and injury prevention activities for a wide range of stakeholders, including coroners, government agencies and researchers.

At a state level, the CCoQ also has a longstanding commitment to support death prevention activities through the provision of data and information to the Queensland Child Death Register maintained by the Queensland Family and Child Commission, and the Queensland Suicide Register (QSR) maintained by the Australian Institute of Suicide Research and Prevention.

This extends to support provided for dedicated research projects, participation in working groups and the earlier release of information in relation to apparent and suspected suicides through the interim QSR, to improve the timely detection of, and response to, emerging trends or issues across the state.

With increased recognition and community expectations of the coronial role, and the complexity of these types of investigations however, there remains an ongoing requirement for specialist advice and assistance to be available for coroners for a range of relevant reportable death categories including suspected suicides, mental health related deaths and deaths in care (disability).

Domestic and Family Violence Death Review Unit

Established in 2011, the Domestic and Family Violence Death Review Unit (DFVDRU) is responsible for the provision of advice and assistance to coroners in their investigations of homicides or suicides that have been identified as domestic and family violence related and child deaths where there has been prior contact with the child protection system.

The unit assists in the identification of any missed opportunities for intervention or systemic shortcomings, as well as the consideration by coroners of whether there were any opportunities to prevent deaths in similar circumstances in the future.

As a result of recommendations from the Special Taskforce on Domestic and Family Violence Final Report, '*Not Now, Not Ever: Putting an End to Domestic*

and Family Violence in Queensland (2015)*'* additional funding of $2.1M was allocated to the CCoQ in the 2015–16 financial year for four years.

Funding was provided to enhance staffing within the DFVDRU to ensure it is adequately equipped to support coroners with their investigations into these types of deaths, and to support the establishment of a new Domestic and Family Violence Death Review and Advisory Board (the Board).

A key recommendation of the Special Taskforce, the Board is responsible for the identification of common systemic failures, gaps and issues, and is required to make recommendations to improve systems, practices and procedures.

In October 2015, the legislative framework for the Board was established through the *Coroners (Domestic and Family Violence Death Review and Advisory Board) Amendment Act 2015* which sets the Board's role and function.

While the review process is independent of, and separate to, the coronial investigation either the State Coroner or the Deputy State Coroner must be appointed by the Minister as the Chairperson of the Board. This provides an important connection between the coronial jurisdiction and the Board, with the DFVDRU now also responsible for the provision of secretariat support to the Board.

During this reporting period the DFVDRU also provided assistance to the State Coroner for the *Inquest into the death of Elsie Robertson* who was killed by her intimate partner, James Grannigan, following a prolonged violent assault lasting many hours. Their relationship was characterised by a prior history of domestic and family violence and Mr Grannigan had a previous history as a perpetrator of domestic and family violence with multiple other intimate partners and family members.

In his findings the State Coroner highlighted the disproportionally high rates of family violence within Aboriginal and Torres Strait Islander families and communities, both in terms of incidence and severity, and the complexities associated with responding to this type of violence. While recognising the significant reform being undertaken across Queensland at this time with respect to domestic and family violence, the State Coroner recommended that the current review of police training[1] be extended to include both police officers and administrative officers, in recognition that the latter cohort play an important role in frontline responses to domestic and family violence.

[1] As per recommendation 138 of the Special Taskforce Final Report: *The Queensland Police Service facilitates an external independent audit and review of training packages currently available to officers, with a view to assessing the appropriateness and frequency of compulsory professional development opportunities relevant to domestic and family violence. Components for enhancement of officers' conceptual understanding of dynamics of domestic and family violence, communication skills, as well as cultural awareness and sensitivities should be assessed*.

Domestic and family violence homicides

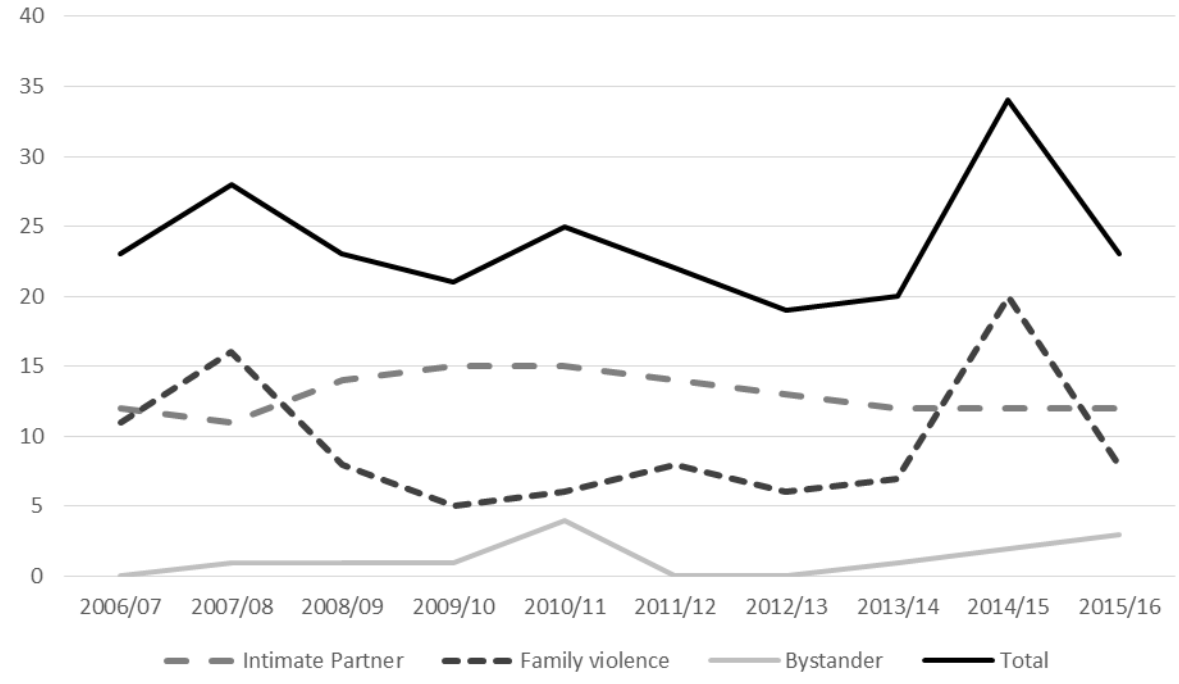
The DFVDRU collates data in relation to homicides that have occurred within an intimate partner or family relationship in Queensland since 2006. Based on the current dataset, between 1 January 2006 to 30 June 2016, 238 women, men and children have been killed by a family member, or by a person in which they were, or had been, in an intimate partner relationship in Queensland. A further 14 bystanders have been killed in this period.

In the 2015–16 financial year, 12 homicides occurred within an intimate partner relationship and eight within a family relationship. There was also one death of a bystander who was killed intervening in a domestic and family violence incident, and two deaths where a spouse's new partner has killed the spouse's former partner.

This equated to a total of 23 homicides during this reporting period.[2] This figure was lower than the 34 fatalities recorded for the 2014–15 financial year which was inflated due to one particular case which had multiple victims. Due to the comparatively low numbers of domestic and family violence homicides, care should be taken when interpreting these findings.

The trends in relation to domestic and family violence homicides are shown in Figure 1.

Figure 1: Domestic and family violence homicides, by relationship type, 2006–07 to 2015–16



Females continue to be overrepresented as victims of intimate partner homicides (82.0 per cent female, 18.0 per cent male), while there is little

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

gender difference among victims of homicides in a family relationship (47.6 per cent female, 52.4 per cent male).

Nearly one in five victims (18.0 per cent) of intimate partner homicide identified as Aboriginal or Torres Strait Islander.

Across all intimate partner and family homicides, about 80 per cent of all offenders were male.

In the majority of these deaths a previous history of violence and abuse was identifiable, as were opportunities for intervention by services and agencies prior to the death.

In about one-half (46.2 per cent) of intimate partner homicide cases, there had been a history of domestic and family violence reported to police, and a domestic violence protection order was in place in about one-third (29.8 per cent) of intimate partner homicides. Homicide victims were also more likely than offenders to have had a history of contact with social services, however victims and offenders had comparable rates of contact with government services, largely due to previous calls to service for police intervention.

The DFVDRU notes that in a significant proportion of the deaths that occurred within an intimate partner relationship, in which a female deceased was killed by a male partner, the deaths occurred after the couple had separated (31.4 per cent), or when there was an intention to separate (9.3 per cent). Stalking (14.5 per cent) and other non-physical controlling behaviour (42.7 per cent) were also apparent.

However, in a substantial proportion of cases subject to a review by the DFVDRU, these coercive controlling behaviours were not reported, or not recognised as acts of domestic and family violence, despite meeting the legislative definition as outlined in the *Domestic and Family Violence Protection Act 2012* (the Act).

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

While relationship separation is a known risk factor for domestic and family violence related homicides as well as suicides, the intersection between domestic and family violence and suicidal threats and attempts requires further exploration; particularly with respect to male perpetrators of violence who represent a large proportion of these types of deaths reviewed by the unit.

