CORONERS COURT
OF QUEENSLAND

QUEENSLAND COURTS

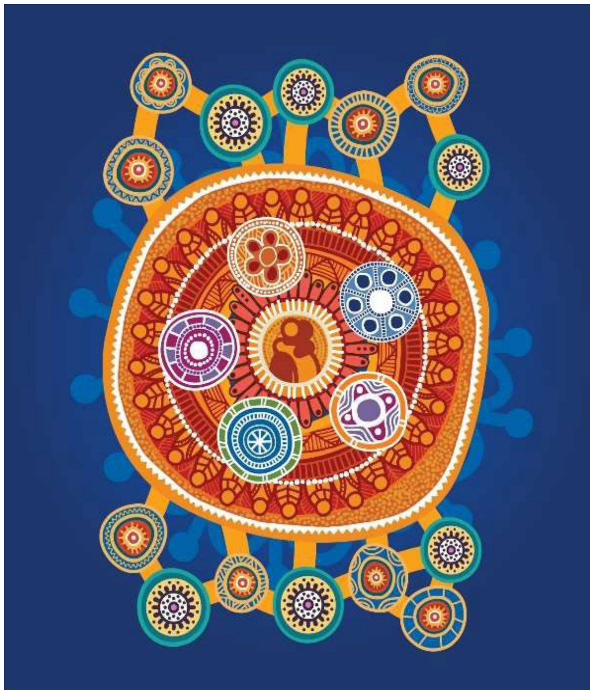
The coronial system is underpinned by a shared understanding that society values and protects the life of every person.

We appreciate that each death brings sadness, disruption, and trauma to the families of those who are entrusted to our care.

When someone we love dies suddenly or in a way that is unexplained or unexpected, those feelings are magnified.

WARNING: Please be advised some content in this report may be distressing to readers.

Aboriginal and Torres Strait Islander people are advised that this report contains the names of people who have passed away.



Acknowledgement of Country

The Coroners Court of Queensland acknowledges the Traditional Owners and Custodians of the lands across the State of Queensland. The Court pays respect to Elders past and present. We value the culture, traditions and contributions that Aboriginal and Torres Strait Islander people have made to our communities, and recognise our collective responsibility as government, communities and individuals to ensure equality, recognition and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

09 December 2024

The Honourable Deb Frecklington MP
Attorney-General and Minister for Justice
and Minister for Integrity
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

In accordance with section 77 of the *Coroners Act 2003*, I am pleased to present the Coroners Court of Queensland Annual Report for the year ended 30 June 2024.

As required by section 77(2) of the Act, the report contains a summary of each death in custody investigation finalised during the reporting period. The report also contains a summary of other investigations of public interest and the names of persons given access to coronial investigation documents as genuine researchers.

No updates were made to the State Coroner's Guidelines during the reporting period.

The guidelines are publicly available at:
https://www.coronerscourt.qld.gov.au/resources/legislation-and-resources.

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

Yours sincerely

Terry Ryan
State Coroner

Purpose

The Coroners Court of Queensland Annual Report provides information about the Court's structure and operations as well as financial and non-financial performance measures for the period 1 July 2023 to 30 June 2024. The report has been prepared in accordance with the requirements of the *Coroners Act 2003*.

This report is accessible online at: Publications Queensland Courts at: www.courts.qld.gov.au/about/publications and the Coroners Court of Queensland website at: www.coronerscourt.qld.gov.au.

Data

Data contained in this report has been obtained from the SAS Dashboard and the Coroners Case Management System (CCMS). CCMS is a 'live' operational database in which records are updated as the status of the coronial investigations change and/or input errors are detected and rectified. Content presented in this report was correct at the time of publication but data verification may result in variance of figures over time.

Enquiries

If you have any questions about this report, please contact:

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Email: coronerscourt@justice.qld.gov.au.

For further information about the Coroners Court of Queensland, please visit our website: https://www.coronerscourt.qld.gov.au.

Feedback

The Coroners Court of Queensland values your feedback on this report. Any comments can be provided through the *Get Involved* website: Your say | Queensland Government (getinvolved.qld.gov.au).

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on telephone (07) 3738 7050 and we will arrange an interpreter to effectively communicate the report to you.