The DFVDRU has recently partnered with the Australian Institute for Suicide Research and Prevention to improve the identification of those apparent or

suspected suicides that are domestic and family violence related. The DFVDRU is currently exploring the feasibility of establishing a dataset for domestic and family violence suicides to enable the unit to capture and report on these deaths.

Child protection death review processes

The inclusion of a review function for the DFVDRU to consider 'Child Protection' deaths as part of the implementation of recommendations from the *Queensland Child Protection Commission of Inquiry* (2013) has increased the number of cases subject to a review by the Unit substantially.

While domestic and family violence related deaths are restricted to an analysis of homicides and homicide-suicides which have occurred in a domestic or family relationship, and suicides of a perpetrator or victim of domestic and family violence, the establishment of the child protection role expanded the reportable death categories considered by the DFVDRU.

In addition to homicides and suicides, child protection deaths also include those deaths where a child may have had a severe disability or has died of an illness, accidental deaths as well as SIDS and SUDI deaths. These latter deaths may involve consideration by the coroner of such issues as neglect of a child prior to the death, timely access to appropriate medical care, or parental capacity to supervise and protect.

When compiling reviews for these types of death, the DFVDRU applies a Child Protection Framework and the principles of the *Child Protection Act 1999* which requires that the main principle in administering the Act is that the safety, wellbeing and best interests of a child are paramount. Applying this framework means that consideration is given to the presence of individual, familial and environmental risk factors that heighten a child's vulnerability and risk of harm.

This review process is intended to extend upon, not replicate, the existing Queensland Child Death Review Process established in the *Child Protection Act 1999* and considers the actions of the entire child protection system, including police, health, education and the non-government system.

The DFVDRU completed in-depth reviews of eighteen 'child protection' deaths within this reporting period which highlighted a range of common themes and issues associated with service provision to the deceased child, and their familial network prior to the death.

In all cases subject to a review by the unit there were shortcomings in the identification, assessment and response to risk indicators prior to the death by individual practitioners and agencies.

Multiple agencies or persons held information that, with the benefit of hindsight, may have led to a more informed assessment of risk thereby enhancing interventions with the deceased child and their familial network prior to the death.

Despite the presence of legislation that governs the exchange of information with respect to safety concerns for children there were also barriers in timely information sharing and provision within, and across agencies in half of the cases reviewed by the DFVDRU. This was compounded by an overreliance on self-reporting in 88.9 per cent of the cases, and an under-reliance on collateral information gathering (66.7 per cent cases).

There was also an inability to understand or respond to patterns of abuse over time or cumulative harm, with an ongoing need for agencies to be better equipped to be able to intervene at an earlier point. This is particularly salient with respect to the long-term impact of childhood exposure to domestic and family violence, irrespective of whether the child was physically hurt during a reported episode of violence.

Resourcing demands were noted in 44.4 per cent of the cases subject to a review which impeded effective provision of services. Similar to domestic and family violence deaths, agencies can only respond to reported concerns or notifications with respect to the child at risk of harm, with reported incidents often not being reflective of the underlying issues within a familial network. This limits the capacity of formal services to intervene, and prevent these types of deaths.

Enhancing suicide mortality review capability

Death by apparent or suspected suicide is one of the largest categories of non-natural deaths reported to coroners each year. In 2015–16 they represented 13.73 per cent of the total deaths reported to the office.

Table 7: Number of suspected suicides and percentage of total deaths per year

Reporting period	Total deaths reported	Total suspected suicides
2011–12	4461	581 (13%)
2012–13	4762	571 (12%)
2013–14	4682	661 (14%)
2014–15	4962	716 (14.4%)
2015–16	5287	726 (13.73%)

Queensland coroners continue to struggle with access to timely, cost effective and appropriate expertise to assist their investigations of these types of deaths. Consideration may be given to the person's psycho-social circumstances, their access to or assessment and treatment by the mental health system, or their contact with other social services and gatekeeper agencies who may be in a position to detect or respond to a persons increased suicide risk.

There continues to be a pressing need for the Queensland coronial system to be equipped with access to a source of independent suicide mortality review expertise to better position the coronial system to inform and influence suicide prevention and mental health reform; similar to that currently provided for domestic and family violence and child protection deaths.

The benefit of such a review process for coroners is well established as the DFVDRU has provided advice to coroners with respect to those suicides that have been identified as potentially domestic and family violence or child protection related for a number of years; with coroners publishing recent findings without inquest into these deaths[3].

In mid-2016, at the request of the Deputy State Coroner, the DFVDRU extended beyond this existing function and provided assistance for the *Inquest into the death of John Edward Drane*[4]*,* by conducting research into suicide risk and prevention in elderly persons with co-occurring physical health conditions to inform his investigation and assist in the identification of opportunities to prevent deaths in similar circumstances in the future.

In addition to including the research summary conducted by the unit as part of his findings, the Deputy State Coroner also recognised the unit's considerable multidisciplinary experience over a wide range of areas of social issues including not only domestic violence, but child protection and mental health/suicide prevention.

Deaths in care of people with a disability

The role and responsibility of coroners, and their need for specialist advice and assistance was again recognised in the Office of the Public Advocate report '*Upholding the right to life and health: a review of the deaths in care of people with disability in Queensland*' released in March 2016. The report made a number of recommendations with respect to improvements in the systemic review of deaths in care of people with a disability, specifically that:

- The State Coroner should be required to report annually on deaths in care
- That coroners should be provided with further expert advice in relation to health and support issues for people with intellectual and cognitive impairments
- There should be enhanced education and awareness raising about the reporting requirements in relation to the deaths of people with disability in care
- An appropriate agency should be resourced and tasked to carry out regular systemic reviews of people with a disability who have died in care in Queensland; with a report detailing the outcomes of these reviews to be tabled in Parliament at least biennially.

As a result of these recommendations, the State Coroner has indicated his commitment to reporting annually on deaths in care, and to the development of a guideline for coroners to provide guidance in their investigations of these types of deaths.

[3] For example here: tauati-td-20160503.pdf
[4] Findings for this death can be found here: drane-je-20160615.pdf

The State Coroner also approved a trial Expert Advisory Panel to consider a group of apparent natural causes deaths in care of people with a disability. The intent of this process was to consider a range of issues including:

- The health care management of the person prior to the death, including whether the care provided was appropriate, and whether any of these deaths could reasonably be considered to have been preventable
- The identification of any gaps, or potential opportunities for improvement, in the health care management of people with a disability with complex needs in care, including where there are multiple care providers (i.e. primary and specialist health care providers, community support agencies).

The Panel will draw on the expertise of the Clinical Forensic Medicine Unit within Queensland Health who provide expert advice to coroners regarding the identification of clinical management issues prior to a death. Investigative and secretariat support will be provided by the DFDVRU with Panel Members selected based on their expertise with working with this vulnerable cohort.

Future consideration needs to be given to the requirement for additional resourcing to equip the CCoQ, through the DFVDRU, with the capacity to provide support to coroners with respect to their investigations of other relevant reportable deaths, including deaths in care, suspected suicides and other mental health related deaths.

Coronial performance – measuring outcomes

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

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

Clearance rate

In 2015–16, 5,287 deaths were reported state wide. Compared to the total numbers of deaths reported in 2014–15, this represents an overall increase of 6.55 per cent of 'lodgements' (up from 4,962).

In 2015–16, coroners finalised 5,313 matters achieving a clearance rate of 100.49 per cent.

Many matters reported to coroners are, following review of medical records and circumstances of death, found to be not reportable or reportable but not requiring autopsy and further investigation. During 2015–16, of the 5,313 deaths finalised, 1,813 were found not to be reportable within the meaning of s. 8(3) of the Coroners Act.

These matters are included in the lodgement figures on the basis that the coroner performs work in considering whether a death certificate can be authorised. This may involve obtaining medical records using the powers

under the Coroners Act, discussing the matter with treating clinicians and obtaining advice from doctors at the CFMU, discussing treatment with family members and liaising with funeral directors. Significant time is often involved in processing these matters.

Pending cases and backlog indicator

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

There has been a decrease in the overall number of pending cases during the reporting period (2,127 down from 2,162 as at 30 June 2015) but an increase in the backlog indicator from 11.89 per cent to 13.63 per cent.

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

- coroner and registrar leave – historically the coroners have absorbed the impact of their and the registrar's absences on leave without routinely seeking relief from the Magistrates relieving pool. The appointment of the registrar as an Acting Magistrate in April 2015 and the use of deputy registrars to perform the registrar role in the registrar's absence from that role are expected to help manage this issue into the future
- increased inquest commitments – time spent in court coupled with the time required to prepare complex inquest findings reduces the coroner's capacity to finalise non-inquest investigations.

As at 30 June 2016, 290 or 13.63 per cent of pending matters were more than 24 months old. This figure exceeds the national benchmarking target of 0 per cent largely due to the increasing number of lodgements and the more rigorous investigation required under the Coroners Act. The finalisation of a coronial investigation also depends on the completion of autopsy, toxicology and police reports. Coroners also await the outcome of other expert investigations and criminal proceedings.

As at the end of the reporting period, of the 290 matters that were older than 24 months, 63 per cent (183 matters) were waiting for police or other expert investigations or the outcome of criminal proceedings. Excluding these cases, 107 matters i.e. 5.03 per cent of pending matters are older than 24 months.

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

Funeral Assistance

The *Burials Assistance Act 1965* requires the Department of Justice and Attorney-General to organise a simple burial or cremation of any deceased person whose estate cannot cover the funeral costs and whose relatives and

friends cannot arrange or pay for their funeral in the interests of public health. This service is called Funeral Assistance. CCoQ manages this scheme throughout the state. During 2015–16, 489 applications for funeral assistance were approved state-wide at a cost of $930,827.10. CCoQ recovered $321,352.12 from the estates of the deceased. This amounts to 34.52per cent of expenditure.

Inquests

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

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

Inquests into the deaths of 70 persons were opened and/or closed during 2015–16.

In-house counsel assisting at inquests

Each of the full time coroners is assisted by a legal officer. These legal officers are increasingly performing the role of counsel assisting and during 2015–16 assisted in inquests into the deaths of 63 persons. Having in house counsel assisting is beneficial as coroners are supported by lawyers with specialised skills and experience in the jurisdiction and inquest costs are kept to a minimum.

Deaths in custody

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

The complete inquest findings are posted on the Queensland Courts website at: coroners-court-findings

Police shootings inquests 2015-2016 – avoiding custody

Between August 2013 and November 2014, officers of the Queensland Police Service (QPS), acting in the course of their duties, shot and killed five men in separate incidents. The incidents occurred at the Sunshine Coast (2), Brisbane (2), and the Gold Coast. In particular, three of the deaths occurred over the period of a week, from 18 November 2014 – 24 November 2014.

As each of the deaths occurred in custody a joint inquest was held. Separate factual inquests were heard throughout 2015-2016 with respect to each death and findings handed down pursuant to s. 45 matters. A final joint inquest is being held in October 2016 relating to recommendations and preventative measures.

Anthony William Young was a 42-year-old man who died on 21 August 2013 after being shot by police outside his residence at 96 Yandina-Coolum

Road, Coolum. He had been living there with his older brother, David Young, and David's partner, Louise Dekens, and their 12 year old daughter. Communications with 000 began at 9:52pm on 21 August 2013 when Sunshine Coast Police Communications received a call from Anthony Young.

He was calm but was talking about a sex cult from China attempting to take over Australia. From 10:00pm, a series of 000 calls were received by police. Each call related to an incident at 96 Yandina-Coolum Road, Coolum. The calls were from various neighbours and made reference to screams of racial abuse, persons having been stabbed and, later, shots being fired.

Two first response police officers were tasked to attend the house on the basis of a Code 2 urgency. When they arrived, Anthony was standing in the front driveway of 96 Yandina-Coolum Road. He was initially in a position described as 'submissive' or 'calm'. The officers opened their car doors to get out, and one officer identified himself by saying 'it's the police, mate'. As he said this, Anthony immediately advanced towards one officer and raised his right hand, which held a large bladed machete. He was warned to 'just stop there', and the officer began to move backwards. The officer continued to retreat and then discharged his firearm once, and then a further four times, in a string of shots. The QAS was called, and Mr Young was taken to the Nambour Hospital, where he died during surgery. It was after Mr Young was shot that the bodies of David Young and Louise Dekens were found inside the residence. They had each been fatally stabbed by Anthony.

Upon being notified of the deaths, the QPS Ethical Standards Command (ESC) promptly attended and an investigation ensued. The investigation was informed by statements and recorded interviews with all police officers involved, attending QAS staff, the child who was inside the residence in the lead up to the death, neighbours of the residence and Mr Young's family. Relevant sections of the QPS Operational Procedures Manual were examined. Forensic analysis was conducted and photographs were taken. An internal autopsy was conducted which confirmed the cause of death as being from gunshot wounds to the body and arm.

The State Coroner accepted in his findings that the final actions and decisions made by the attending police officers to discharge their firearms were appropriate. The State Coroner was satisfied that the investigation conducted into the death by the ESC was appropriate, thorough, and covered all relevant areas of investigation.

All other comments and recommendations remain pending.

Edward Wayne Logan, originally from Victoria, was a 51-year-old man who died on 23 November 2014 after being shot by police outside his son Thomas' residence at 7 Outlook Drive, Tewantin. He had been visiting his son for his birthday. His son's partner Teegan and their three year old son also resided at this address.

On the day of his death, an argument ensued between Thomas and his father. It appears that this was about Thomas' dislike of birthdays. Thomas made some comments about the quality of his upbringing and expressed unhappiness about the way he had been brought up. Thomas' comments appear to have made Mr Logan particularly agitated and a verbal argument ensued. Mr Logan then said words to the effect of 'Fuck it -I'll do you all'. Teegan then saw him head into the kitchen and grab two knives from the knife block. He was holding a knife in each hand.

Everyone except Mr Logan eventually managed to get themselves out to the backyard area of the residence. Whilst outside, they could hear Mr Logan banging and smashing things and they heard the sound of breaking glass. Teegan had called 000 by this time. They were all jumping the fence to head into the neighbour's yard, when they heard gunshots from the front of the house.

Two police officers had responded to the 000 call. When they arrived at the residence, they noticed Mr Logan damaging a red car which was parked out the front of the residence. The officers thought Mr Logan was carrying a sword, but he was actually carrying the metal pole which had been detached from a letter box. Mr Logan ran straight at one of the officers with the metal pole. Both officers discharged their firearms, with a total of three shots being fired. The QAS was called, however Mr Logan died at the scene.

Upon being notified of the death, the QPS Ethical Standards Command (ESC) promptly attended and an investigation ensued. The investigation was informed by statements and recorded interviews with the police officers involved, attending QAS staff, the family who were inside the residence in the lead up to the death, neighbours of the residence and Mr Logan's partner and other family. Relevant sections of the QPS Operational Procedures Manual were examined. Forensic analysis was conducted and photographs were taken. An internal autopsy was conducted which confirmed the cause of death as being from gunshot wounds to the chest.

The State Coroner accepted in his findings that the final actions and decisions made by the attending police officers to discharge their firearms were appropriate. The State Coroner was satisfied that the investigation conducted into the death by the ESC was appropriate, thorough, and covered all relevant areas of investigation.

All other findings and recommendations have been left to the second phase.

Shaun Basil Kumeroa was a 42-year-old man who died on 29 September 2014 after being shot by police outside a block of units at 16 Gannet Street, Inala. He had recently separated from his partner, with whom he had a daughter. The custody of his daughter was a matter in dispute at the time of his death. Police were called to the address after an anonymous call was made suspecting a drug deal was taking place between Mr Kumeroa and another person.

When police arrived on scene, they saw Mr Kumeroa sitting inside a red Mitsubishi Lancer. They approached him, and he said he was waiting for a friend, and then produced what appeared to be a gun. Police produced their firearms, and a rather lengthy stand-off ensued whereby Mr Kumeroa was repeatedly told by police to drop the gun. Police from the Special Emergency Response Team (SERT) were called in, and a Forward Command Post was created. SERT officers brought a BearCat heavy duty vehicle, which police negotiators used to safely communicate surrender plans to Mr Kumeroa. The siege situation continued for almost four hours.

At 3:49pm, Mr Kumeroa exited the vehicle with the gun in his right hand at waist height. As he turned to face police officers, he continued to raise the gun. He was subsequently shot by three SERT officers, who administered CPR immediately. The QAS was also on scene. However, Mr Kumeroa died from his injuries at the scene.

Upon being notified of the death, the QPS Ethical Standards Command (ESC) promptly attended and an investigation ensued. The investigation was informed by statements and recorded interviews with the police officers involved, attending QAS staff, friends and associates whom had contact with Mr Kumeroa in the lead up to his death, witnesses surrounding the block of units and Mr Kumeroa's ex-partner and other family members. Relevant sections of the QPS Operational Procedures Manual were examined. Forensic analysis was conducted and photographs were taken. An internal autopsy was conducted which confirmed the cause of death as being gunshot wounds to the chest and abdomen.

The State Coroner accepted in his findings that the final actions and decisions made by the attending police officers to discharge their firearms were appropriate. The State Coroner was satisfied that the investigation conducted into the death by the ESC was appropriate, thorough, and covered all relevant areas of investigation.

All other findings and recommendations have been left to the second phase.

Laval Donovan Zimmer was a 33-year-old man who died in the early hours of 18 November 2014 after being shot by police inside his residence at 389 Elizabeth Avenue, Kippa Ring. He was a longstanding sufferer of schizophrenia. He had been released from the Redcliffe watch house only a few hours earlier, after an incident involving police whereby he had been tasered. Police were called to the address after Mr Zimmer made a series of phone calls to 000, complaining about how he was treated earlier in the day. These calls were eventually classed as 'nuisance calls', and as such a team of police were dispatched to attend the residence to investigate the calls.

When the team of police arrived, they entered the house and were directed to Mr Zimmer's bedroom by one of his house mates. They were unaware that Mr Zimmer had ceased his contact with the 000 service, and had changed to the non-urgent PoliceLink line. Mr Zimmer opened his bedroom door, and when he noticed the police he reacted by grabbing a kitchen knife. Capsicum spray

was deployed, however it missed Mr Zimmer, instead coming into contact with the house mate. Police withdrew their firearms, and Mr Zimmer continued out of his bedroom and into the confined hallway. He was holding the knife up near his head.