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Our Year In Review

Performance measures - cases

6,071	6,055	99.74%	2,867	17.54%
Cases lodged	Cases finalised	Clearance rate	Cases pending - total	Backlog indicator

Timeframes

167	82.36% or 4,987 cases	42.33%
Average days to finalise case	Cases finalised in less than 12 months	Bodies released >3 days and <7 days

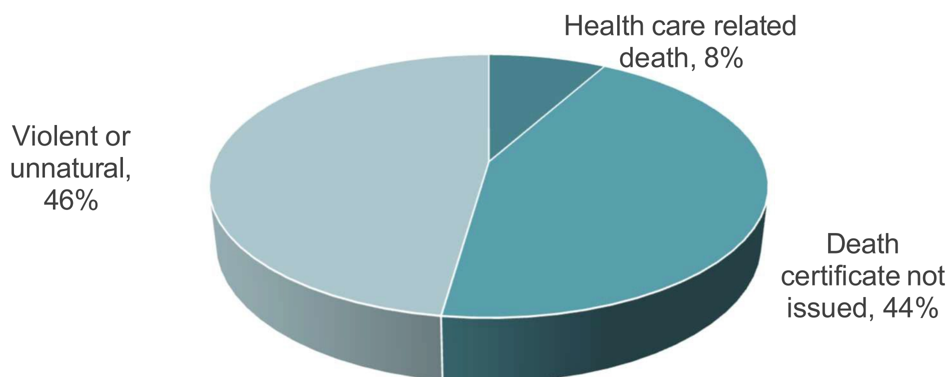
Inquests

23	31	3	27
Inquests finalised	Deaths investigated at inquest	Joint inquests finalised	Recommendations made

Death type

Natural causes	Domestic Accident	Suspected Suicide	Hospital/Medical procedure	Transport related - road
2982	976	784	351	320

Reportable type



Death Type (refers to top five reported) and **Reportable Type** (refers to top three reported).

State Coroner

State Coroner Terry Ryan

I am pleased to present the Coroners Court of Queensland Annual Report for the financial year 2023–24.

This year has been a period of significant change and reform for the Coroners Court and the coronial system more broadly. In 2023–24, the court welcomed the creation of three permanent coroner positions, bringing the total number of coroners in Queensland to 10, with seven located in Brisbane and three regionally based. Support provided to coroners has also been enhanced by additional registry staff and leadership positions.

The Queensland Government also allocated funding in the 2024-25 State Budget to manage increased demand and strengthen case management support for the delivery of coronial services. Funding was also allocated to the court's key partners, Queensland Health and the Queensland Police Service.

The Queensland Coronial System Board has been active throughout 2023–24, progressing significant work aligned to the Coronial Services System Delivery Framework 2021–2025. A successful Summit Day was held in October 2023 to address the problem statement: "*How can partner agencies efficiently and effectively deliver sustainable, trauma informed, end-to-end coronial services to meet existing and future demand?"*. The Board subsequently determined six areas of reform focused on improving services across the system, raising responsiveness and capacity, and delivering timely outcomes for families. The Board refreshed its governance arrangements to include responsibility to manage performance across the coronial system and has established two sub-committees, a Performance and Operations Sub-Committee and a Coronial System Reform Sub-Committee, to ensure a sustained focus on reform and continuous improvement. This refreshed governance model will oversee work to further improve the coronial system throughout 2024-25 and beyond.

Cross-system collaboration is a critical component of the coronial process. An example can be found in the work led by the Queensland Police Service to enhance reporting of a death to a coroner through the introduction of an automated form that can be more easily completed by police at the scene of an incident. The new process is helping to better inform police in providing information to support families and is streamlining the sudden death investigation and reporting process by reducing manual data entry.

This year the court received 6,071 lodgments, a 7 per cent decrease from the record number received in 2022–23 (6,530). This decrease is primarily a result of coordinated work across the system to reduce the number of deaths reported to CCQ in circumstances where the deaths are clearly outside the reportable framework established under the *Coroners Act 2003*. The court's clearance rate increased by more than 8 per cent to 99.74 per cent.

Coroners recognise that post-mortem examinations, although often vital to coronial investigations, can increase the emotional impact of a death on grieving families. For the first time, the annual report includes data on preliminary medical examinations and investigations, which may involve visual inspections, performing scans or collecting samples without undertaking a full or partial autopsy. These less invasive procedures are enabled by legislative amendments passed by the Queensland Parliament in 2020. Although the number of examinations ordered by coroners increased in 2023–24, the number of internal autopsies reduced.