The police officers were attempting to withdraw back down the hallway, however Mr Zimmer was moving towards them faster than they could move backwards. He was told to drop the knife numerous times. Two police officers discharged their firearms a total of three times. Mr Zimmer fell to the ground, and CPR commenced. The QAS arrived on scene, but despite resuscitation efforts, Mr Zimmer was pronounced deceased at the scene.

Upon being notified of the death, the QPS Ethical Standards Command (ESC) promptly attended and an investigation ensued. The investigation was informed by statements and recorded interviews with the police officers involved, attending QAS staff, friends and associates whom had contact with Mr Zimmer in the lead up to his death, his house mates who were inside the house at the time of Mr Zimmer's death and Mr Zimmer's family members. Relevant sections of the QPS Operational Procedures Manual were examined. Forensic analysis was conducted and photographs were taken. An internal autopsy was conducted which confirmed the cause of death as a gunshot wound to the chest.

The State Coroner accepted in his findings that the final actions and decisions made by the attending police officers to discharge their firearms were appropriate. The State Coroner was satisfied that the investigation conducted into the death by the ESC was appropriate, thorough, and covered all relevant areas of investigation.

All other findings and recommendations have been left to the second phase.

Troy Martin Foster was a 32-year-old man who died on 24 November 2014 after being shot by police outside his mother's residence at 1/26 Nakina Street, Southport. He had recently been released from prison in Victoria, and had flown straight to Queensland to see his mother. Earlier on the day of his death, he had left the Gold Coast University Hospital unbeknownst to clinicians, after being held there for the purposes of an Emergency Examination Order. Police were called to his mother's address after she made an 'open line' 000 call, whereby it was relayed that Mr Foster had a knife, he had smashed up the house and had assaulted his mother.

When police arrived at the address, they initially conducted a drive by in an unmarked police car so as to assess the situation. Mr Foster was seen out on the front driveway. Mrs Foster was present as well as her granddaughter. Dog squad officers were also enroute to the address, and they arrived separately to the other first response police. Upon hearing that there was a perceived assault occurring on the driveway, the dog squad officers drove towards the address.

Mr Foster was lying down on the end of the driveway closest to the street. As the dog squad officers pulled up at the house, Mr Foster stood up, and was holding a kitchen knife in his right hand. Both dog squad officers drew their firearms as a result, and Mr Foster started to walk up the driveway in the direction of Mrs Foster and her granddaughter. The officers maintained triangulation between the women and Mr Foster.

Mr Foster then stopped, and angled his body to look at one of the officers. His demeanour changed at this point, and he was described as having a look of malevolence. His eyes were wide and he looked evil. Mr Foster then turned to face the other dog squad officer, and took two purposeful steps. The knife was raised to shoulder or chest level with the blade facing the officer. As he stepped, he pushed the knife forward. Both dog squad officers discharged their firearms a total of seven times. Mr Foster fell to the ground on the driveway as a result of the shots, and the dog squad officers commenced CPR immediately. The QAS arrived on scene, but despite resuscitation efforts Mr Foster was pronounced deceased at the scene.

Upon being notified of the death, the QPS Ethical Standards Command (ESC) promptly attended and an investigation ensued. The investigation was informed by statements and recorded interviews with the police officers involved, attending QAS staff, friends and associates who had contact with Mr Foster in the lead up to his death, his mother and niece who were inside the house and on the driveway in the lead up to Mr Foster's death, and Mr Foster's other family members. Relevant sections of the QPS Operational Procedures Manual were examined. Forensic analysis was conducted and photographs were taken. An internal autopsy was conducted which confirmed the cause of death as being a gunshot wound to the chest.

The State Coroner accepted in his findings that the final actions and decisions made by the attending dog squad officers to discharge their firearms were appropriate. The State Coroner was satisfied that the investigation conducted into the death by the ESC was appropriate, thorough, and covered all relevant areas of investigation.

All other findings and recommendations have been left to the second phase.

Death in custody, fentanyl overdose

Michael Wayne Blutcher was a 31-year-old man who died on 17 September 2013 in his cell at the low security farm precinct of the Capricornia Correctional Centre (CCC). Mr Blutcher had been incarcerated there since 11 March 2013. Mr Blutcher had a history of illicit drug use and was going through morphine withdrawal at the time of his incarceration.

On the morning of 17 September 2013, Mr Blutcher was outside with Mr Williams when he asked a fellow prisoner to 'throw a can over the fence for him'. Mr Blutcher and Mr Williams returned to Mr Blutcher's cell, where another prisoner, Mr Smith was waiting. The can was opened, and it contained a fentanyl patch, some 'weed' and three syringes, along with a quantity of gravel. Mr Williams left, and soon after, passed Mr Smith in the

hallway and was told that he 'had his share'. He also saw Mr Blutcher who said 'that thing is in my room'. Mr Blutcher was slurring his words and 'his eyes were all over the place'.

Mr Williams found Mr Blutcher in his cell sitting, leaning against the wall with a syringe in his hand. After prison officers were alerted, a Code Blue emergency response was called. Mr McDonald gave evidence that he saw a tourniquet around Mr Blutcher's arm and a needle was still in his arm. On the arrival of correctional staff, Mr Blutcher was lying flat on his back on his bed and did not respond to verbal commands or shaking. CPR was commenced by prison staff using an 'oxy reviver unit' and an automated external defibrillator. QAS officers were also in attendance. Mr Blutcher could not be resuscitated and was pronounced deceased. Afterwards, various items suggesting the use of drugs were found in Mr Blutcher's room including three syringes, a fentanyl patch that had been cut up, lemon juice, a small bowl with some water, a dessert spoon, and a cigarette lighter.

Upon being notified of Mr Blutcher's death by CCC, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. The investigation obtained Mr Blutcher's correctional records and his medical records. The investigation was informed by statements from all QPS personnel, relevant custodial officers and fellow inmates. A full internal autopsy was conducted which showed the cause of death as being from an overdose of fentanyl. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

The CCC confirmed that the prison did not supply the syringes used by Mr Blutcher, and the fentanyl was not obtained by any lawful means. Because of this, the inquest investigated the following additional issues:

1. The adequacy of the security and surveillance surrounding the Capricornia Correctional Centre Farm to prevent prohibited items being accessed by prisoners; and
2. The adequacy of the surveillance within the Capricornia Correctional Centre Farm to detect prohibited items in the possession of prisoners.

The evidence at the inquest established that there was a simple but effective arrangement in place between three prisoners at the Farm for drugs to be delivered in soft drink cans. The CCC had made a request for improvements to external surveillance at the CCC Farm precinct, by way of improved CCTV surveillance and lighting. This request was still under consideration at the time of the inquest. The State Coroner accepted that QCS had examined the circumstances of the death with a view to reviewing systems in place at the CCC Farm to minimise the entry of contraband, including the supervision and surveillance of the boundary fence.

The State Coroner made no recommendations.

Death in custody, natural causes

Maxwell John Brown was a 57-year-old man who died on 25 February 2014 from natural causes whilst in the secure palliative care unit at the Townsville

Hospital (TTH). He had been admitted there, from the Townsville Correctional Centre (TCC), on 22 February 2014.

In early 2011, Mr Brown was diagnosed at the Princess Alexandra Hospital (PAH) in Brisbane with hilar cholangiocarcinoma, a type of cancer arising from the proximal bilary tree, where the hepatic bile ducts come together. The PAH records confirm that the cancer was inoperable and that most patients in Mr Brown's condition would not survive more than 12 months. As such, he was referred for palliative care at the Townsville Palliative Care Service (TPCS) at TTH for ongoing treatment of his symptoms, mainly pain relief.

In September 2012, Mr Brown communicated to clinic staff that he no longer wanted to attend the clinic, as he perceived it as of no value. Instead of regular reviews at the clinic, it was agreed that he would be referred by the prison on an 'as needed' basis. Mr Brown's final admission to TTH was from 22 February 2014. His condition had been deteriorating and he was admitted directly to the palliative care unit. The deterioration was expected and was consistent with the natural progression of the disease. He had poor oral intake, had been vomiting and had suffered a fall three days earlier. By 11:00pm on 24 February his death appeared imminent. Early in the morning on 25 February he began coughing up large amounts of blood. He died at 4:30am.

Upon being notified of Mr Brown's death by TTH, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. The investigation obtained Mr Brown's correctional records and medical records. The investigation was informed by statements from all QPS personnel and relevant custodial officers, in addition to Queensland Health staff from TTH. An autopsy was conducted which showed the cause of death to be ascending cholangitis due to or as a consequence of cholangiocarcinoma. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

Evidence from the Clinical Forensic Medicine Unit was obtained surrounding the adequacy of Mr Brown's medical care and treatment whilst in custody at TCC. The State Coroner accepted that the health care provided to Mr Brown during this time was adequate and appropriate. The State Coroner accepted that there were no concerning factors contributing to Mr Brown's demise. No third party caused or contributed to his death.