I am grateful to my fellow coroners, the coronial registrars and the dedicated staff of the court. Their work, together with the efforts of the Queensland Police Service, particularly the Coronial Support Unit, and Queensland Public Health and Scientific Services are critical to ensuring the coronial system continues to provide independent, family-centred and timely death investigations.

Executive Director

Therese Oxenham

This year, the CCQ registry grew significantly, bringing exciting opportunities to enhance support for our coroners and ensure timely and family-centred coronial services in collaboration with our critical system partners.

New registry positions to support coroners undertaking their important independent judicial functions included a strengthened leadership team, with my position as Executive Director reporting to the Deputy Director-General, Courts and Tribunals, supported by three directors with oversight of operations, legal services and practice prevention and reform. Additional registry positions included operational positions to support the new coroners, together with positions assisting important practice, prevention and reform functions of the court and the Domestic and Family Violence Death Review and Advisory Board.

The position of Manager, Cultural Capability was created and filled. This new position embeds cultural perspectives of Aboriginal and Torres Strait Islander people within the registry, supporting a commitment to engaging in culturally sensitive and appropriate ways. The registry is continuing work to improve the provision of court services that are culturally safe and respectful.

In line with legislation, all coronial forms and the case management system have been updated to include non-binary sex descriptors. This effort has also involved taking on responsibility for the coding of data directly into the National Coronial Information Service (NCIS).

A key priority for the registry during the reporting period has been enhancing employee wellbeing. This included engaging an external provider to deliver ongoing support to address psychosocial hazards in the workplace, including vicarious trauma, through tailored, regular team workshops and one-on-one support (upon request).

The Coronial Services Practice, Prevention and Reform team was formed in 2024, building on the existing Domestic and Family Violence Death Review Unit and Information Release Team. A new Practice and Reform unit supports the Coronial System Board and its subcommittees, in addition to other activities to support coroners and coronial system reform.

As in previous years, the Legal Services team continues to have a presence in Cairns, Mackay, Southport and Brisbane providing in-house Counsel Assisting services to coroners. This complement of in-house lawyers provides advice to coroners and appears in inquests as Counsel Assisting the coroner.

New standing offer arrangement (SOA) contracts for government contracted undertakers (GCU) commenced on 1 February 2024. The new contracts include the requirement for GCU site visits, undertaken by the Business Services team, in accordance with an assurance program and contract management framework. The Business Services team in CCQ administers GCU contracts and the Funeral Assistance Scheme on behalf of the Department of Justice and Attorney-General.

I thank the State Coroner for his leadership and guidance through the year which has seen significant registry reform. I also wish to acknowledge and thank the Deputy State Coroner and coroners for their support. Finally, I would like to acknowledge CCQ registry staff for their hard work and commitment, evident in the care and respect given to families experiencing loss, and their ongoing dedication to supporting the coroners in their important work.

Our Vision

Coronial services that partner to deliver independent, family-centred, and timely investigations.

Our Court

The Coroners Court of Queensland (CCQ) provides Queenslanders with a consistent and coordinated system to investigate deaths that are violent, unnatural, sudden, unexpected or occur in custody, police operations, or in care.

Our Jurisdiction

Queensland's coronial jurisdiction operates in accordance with the functions outlined in the *Coroners Act 2003* (Qld) (the Act). The Act establishes the position of the State Coroner, requires the reporting of certain deaths, authorises the State Coroner to issue guidelines for investigations and inquests, provides for the prevention of future deaths by authorising coroners to make comments and recommendations and establishes the Domestic and Family Violence Death Review and Advisory Board.

Our Purpose

Coroners and coronial registrars are responsible for investigating 'reportable deaths'[1] as set out in section 8 of the Act. Coroners are required to establish, if possible, who the deceased person was, when, where, and how they died, and the medical cause of the death.

Most deaths are finalised administratively through the completion of chamber findings and do not require an inquest to be held. Whether an inquest is held is determined by requirements outlined in sections 27 and 28 of the Act, which include requirements for inquests into deaths occurring in custody or care. Coroners have a broad discretion to hold an inquest if satisfied it is in the public interest.

Where an inquest is held coroners can make comments and recommendations about systemic issues or policy and procedural changes that could contribute to improvements in public health and safety, the administration of justice, or prevent or reduce similar deaths in future. It is not the role of a coroner to find people guilty of criminal or civil offences.

Our Commitment

A coronial investigation is an independent, impartial, open, and transparent inquisitorial process. The investigation provides answers to families and informs the community about death prevention. We aim to deliver timely, family-focused services and are continuously working towards improving how we engage and support bereaved families, our stakeholders and our coroners.

[1] Refer to Appendix 1 – Reportable death types within Queensland.

Our Partnerships

The coronial jurisdiction operates within a multidisciplinary framework, with the work of CCQ supported by two key partner agencies, the Queensland Police Service and Queensland Health. These agencies each have expertise which are applied at different stages of the coronial process, facilitating a seamless and interdependent system of coronial services.

Coroners Court of Queensland (CCQ)

CCQ is a specialist court established under the Act. Under the Act, the State Coroner's functions include oversight and coordination of the coronial system. The CCQ registry provides registry, administrative and legal support to coroners and registrars across the State. CCQ is the central point of contact for families and friends about coronial matters.

The Business Services team in CCQ, on behalf of the Department of Justice and Attorney-General, administers Queensland's Funeral Assistance Scheme and manages Government Contracted Undertakers for burial and cremation assistance and coronial conveyance services.

Queensland Police Service (QPS)

QPS provides the statewide frontline and specialist investigative capability for coroners. QPS officers attend the scene of a death and obtain initial information from family, friends, and witnesses to assist with a coronial investigation. QPS holds wide ranging specialist forensic and investigative capabilities and will deploy these resources as required by the coroner. The QPS Coronial Support Unit (CSU) co-ordinates coronial processes on a statewide basis with officers liaising with coroners, Coroners Court of Queensland staff, forensic physicians, forensic pathologists, coronial counsellors and mortuary staff. The Detective Inspector is the Deputy Commander of the Disaster Victim Identification Squad (DVIS). The DVIS is responsible for the removal and identification of deceased persons from mass fatalities, air and natural disasters.

Queensland Health (QH)

QH, through Forensic Pathology and Coronial Services (FPaCS),[2] provides clinical, advisory, scientific and forensic pathology services, including autopsies to support Queensland's coronial and criminal justice systems. FPaCS is a statewide service and coronial post-mortem examinations are performed in Pathology Queensland mortuaries located in Brisbane (Coopers Plains), Gold Coast University Hospital, and Townsville University Hospital. Working in partnership with CCQ and the QPS, FPaCS is responsible for undertaking examinations and investigations where a person's death is reportable to the coroner. FPaCS comprises professionals from a range of medical, scientific, technical, nursing, counselling, radiography disciplines and support staff. FPaCS' Coronial Family Services provide information and counselling support to families, work through objections to autopsies, organ and tissue retention and inform families of post-mortem examination findings.

Forensic Physicians within Forensic Medicine Queensland[3] (FMQ) based in Brisbane provide independent clinical advisory services including toxicology interpretation, expert opinions, and advice about issues requiring further investigation. FMQ provides statewide assistance to CCQ and clinicians regarding coronial matters. The Gold Coast Forensic Medicine Team based in Southport is also able to assist the Southern Coroner.

[2] Formerly known as Forensic and Scientific Services.
[3] Formerly known as Clinical Forensic Medicine Unit.

Our Coroners

Queensland has ten coroners located in Southport, Brisbane, Mackay, and Cairns.

During the reporting period the court also had the assistance of Magistrates Jane Bentley, Kerrie O'Callaghan, Christine Roney and Anne Thacker, and Acting Magistrates John Aberdeen, Don Buchanan, Christine Clements, Gary Finger, Jessica Lambert and James McDougall.

State Coroner – Terry Ryan

State Coroner Terry Ryan was appointed as a Magistrate and as State Coroner in July 2013. He commenced his career in 1984 as a social worker in the fields of child protection and youth justice. After being admitted as a solicitor in 1991, he worked in private practice before returning to the Queensland Government where he worked in legal and policy roles. State Coroner Ryan holds a Bachelor of Social Work, Bachelor of Laws (Hons), Master of Laws and a Graduate Diploma in Legal Practice. In the period 2001 to 2010 State Coroner Ryan served as the Director of the Strategic Policy Unit and Assistant Director-General, Strategic Policy, Legal and Executive Services in the Department of Justice and Attorney-General (DJAG). From 2010 up until his commencement with the Coroners Court, State Coroner Ryan was the Deputy Director-General of DJAG. State Coroner Ryan was the Chair of the Domestic and Family Violence Death Review and Advisory Board until October 2022.