The State Coroner made no recommendations.

Thomas Gerard McCart was a 55-year-old man who died on 5 October 2014 from natural causes whilst in the secure palliative care unit at the Princess Alexandra Hospital (PAH). At the time of his death, Mr McCart was in custody at the Arthur Gorrie Correctional Centre (AGCC).

Upon his reception to the AGCC on 16 September 2014, he was medically assessed and noted to be confused and disorientated. It was noted that his mental state had deteriorated somewhat over the previous 24 hours. He was

recommended for transfer to the PAH secure unit for further medical examination and assessment. Mr McCart underwent an MRI scan on 17 September 2014, which showed a large right frontal tumour. Preparations were then made for surgery. During the interval leading up to surgery Mr McCart suffered a seizure and was subsequently transferred to the ward.

On 25 September 2014, Mr McCart underwent surgery for a right frontal craniotomy and resection of the tumour. The surgery was performed by Dr Koefman, who reported the procedure to be uncomplicated. The goal of the surgery was to get a diagnosis and reduce the mass effect of the tumour. Dr Koefman reported that the majority of the tumour was removed. However, residual tumour was deliberately left along the midline as there was adjacent eloquent brain.

Post-operatively, Mr McCart was reported to be well with no neurological deficit. He had a post-operative MRI scan which showed gross resection of the tumour with the small medial residual as expected. He underwent normal post craniotomy convalescence on the ward before being transferred back to the PAH secure unit. His condition, despite the uncomplicated surgery, was still considered to be incurable. Mr McCart was pronounced deceased at 10:30pm on 5 October 2014.

Upon being notified of Mr McCart's death by PAH, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. The investigation obtained Mr McCart's correctional records and his most recent hospital records. The investigation was informed by statements from all QPS personnel, relevant custodial officers and Queensland Health staff at PAH and information from Mr McCart's partner, Ms Boyce. An autopsy was conducted which showed the cause of death to be from renal cell carcinoma. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

Evidence from the Clinical Forensic Medicine Unit was obtained surrounding the adequacy of Mr McCart's medical care and treatment whilst in custody at AGCC. The State Coroner accepted that the health care provided to Mr McCart during this time was adequate and appropriate. The State Coroner accepted that there were no concerning factors contributing to Mr McCart's demise. No third party caused or contributed to his death.

The State Coroner made no recommendations.

Melvin Thomas Mott was a 70-year-old man who died on 13 May 2014 from natural causes whilst in the secure palliative care unit at the Princess Alexandra Hospital (PAH). At the time of his death, Mr Mott was in custody at the Wolston Correctional Centre (WCC).

On 17 February 2014, Mr Mott presented to the WCC medical centre in relation to pain in his lower abdomen. He had reportedly been experiencing this pain for some two weeks. A CT scan was conducted and a large mass was identified on his bladder, originating from the ureteral-vesico junction,

with prominent pelvic nodes. On 19 February 2014, a transurethral resection of the bladder tumour was performed at the PAH without complication, which confirmed bladder cancer. Radiation therapy was recommended and booked to commence in April 2014.

On 24 April 2014, Mr Mott was readmitted to the PAH for the commencement of his radiation therapy. Upon examination, Mr Mott was found to have a significantly distended bladder and bilateral pedal oedema. Radiation therapy was aborted and a staging CT scan showed progression of the cancer. Investigations over the following days showed that Mr Mott had an acute kidney injury as a result of the bladder obstruction, severe prostatitis, bilateral hydro-ureters and bilateral pyelonephritis. A repeat CT scan was conducted, which showed ongoing progression of the malignant process involving the bladder and prostate, with a possible infective component.

On 8 May 2014, Mr Mott underwent surgery. Findings showed necrotic prostatic tissue with small amounts of pus, and histology was consistent with high grade invasive urothelial carcinoma. On 9 May 2014, Mr Mott was transferred to the secure palliative care unit. He was pronounced deceased on 13 May 2014 at 10:37pm.

Upon being notified of Mr Mott's death by PAH, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. The investigation obtained Mr Mott's correctional records and his most recent hospital records. The investigation was informed by statements from all QPS personnel, relevant custodial officers and Queensland Health staff at PAH. An autopsy was conducted which showed the cause of death to be from urithelial carcinoma (invasive bladder cancer). The State Coroner was satisfied the matter was investigated thoroughly and professionally.

Evidence from the Clinical Forensic Medicine Unit was obtained surrounding the adequacy of Mr Mott's medical care and treatment whilst in custody at AGCC. The State Coroner accepted that the health care provided to Mr Mott during this time was adequate and appropriate. The State Coroner accepted that there were no concerning factors contributing to Mr Mott's demise. No third party caused or contributed to his death.

The State Coroner made no recommendations.

Michael John Reynolds was a 55-year-old man who died on 24 March 2014 from natural causes whilst in his cell at the Palen Creek Correctional Centre (PCCC). He had been in custody since 28 August 2013, and was transferred to the PCCC from Brisbane Correctional Centre on 22 November 2013.

Mr Reynolds' medical history included a previous heart attack, alcohol related issues and a head injury in 2010 which led to a decline in his thought process.

On 21 November 2013, Mr Reynolds was seen by a registered nurse, who documented Mr Reynolds' non-compliance with prescribed medication,

particularly medication to treat heart disease. Mr Reynolds had told Ms Peters he 'did not believe in medicines'.

The medical records show that Mr Reynolds had not taken any medication to manage his cardiac condition from about six months after his heart attack in 1991 when he was aged 32 years. This decision pre-dated his fall and subsequent head injury, thus demonstrating his desire not to manage his condition with medication was consistent throughout his life. This decision by Mr Reynolds did not prevent doctors and nurses from undertaking routine preventative screening of his blood pressure and an attempt to check his cholesterol levels.

At 6:00am on Monday 24 March 2014, Mr Reynolds was seen exercising by walking around the running track. He returned to his cell in cell block, and at 7:00am, correctional officers attended for the purposes of conducting a headcount. Mr Reynolds did not present for the headcount, which resulted in correctional officers attending at his cell. Upon attending the cell, correctional officers saw Mr Reynolds lying on his back and otherwise unresponsive. A 'Code Blue' was called and correctional officers commenced CPR. The prison nurse and shift supervisor immediately attended, and also attempted CPR. Mr Reynolds was pronounced deceased at 7:17am.

Upon being notified of Mr Reynolds' death by PCCC, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. The investigation obtained Mr Reynolds' correctional records. The investigation was informed by statements from all QPS personnel and relevant custodial officers. An autopsy was conducted which showed the cause of death to be from coronary atherosclerosis. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

Evidence from the Clinical Forensic Medicine Unit was obtained surrounding the adequacy of Mr Reynolds' medical care and treatment whilst in custody at PCCC. The State Coroner accepted that the health care provided to Mr Reynolds during this time was adequate and appropriate. The State Coroner accepted that there were no concerning factors contributing to Mr Reynolds' demise. No third party caused or contributed to his death.

The State Coroner made no recommendations.

Death in custody, siege, avoiding custody

Brent William Rivett was a 45-year-old man who died on 26 December 2013 from a self-inflicted gunshot wound to head. In the months prior to his death, Mr Rivett experienced a relationship break down. He had also left his job at Pacific Rim Trading in November 2013, and was subsequently unemployed. He lived in motels at Northgate and Wynnum from 10 to 26 December 2013. Bank records indicated that he was quickly exhausting the proceeds of his savings account.

On Boxing Day morning 2013, Mr Rivett boarded a train from Wynnum Central to the City at 6:43am. He then boarded another train to the Northgate

Station, where he arrived at 8:23am. He carried a shopping bag, a backpack and another small bag. These contained six sets of handcuffs, three gags and a bottle of chloroform. The backpack also contained a hunting knife, a sawn off double-barrel shotgun and approximately 20 shotgun cartridges.

It was a thirty-minute walk from the Northgate Station to the residence of the ENW family, who were known to Mr Rivett. He had previously been a guest at the residence. The family consisted of Mr and Mrs ENW and their teenage daughter. He arrived at the ENW residence at around 10:55am and took Mrs ENW and her 13-year-old daughter hostage after placing handcuffs on their wrists and ankles, and a rubber ball-shaped gag in Mrs ENW's mouth. Prior to being taken hostage, the daughter was able to call police. After taking an amount of cash, Mr Rivett attempted to leave the residence through the garage door. Police entered through the garage door, as Mr Rivett was about to leave in the family's car. Mr Rivett fired his rifle towards the police and retreated into the house.

At 11:17am, a second gunshot was heard, but it was unclear at that time whether anyone had been shot. At approximately 4:15pm the hostages were extracted from the house via the window of the bathroom they occupied. At around 7:20pm, and through the use of camera technology, police were able to confirm that Mr Rivett had been shot and was deceased.

Upon being notified of Mr Rivett's death, the QPS Ethical Standards Command (ESC) promptly attended and an investigation ensued. The investigation was informed by statements and recorded interviews with all police officers involved, attending QAS staff, persons who were inside the residence in the lead up to the death, neighbours of the residence and Mr Rivett's next of kin. Relevant sections of the QPS Operational Procedures Manual were examined. Forensic analysis was conducted and photographs were taken. An external and partial internal autopsy was conducted which confirmed the cause of death as being from a gunshot wound to the head.

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

The State Coroner was satisfied that the investigation conducted into the death by the ESC was appropriate, thorough, and covered all relevant areas of investigation. It was accepted that the protocols established to investigate deaths in custody in accordance with the *Coroners Act 2003*, and Queensland Police Operational Procedures Manual were complied with.

The State Coroner made no recommendations.

Death in custody, high caffeine levels

John Michael Spence was a 51-year-old man who died on 4 September 2013 in the Health Centre at the Capricornia Correctional Centre (CCC). Mr Spence had just returned to the CCC earlier that day, after spending five days

at the Rockhampton watch house. Mr Spence had very poor health. He had a history of alcoholism, complicated by seizures in the setting of alcohol intoxication and withdrawal, malnutrition and poor self-care.

At 5:25pm on the evening of his death, a Code Blue was called when Mr Spence had difficulty walking when being escorted to the Health Centre. He was taken by stretcher to the Health Centre and suffered a seizure 15 minutes later. He was noted to be behaving bizarrely, jumping around and dancing. However, he recovered and at 5:50pm he was noted to be alert. He did not voice any concerns to medical staff. At 7:50pm, a nurse proceeded from the Health Centre to secure units on a medication round. When he returned to the Health Centre at 8:20pm his attention was drawn to Mr Spence, who was found to have no respiratory movement, his pupils were fixed and dilated, he was cool to touch and there was no pulse. Resuscitation was commenced but was unsuccessful. Mr Spence was subsequently declared deceased.

Upon being notified of Mr Spence's death by CCC, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. The investigation obtained Mr Spence's correctional records and his medical records. The investigation was informed by statements from all QPS personnel, relevant custodial officers and fellow inmates. A full internal autopsy was conducted which showed the cause of death as being from coronary atherosclerosis. A high level of caffeine was also detected.

An expert review of the autopsy findings was provided, which determined the cause of death to be *the combined effects of atherosclerotic cardiovascular disease and seizure activity in the setting of excessive caffeine use*. An expert toxicologist provided opinion that the concentration of caffeine in Mr Spence's blood was consistent with toxicity and, in particular, cardio-vascular stimulation. Overall, it was likely that in an individual like Mr Spence (with a compromised cardio-vascular system) the caffeine at least contributed to his death insofar as it most likely added stress to his cardiovascular system that, in its absence, would not have been present. The inquest tried to establish the source of the caffeine, however was ultimately unsuccessful.

The adequacy of the response to the Code Blue was also investigated. The State Coroner considered that the response of the officers and medical staff at the CCC to Mr Spence's presentation was adequate. The response had to be considered in the context of their knowledge of Mr Spence's history and the fact that his presentation was not considered to be unusual. This was found to be understandable in the circumstances, given the fact that Mr Spence suffered from some type of seizure several times a week. The correctional services officers and medical staff could not reasonably have been expected to be aware that Mr Spence also had very high levels of caffeine in his blood, and was suffering from 90 per cent occlusion of the left anterior descending coronary artery. There was no evidence that these conditions had manifested themselves in any way before his death.

Prison Health conceded that there was not an adequate care plan put in place for Mr Spence following the Code Blue at 5:25pm. The State Coroner

concluded that it was clear a plan should have been in place, and that this plan should have included a clinical observations regime. However, having regard to his significant co-morbidities and the level of caffeine in his blood, the State Coroner was unable to conclude that Mr Spence's death might have been prevented had he been observed at more regular intervals.

The State Coroner was satisfied the matter was investigated thoroughly and professionally. Prison Health confirmed that the limitations in documented procedures and medical records relating to the direct care of prisoners within the observation area of the Health Centre were identified following Mr Spence's death, and had now been rectified. The State Coroner was satisfied that this was a significant step towards ensuring future deaths in similar circumstances would be prevented.

The State Coroner made no recommendations.

Death in custody, suicide

Scott Matthew O'Connor was a 31-year-old man who died at the Arthur Gorrie Correctional Centre (AGCC) Maximum Security Unit (MSU) Detention Unit (DU) on 22 January 2013. At the time of his death, Mr O'Connor was awaiting trial for a fellow prisoner's murder, which occurred in December 2011. The MSU DU was shut down by AGCC shortly after Mr O'Connor's death. The former General Manager of the AGCC described Mr O'Connor as 'one of the most difficult prisoners I had to manage in my 38 year career in corrective services'. Mr O'Connor was the subject of various safety orders which were imposed on him to manage the violent and dangerous conduct he demonstrated.

In the days before his death, Mr O'Connor had refused all medication except tramadol. He was covering the camera in his cell and refusing to remove it. His mental state appeared to rapidly deteriorate after this time. Concerns were raised and escalated by custodial corrections staff. His mood was flat and he was pacing and not sleeping. It was apparent that Mr O'Connor was wanting to see a psychiatrist. He was also wanting to give away his pet bird. Mr O'Connor's request to see a psychiatrist proceeded through a number of staff at the prison. The duty psychiatrist at the prison on 18 January 2013 was fully booked and could not see him. A 'notification of concern' was raised and he was placed on a 30 minute observations regime. This meant he was assessed at high risk of harm to himself.

On 21 January 2013, a psychologist spoke with Mr O'Connor at length for the purposes of conducting an assessment of his risk. She recommended he be maintained on 30 minute observations, thus remaining at high risk of harm.

Mr O'Connor's cell was equipped with a lockable exercise yard attached to the cell. Mr O'Connor's access to the exercise yard was not restricted. On 22 January 2013, the MSU had lock down training scheduled that afternoon. Contrary to AGCC policy, there were only two officers left in charge of the MSU. Mr O'Connor's camera had been covered the previous day, and nothing had been done to remove that cover. It was ascertained that Mr O'Connor's

cell camera fed through to a dedicated screen. The control room operator gave evidence that he did not see that the exercise yard camera had been covered on the loop screen. The State Coroner was satisfied that if a correctional officer was diligently looking at the screens as required, it would be readily apparent that a camera had been obscured.

Just after 3:30pm, an unsuccessful attempt was made to contact Mr O'Connor via his cell intercom. He could not be seen from the cell camera, leading correctional staff to believe that he was in the exercise yard. He could not be seen from the exercise yard's CCTV camera, as this was covered. A code yellow and a code blue were called and entry was gained to the cell. Officers went into the exercise yard where they found Mr O'Connor hanging from the mesh roof frame. He was cut down and QAS paramedics attended. However; he was unable to be resuscitated and was pronounced deceased.

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

The State Coroner found that none of the correctional officers or other inmates at AGCC had any direct involvement in Mr O'Connor's death. The State Coroner accepted that whilst Mr O'Connor's behaviours required further exploration by a psychiatrist, the MSU DU was the best place for him to remain under close observations. The State Coroner was unable to conclude that Mr O'Connor's death might have been prevented if his request to see a psychiatrist had been expedited. The State Coroner found that Mr O'Connor's death may have been prevented if he had been observed in his cell in accordance with the instructions that he be observed both physically and visually every 30 minutes. That this was not done was a dereliction of duty on the part of the rostered custodial officers. Appropriate disciplinary action had been taken in this regard by the GEO Group.

The State Coroner adopted the majority of the findings of the Chief Inspector and found the recommendations made by the Chief Inspector to be appropriate. The implementation of relevant recommendations was confirmed. The State Coroner commented that every effort must be made to ensure that prisoners who are identified as being at risk of self-harm are not accommodated in cells where they have ready access to hanging points or the means to fashion a ligature.

Death in care, death in police operations

P was a 13-year-old girl who died in a motor vehicle accident at Redbank in Queensland on 11 April 2012. She had been involved in the child protection system since she was an infant. She had been the subject of fourteen

separate out of home placements. P was living at a residential care facility run by a licensed care service under the *Child Protection Act*.

On the day of her death, two youth workers were rostered to work with P. That afternoon P was returned to the facility by her youth justice worker. While her mood was described as 'baseline' it appeared that she was unhappy that a planned contact with her mother at the local courthouse did not eventuate earlier that day. P asked to go to the local park, so the workers took the car keys from a locked box in the staff area so they could drive to the park. P opened the driver's side door, reached in and grabbed the keys from the ignition and demanded that the youth worker leave the vehicle.

The youth workers attempted to retrieve the keys at the same time as trying to prevent P from getting into the car. In the course of an extended incident over at least 45 minutes, P assaulted Ms Makoare and refused to return the keys until she was eventually able to access the car and drive away. During the course of this incident, police were contacted. Before police arrived at the facility, they were informed that P had driven off. Police attempted to intercept the Commodore after it stopped at the intersection of Collingwood Drive and Duncan Street. Police activated police lights after the light turned green. However, the Commodore accelerated rapidly away and narrowly missed another vehicle at the intersection.