Deputy State Coroner – Stephanie Gallagher

Deputy State Coroner Gallagher was appointed as a Magistrate on 29 July 2021 and commenced in the role of Brisbane Coroner on 2 August 2021. On 23 May 2022, Magistrate Gallagher was appointed to the role of Deputy State Coroner. Deputy State Coroner Gallagher has more than 30 years' experience as a solicitor and barrister with specialisation in the regulation of the health professions, medical and health-related litigation and policy, mediations, guardianship matters, special health matters and coronial inquiries. Deputy State Coroner Gallagher was Chair of the Queensland Interim Medical Board in Queensland for approximately one year, the chair of the Professional Standards Committee of the Nursing Council for seven years and sat on the Boards of St Andrew's War Memorial and QEII Hospitals. She also sat as a member of Institutional Ethics Committees at tertiary hospitals for more than 15 years. Deputy State Coroner Gallagher is an Adjunct Associate Professor in the School of Applied Psychology at Griffith University. Deputy State Coroner Gallagher was appointed by the Attorney-General as Chairperson of the Domestic and Family Violence Death Review and Advisory Board on 10 March 2023, for a term of three years.

Brisbane Coroner – Ainslie Kirkegaard

Coroner Kirkegaard was the inaugural Coronial Registrar of the Coroners Court of Queensland. This unique role was designed to triage deaths reported daily across Queensland. Coroner Kirkegaard held this role from early 2012 and previously held the positions of Counsel Assisting the Deputy State Coroner and Acting Director, Office of the State Coroner. Coroner Kirkegaard joined the Queensland coronial system in 2008, bringing more than 15 years' experience in policy and legislation development in the health, education, and justice portfolios, with specialist expertise in coronial and health regulatory law and policy. Coroner Kirkegaard was appointed as an Acting Magistrate in April 2015, and appointed as a Magistrate and Brisbane Coroner in December 2023.

Brisbane Coroner – Don MacKenzie

Coroner Don MacKenzie has worked within the Criminal Justice System for over 30 years, commencing as a law clerk in the Public Defenders Office in 1990. He holds a Master of Laws, a Bachelor of Arts and a Graduate Diploma of Military Justice. He was admitted as a barrister in 1993, spending five years working for the Legal Aid Office and 14 years at the Office of the Director of Public Prosecutions (Qld), rising to the positions of Senior Crown Prosecutor then Consultant Crown Prosecutor. In 2008, Mr MacKenzie joined the private Bar, practicing as a member of More Chambers in Brisbane. Mr MacKenzie has prosecuted or defended over 800 jury trials (including dozens of murder trials), has appeared on hundreds of Court of Appeal matters and as sole counsel in the High Court of Australia. He is also an officer in the Royal Australian Navy with the Inspector-General Australian Defence Force and held the statutory appointment as the Chairman, Public Records Review Committee of Queensland before his appointment as a Magistrate in 2017 and Coroner in 2019. He has regularly appeared as a guest lecturer on criminal law and evidence for the Queensland Law Society and at the University of Queensland and is the senior editor of the Thomson Reuter's loose-leaf publication Summary Offences Queensland. He was appointed a Brisbane Coroner in 2019.

Brisbane Coroner – Melinda Zerner

Coroner Zerner holds tertiary qualifications in law, education, and nursing. Before her appointment, she had a successful 13-year practice as a barrister at the private Bar. She was regularly briefed in medical and non-medical inquests as either Counsel Assisting or for an interested party. She was junior counsel in the Commonwealth Disability Royal Commission. Coroner Zerner's civil practice was in medical negligence and public liability insurance. She was recognised in Doyle's Guide as Recommended Counsel for Leading Professional Indemnity Junior Counsel Queensland, and Leading Insurance and Personal Injury Junior Counsel Queensland over a number of years. Prior to being called to the Bar, Coroner Zerner worked as a solicitor in the professional indemnity group at a large Brisbane law firm and as in-house legal counsel for the Department of Community Safety. While working for the Department, Coroner Zerner was awarded an Australia Day Achievement Medallion for provision of exceptional legal services. During her 17-year career as a nurse, she worked as a clinician, educator, and clinical nurse manager.