Attending police did not attempt a pursuit because of the circumstances and in particular their awareness that the driver was a 13-year-old child. P's vehicle was estimated to be travelling at 147km per hour when it started to slide on Kruger Parade while attempting to negotiate a right hand bend. The vehicle left the road across a concrete gutter and crashed into trees in adjacent bushland. The vehicle was mechanically inspected after the crash and was found to be in sound mechanical condition.

Upon being notified of P's death, the QPS Ethical Standards Command (ESC) promptly attended and an investigation ensued. Relevant sections of the QPS Operational Procedures Manual were examined. Forensic analysis was conducted and photographs were taken. A full internal autopsy was conducted which confirmed the cause of death as being multiple injuries due to a motor vehicle accident.

The State Coroner accepted in his findings that the workers could not have anticipated the tragic outcome of the incident or whether, if they tried to physically restrain her, they might have prevented her death. The decision to call the police was appropriate on this occasion. The State Coroner found that the actions and decisions made by the attending police officers in the immediate lead up to P's death were appropriate and timely. P's death could not have reasonably been prevented by the attending officers. It was found that there was no pursuit on the part of the police officers. The State Coroner was satisfied that the investigation conducted into the death by the ESC was appropriate, thorough, and covered all relevant areas of investigation. It was accepted that the protocols established to investigate deaths in custody in

accordance with the *Coroners Act 2003*, and Queensland Police Operational Procedures Manual were complied with.

The Child Death Case Review Report made nine recommendations covering matters such as improved mechanisms to engage senior officers in decision-making in complex cases, staff training, mandatory qualifications for residential care workers and responding to trauma. The State Coroner was satisfied that each has been implemented by the Department. The evidence in relation to the service system confirmed a number of deficiencies in the system that were identified in the 2013 report of the Queensland Child Protection Commission of Inquiry.

The State Coroner made the following specific recommendations:

1. That the Department of Communities Child Safety and Disability Services work with licensed care services to implement policies and procedures, including the introduction of technology such as tracking and PIN immobilisers, to ensure that children in care with complex needs are not able to take control of vehicles.

2. That in implementing recommendation 8.7 of the Carmody Report, the extent to which licensed care services should engage the QPS to respond to placement related behaviours be reviewed, and consideration be given to an audit tool to monitor this practice and outcomes for young people in care in terms of entry to the criminal justice system.

3. That the Department of Communities Child Safety and Disability Services review its Positive Behaviour Support policy to ensure that it provides more guidance in relation to the circumstances in which reactive restraint can be used, and the types of restraint permitted. The policy should also highlight the significant risks, including asphyxiation, posed to the wellbeing of persons being restrained by inappropriate restraint techniques.

Inquests of Public Interest

Verris Dawn Wright and Jasmyn Louise Carter

Verris Wright was 86 years old when she died at Oakey Hospital on 26 December 2013. Mrs Wright had been brought to the hospital by her family two days earlier, on Christmas Eve, with symptoms that suggested to hospital staff she might have a urinary tract infection or kidney stones. Mrs Wright was given pain relief and antibiotics and, after reporting that she felt better, was discharged into the care of her family.

On the morning of Boxing Day, 26 December, Mrs Wright's family again brought Mrs Wright to the hospital, reporting that she had become increasingly unwell with symptoms including vomiting and severe abdominal pain. Mrs Wright remained in the hospital's Emergency Department for some hours awaiting a review by a doctor, with nursing staff providing care and

taking observations during this time. By midday, Mrs Wright had not been seen by a doctor and nursing staff realised her condition had deteriorated significantly. Mrs Wright passed away at 12.30pm.

A subsequent autopsy identified that Mrs Wright had died due to septic shock from a severe infection, the underlying cause of which was an obstruction in her small bowel.

As a result of Mrs Wright's death the Darling Downs Hospital and Health Service (DDHHS) conducted a Root Cause Analysis. A recommendation was made that the DDHHS mandate, as a matter of urgency, implementation of a tool to help clinical staff recognise and respond to deteriorating patients. This tool is called the Queensland Adult Deterioration Detection System (Q-ADDS).

In August 2014, some seven months after Mrs Wright's death, a patient died in similar circumstances at the Warwick Hospital, another DDHHS facility. By the time of this admission the Q-ADDS tool was in place.

Jasmyn Carter (aka Carter-Maher) was 17 years old when she presented to the Warwick Hospital Emergency Department in the afternoon of Sunday, 3 August 2014. She had played a game of Australian Rules football the day before and was complaining of a headache, dizziness, and aches in her arms and legs. Jasmyn was initially assessed by a doctor and admitted to a ward overnight, where she was given intravenous fluids and pain relief. Jasmyn remained in the care of nursing staff that evening, with a doctor not present but available on call. Jasmyn's vital signs were observed and recorded using the Q-ADDS tool. If the recommendations for action noted on the QADDS tool had been followed an emergency call should have been made soon after her attendance at the ED or any time after her admission to the ward, due to Jasmyn's very low blood pressure readings.

In the early hours of Monday morning, 4 August, Jasmyn began experiencing breathing difficulties. Nursing staff who came to assist observed that a purple rash had developed on Jasmyn's face, abdomen, chest and neck. They were unable to obtain a blood pressure reading from Jasmyn at this time. The treating doctor was contacted and advised of Jasmyn's deteriorating condition. A short time after the doctor arrived at the hospital to attend to Jasmyn, she stopped breathing and went into cardiac arrest. CPR and other resuscitation efforts were performed, however these were unsuccessful and Jasmyn passed away at around 3:30am.

Autopsy found the cause of death was due to meningococcal septicaemia, a serious and deadly condition that occurs when meningococcal bacteria enters the bloodstream and multiplies, damaging the walls of blood vessels and causing internal bleeding and organ failure.

As with Mrs Wright, during Jasmyn's admission her abnormal physiological observations were consistent with her suffering from a severe infection. The underlying cause of Mrs Wright's infection was an obstruction in her small

bowel. The source of Jasmyn's infection was meningococcal bacteria. Unfortunately, in both cases, clinical staff appeared to have failed to recognise or explore sepsis as a possibility.

A joint inquest was held into the two deaths given they involved the same Hospital and Health Service and, in both cases, there appeared to be an issue in relation to clinical detection of a deteriorating patient.

The Deputy State Coroner found that, in both cases, there was a failure to recognise the seriousness of the patient's condition, and therefore insufficient escalation of concerns to senior clinical staff for more timely review.

The Deputy State Coroner noted in his findings that the failure to recognise and respond to clinical deterioration has been consistently noted to be a significant factor in many hospital related adverse events. The Q-ADDS tool, which was developed and designed specifically in response to human factors impacting on the recording and interpreting of physiological observations in detecting deterioration, had not been implemented at the time of Mrs Wright's death. By the time of Jasmyn's death, the tool had been implemented but did not result in detection of Jasmyn's deterioration.

The Deputy State Coroner formed the opinion that it was unnecessary to make any specific recommendations arising from the joint inquest, acknowledging that DDHHS had taken each of these tragic cases very seriously and acted to address system and staffing issues. The Deputy State Coroner urged hospitals to be vigilant regarding education into and use of early warning and response system tools such as Q-ADDS into the future.

Sapper James Thomas Martin; Private Robert Hugh Frederick Poate; Lance Corporal Stjepan Rick Milosevic

The deceased were members of an Australian Army platoon (India 21), which was deployed to Patrol Base Wahab, in the Uruzgan province of southern Afghanistan on 28 August 2012. Their mission was to mentor Afghan National Army members in the context of assisting Afghanistan to transition to stability and security.

Due to a spike in 'insider attacks' by Afghan soldiers on coalition soldiers in the month of August 2012, there was supposed to be an increased alertness to the insider attack threat, and minimum 'force protection' plans in place to mitigate the risk.

Despite this, India 21 was set up in a Patrol Base they knew little about and they did not achieve mandatory force separation from the Afghan soldiers. On the evening of 29 August 2012, the Australian platoon members were permitted to be in a very relaxed dress state (t-shirts and shorts, with some wearing thongs as footwear). They did not have their weapons at hand. They had been playing cards and board games with Afghan Army members who visited their area over a number of hours; and they only had one armed guard at ground level to protect them (a 'roving piquet'). The armed guard was also

in a t-shirt and shorts, but with body armour. The Afghan soldiers manned all of the guard towers, which surrounded the Australian area.

One of the Afghan soldiers who visited the Australian area that night was Zabet (Sergeant) Hekmatullah. This enabled him to conduct a detailed reconnaissance of their position and to gain an appreciation of their lack of preparedness against an insider attack. He left the Australian area when he was rostered on to conduct guard tower duty, and returned shortly after at about 9:45pm with an M-16A2 assault rifle. He took a covered position, and fired almost 30 rounds into the group of Australians from around five metres away.

Sapper Martin and Private Poate died immediately from their gunshot wounds and Lance Corporal Milosevic died soon after from gunshot wounds, whilst being evacuated for medical treatment. Two other soldiers were wounded.

A number ADF and Defence related investigations were conducted into the incident but the families of the deceased were unhappy with the level of inquiry, the ADF's failure to learn certain lessons from the incident, and the perceived lack of transparency. The families requested that the ADF hold a more thorough Chief of Defence Force Commission of Inquiry but a decision was made not to hold one. As a result, the families requested an inquest. Deputy State Coroner Lock decided there were sufficient unresolved issues of concern to warrant the holding of an inquest in the public interest.

The key issues for the inquest were:

- the adequacy of the ADF's risk mitigation plan and implementation to prevent insider attacks on the deceased persons' platoon at Patrol Base Wahab; and
- whether any recommendations could be made to reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

Deputy State Coroner Lock found that the ADF's risk mitigation plan and implementation to prevent insider attacks on the deceased's platoon at Patrol Base Wahab was inadequate because:

- The mission planning for deployment to Patrol Base Wahab gave insufficient attention to the insider threat;
- The information relating to Patrol Base Wahab was deficient;
- There was inadequate utilisation of intelligence resources by command;
- There was inadequate communication between the Platoon and the Company, particularly after the Platoon arrived at Patrol Base Wahab; and
- There was inadequate force separation and force protection at Patrol Base Wahab.

The Coroner found that had these deficiencies not existed, at least some of the deaths could have been prevented.

Deputy State Coroner Lock recommended that for future overseas mentoring

operations, the ADF should:

- review the training provided to ensure that cultural sensitivity and maintaining rapport is appropriately balanced with the requirements of force protection against insider attacks;
- review their hand over / take over processes to ensure that key information, such as intelligence regarding locations visited by previous rotations is always passed on to incoming rotations;
- review their methods of storing intelligence information to ensure that key information regarding previous rotations is readily accessible by all levels of the chain of command that require it;
- review their processes regarding communication of higher level orders to ensure that key risk mitigation measures are implemented from the top down to tactical level standard operating procedures; and
- review the way in which intelligence and command can more effectively interact and communicate for the purposes of risk mitigation planning prior to a mission.

In relation to consultation with families of deceased members in future, the Coroner recommended that the ADF:

- consider its open disclosure/methods of communication with families policy to ensure it incorporates best practice based on transparency and therapeutic principles, whilst acknowledging the need to ensure national security implications are also addressed; and
- consider whether the views of families can be taken into account when determining any final level of inquiry (i.e. whether to hold a CDF Commission of Inquiry).

Deputy State Coroner Lock also recommended that the Commonwealth Attorney-General place on a forthcoming agenda of a meeting of the Law, Crime and Community Safety Council an item for discussion between the Commonwealth and the States and Territories as to:

- Whether a funding model should be introduced whereby the Commonwealth contributes to the costs of investigations and inquests in coronial cases where Commonwealth/Federal issues are prominent.

Matthew Stephen Barclay

Matthew Barclay was 14 when, on 28 March 2012, he died while competing in the Australian Surf Life Saving Championships at Kurrawa. Matthew was attempting to negotiate waves during a board race when his board was seen to fly into the air. He was seen to be in difficulty by fellow competitors and jet-ski operators. He became submerged quickly and despite wearing a high visibility vest, could not be located under the surf break. His body was found the following morning 2.5 kilometres away.

This was the third death at Kurrawa during Australian Surf Life Saving Championships since 1995. The State Coroner considered 273 exhibits and heard oral evidence from 17 witnesses during an inquest into the death. He

found that Matthew had drowned after being rendered unconscious by the effects of a dumping wave on a shallow sandbank.

The State Coroner determined that the policies and procedures regarding the abandonment or postponement of competition in place for the 2012 Championships were generally adequate. He found them to have been appropriately applied, though, in the possibly mistaken belief that an inflatable rescue boat (IRB) was operating in the relevant area of competition (despite the IRB assigned to the area being beached due to engine trouble). In any event, it was evident that the absence of a nearby IRB at the time Matthew became submerged greatly reduced his chances of being successfully rescued in the choppy surf.

The State Coroner considered the progress with which recommendations relating to safety equipment made in a previous inquest involving the Championships had been implemented. He found adequate progress had been made by Surf Life Saving Australia (SLSA) even though final manufacturing standards for surf helmets and buoyancy vests had not yet been implemented. The inquest heard evidence of the complex considerations relating to the implementation of such standards.

The State Coroner noted a number of other safety initiatives already implemented by SLSA aimed at reducing risk to competitors. These included the mandated use of helmets in surf boat competition and the moving of Under 15 events from the senior Championships to a separate National Youth Championships. A number of recommendations were made by the State Coroner. Among them was the mandated use of certain lifejackets for ski and board races involving under 17 competitors (and younger); amendments to policies to specify the authority of officials to suspend competition in excessively risky situations; and, the implementing of a mandatory policy to ensure a crewed rescue craft is on the water in the relevant area during competition.

Monitoring responses to coronial recommendations

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

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

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

As of 1 January 2016, a new process of publishing responses to recommendations was commenced. The responses are now published on the Queensland Courts website as an attachment to the relevant coronial findings. These can be found at http://www.courts.qld.gov.au/courts/coroners-court/findings

Publishing responses to coronial recommendations enhances the death prevention role of the coronial jurisdiction by increasing the likelihood that public sector agencies will give them due consideration. It also provides an important feedback mechanism to coroners.

Higher courts decisions relating to the coronial jurisdiction

Isles v State Of Queensland [2015] QDC 335 (18 December 2015)

On 23 September 2009 Michael James Isles, then a senior sergeant in the Queensland Police force attached to the Police station at Ayr, drove away from his home in an unmarked Police vehicle, a Toyota Aurion sedan. The vehicle was subsequently found abandoned on a property off the Ayr-Ravenswood Road. There was no sign at the vehicle of anything untoward having happened, but no trace of Mr Isles, dead or alive, has subsequently been found. On 14 September 2012 the state coroner published findings that Mr Isles had died, that he had died of gunshot wounds, that he died on 23 September 2009 on or near Hillsborough Station near Ravenswood in Queensland, and that he intentionally took his own life. On 1 October 2015 Mr Isles' son, Steven Isles, filed an application in this Court to have these findings set aside.

His Honour was not persuaded that the applicant had shown that grounds existed to set aside the coroner's finding under s. 50(5) of the *Coroners Act 2003*, and the application was dismissed
http://www.austlii.edu.au/au/cases/qld/QDC/2015/335.html

State Coroner's Guidelines

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

There were no reviews or updates to the guidelines issued under section 14 of the Act during the reporting period.

The State Coroner's Guidelines can be accessed at:
coroners-court/fact-sheets-and-publications.

Access to coronial information

Genuine researchers

The coronial system is an important source of information for researchers who in turn provide an invaluable resource for coroners in their preventative role.

Section 53 of the Coroners Act facilitates access to coronial documents by researchers.

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

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

- The Organ Tissue Donation Service - Dr Leo Nunnink & Professor Belinda Carpenter & Dr Nigel Stubbs

- Risk Frontiers - Bush Fire and Natural Hazards Cooperative Research Centre (BNHCRC) - Macquarie University – Lucinda Coates, Dr Katherine Haynes, Deidre Radford and Rebecca Darcy

- Royal Brisbane and Women's Hospital – Dr Deborah Gilmour

- Monash University - Department of Forensic Medicine - Professor Joseph Ibrahim

- Centre for Accident Research and Road Safety - CARRS-Q – (already approved but a new study) Professor Jeremy Davis, Dr Kerry Armstrong, Assistant Commissioner Mike Keating and Ms Lisa Marie O'Donnell

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

Appendix 1: Number of Coronial cases Lodged and Finalised in the 2015–16 financial year and the number cases pending as at 30 June 2016

Court Location	Number of Deaths reported to the Coroner	Number of Coronial Cases finalised			Number of Coronial Cases pending			
		Inquest held	No inquest held	Total	Less than or equal to 12 months old	Greater than 12 and less than or equal to 24 months old	Greater than 24 months old	Total
Brisbane	**3247**	31	3183	**3214**	774	228	143	**1145**
Cairns	**605**	3	504	**507**	279	93	50	**422**
Mackay	**633**	4	645	**649**	160	32	33	**225**
Southport	**802**	5	938	**943**	208	63	64	**335**
	5287	**43**	**5270**	**5313**	**1421**	**416**	**290**	**2127**

Appendix 2: Register of approved genuine researchers 2015–16

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

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

Adjunct A/Prof. George Rechnitzer, Adjunct A/Prof Andrew McIntosh and Mr Declan Patton	Transport & Road Safety - University of New South Wales
Dr Susan Ballantyne	Director, Drugs of Dependence Unit
Professor Robert (Robin) A Cooke	Independent Researcher
Dr Leo Nunnink & Professor Belinda Carpenter & Dr Nigel Stubbs	The Organ Tissue Donation Service
Lucinda Coates, Dr Katherine Haynes, Deidre Radford and Rebecca Darcy	Risk Frontiers - Bush Fire and Natural Hazards Cooperative Research Centre (BNHCRC) - Macquarie University
Dr Deborah Gilmour	Royal Brisbane and Women's Hospital
Professor Joseph Ibrahim	Monash University - Department of Forensic Medicine
Professor Jeremy Davis, Dr Kerry Armstrong, Assistant Commissioner Mike Keating and Ms Lisa Marie O'Donnell	Centre for Accident Research and Road Safety - CARRS-Q – (already approved but a new study)