Brisbane Coroner – Megan Fairweather

Coroner Fairweather was appointed as a Magistrate and commenced in the role of Brisbane Coroner on 7 May 2024. Coroner Fairweather has more than 20 years' experience as a solicitor specialising in health and human rights law, coronial, health regulatory and corrupt conduct matters. Immediately before her appointment, Coroner Fairweather was Chief Legal Counsel for Queensland Health where she led a team of lawyers to manage matters across a full spectrum of legal work including coronial, commission of inquiry, judicial review, commercial, employment and administrative law matters. She is a past chair of (now) Aged and Disability Advocacy and has been a member of the Queensland Law Society Public Law and Human Rights Committee and the Human Rights Law Association.

Brisbane Coroner – Carol Lee

Coroner Lee was appointed as a Magistrate on 23 May 2022 and held the position of Southern Coroner based in Southport until December 2023, at which time she was transferred to the role of Brisbane Coroner. Coroner Lee holds a Bachelor of Laws in addition to the qualification of registered nurse. She has held senior positions in a number of leading law firms, where she specialised in the field of health law. She has had extensive clinical experience in the Queensland public hospital system and has a deep understanding of the multifaceted environment in which the health sector operates. Coroner Lee has also served as a legal member on the Queensland Mental Health Review Tribunal, the Chiropractors and Osteopaths Board of Queensland, West Moreton Human Research and Ethics Committee, General Practice Training Queensland and Acting Ordinary Member of the Queensland Civil and Administrative Tribunal. Coroner Lee has also undertaken nationally accredited mediation training and has been awarded Best Lawyer status in the fields of Health and Aged Care and Medical Negligence for 10+ years.

Central Coroner – David O’Connell

Coroner O'Connell was admitted as a solicitor in 1991. He holds a Bachelor of Laws, Graduate Diploma in Taxation and Master of Business Administration. Coroner O’Connell was appointed to the Magistrates Court of Queensland and to the position of Central Coroner in August 2012. He is based in Mackay covering the Central and Western Queensland regions and is Queensland's longest serving current Coroner.

Southern Coroner – Amanda Bain

Coroner Bain has 20 years’ experience as a barrister with the Office of the Director of Public Prosecutions and Crown Law. Before her appointment on 7 May 2024, Coroner Bain joined the private bar in Holmes Chambers. Throughout her career she has handled prosecutions in various jurisdictions and represented clients at coronial inquests, appeals and applications.

Northern Coroner – Stephanie Williams

Coroner Williams was appointed as the Northern Coroner on 11 December 2023. Before her appointment, Coroner Williams practiced as a specialist criminal and coronial lawyer in Queensland and the Northern Territory. Coroner Williams’ legal experience includes working as a barrister and solicitor in private practice, Counsel Assisting the Northern Coroner and prosecuting for the Queensland and Commonwealth Directors of Public Prosecutions.

Our Coronial Registrars

The Coronal Registrars based in Brisbane triage deaths from an apparent natural cause, review potentially reportable deaths and provide telephone advice to clinicians about whether to issue a cause of death certificate. The Coronial Registrars operate under a delegation from the State Coroner to manage these matters.

During the reporting period the court also had the assistance of Angelica Monardez, Carolyn McKeon, Dean Clifford-Jones, Fiona Banwell, Dr Jessica Page, Julie Pietzner-Hagan and Sarah Lane.

Coronial Registrar – Jessica Lambert

Ms Lambert was permanently appointed the Coronial Registrar on 16 September 2021 and has experience serving as an Acting Magistrate performing the role of Coroner. Admitted as a Legal Practitioner since 2006, she has previously held various positions at the Office of the Director of Public Prosecutions, Supreme and District Courts and within the QUT Law Faculty. Ms Lambert is currently a Member appointed to multiple committees including the Forensic Pathology and Coronial Services Human Ethics and QLS Dispute Resolution Committees and is a co-author of the Thomson Reuters Publication - *Queensland Civil Procedure*. As a nationally accredited mediator, Jessica is also an inaugural Member of the Commonwealth Department of Health’s National Sports Tribunal.

Our Achievements

Cultural Capability

In October 2023, the Manager, Cultural Capability commenced in the CCQ registry in a newly established position to support enhancement of CCQ's cultural capability to effectively support Aboriginal and Torres Strait Islander families, as well as coroners and coronial system partners.

Throughout the reporting period, the role has been dedicated to the following objectives:

- leading design and delivery of practical and tailored training for CCQ registry staff and coroners, focusing on cultural awareness and best practices for culturally sensitive and respectful engagement with families;
- providing high level advice to senior management and coroners on matters pertinent to specific death investigations; and
- cultivating stakeholder relationships with community partners across Queensland.

Early engagement has been recognised as an important factor to ensure families grasp the purpose and process of a coronial investigation from the outset, while sensitively conveying critical information on behalf of the coroner at the time of death. A primary emphasis of the position is to create the opportunity for regular interaction with bereaved families of Aboriginal and Torres Strait Islander people who have passed, to update them on case progress and provide support during coronial inquests if required.

The Manager has also identified and communicated cultural nuances relating to the deceased individual to the investigating coroner, facilitated access to information regarding the Funeral Assistance Scheme, offered guidance on Return to Country protocols and provided referrals to culturally specific services.

During a number of inquest proceedings, the Manager has liaised with registry staff and stakeholders to ensure families receive support and has facilitated cultural care considerations such as the performance of ceremonies and the presence of culturally significant items in the courtroom, including animal skins, blankets, and painted leaves.

Additional Coroner Appointments

In December 2023, Brisbane and Cairns welcomed Coroners Zerner, Kirkegaard and Williams. The addition of these coroners marked a significant milestone for the court.

***Image 1** – left to right - Coroner Zerner, Coroner Kirkegaard, Coroner Williams and State Coroner Ryan.*

Courts and Tribunals (CAT) Awards

In March 2024, the annual CAT divisional award ceremony took place. With over 150 nominations received across the division, CCQ was well-represented in various categories as has been the trend in previous years.

The following CCQ representatives celebrated success in their respective nominated categories:

- Performance – Operations Team for the NCIS Coding project
- Customer Focus – Georgia Moloney
- Workplace Culture – Anna Tame

State Coroner's Guidelines

The State Coroner is tasked with issuing guidelines regarding the investigation of deaths and other relevant matters outlined in section 14 of the Act. These guidelines are designed to ensure best practice standards within the coronial system. Prior to issuing any guidelines or amendments to existing guidelines, the State Coroner is required to consult with the Chief Magistrate.

No updates were made to the State Coroner's Guidelines during the reporting period. All guidelines are available at: https://www.coronerscourt.qld.gov.au/resources/legislation-and-resources.

Practice Directions

The State Coroner may also issue practice directions about the Coroners Court's general procedures under section 69 of the Act.

During the reporting period, two practice directions were issued, both commencing on 1 June 2024.

Practice Direction No. 1 of 2024: Procedures for Pre-Inquest Conferences and Inquests

The aim of the practice direction is to ensure these hearings, which can be particularly stressful families, are conducted as efficiently as possible. The practice direction provides guidance for any person or entity who intends to appear at an inquest and sets out processes for providing notice of pre-inquest conferences, inquests and the delivery of findings. The practice direction addresses how families may seek to display a photograph of the deceased or an item of personal or cultural significance at the inquest or hold a culturally appropriate ceremony before the inquest commences.

Practice Direction No. 2 of 2024: Family Statements

The practice direction clarifies the nature of a family statement and outlines the information it should contain. Moreover, it acknowledges the significance of involving families in coronial proceedings, taking into account their therapeutic needs while participating in an inquest, while also ensuring procedural fairness is maintained.

All practice directions are available at: https://www.coronerscourt.qld.gov.au/resources/practice-directions.

Wellbeing Program

A critical service delivery need for the CCQ registry is the continued recognition of psychosocial hazards, including the risk of vicarious trauma inherent in its work. During the reporting period, CCQ intensified its efforts to mitigate, manage and support teams in this area. Central to this initiative has been the development of a tailored 'wellness program' aimed at both promoting wellbeing and supporting teams. CCQ enlisted the expertise of an external provider consisting of organisational specialists and clinical psychologists, who have been working closely with teams, focusing on wellbeing in the workplace.

In July 2023 the court established a three-year wellbeing strategy to continue support to teams inclusive of the following tailored support services and programs:

Individual wellness checks – an opt in process which provides individuals (virtually or in-person) with the opportunity to unpack any work or personal-related concerns, identify their strengths and develop effective coping strategies to improve their wellbeing.

Professional Group Supervision sessions – an opportunity for teams to discuss the events within in their work roles, providing a safe space to raise any concerns, learning or skill gaps or needs that they may have.

Managing workflow and navigating workplace change and uncertainty – use of practical work-related case studies to unpack strengths and pain points and to understand the drivers and impacts of change and the neuroscience behind responses to change.

Induction and Onboarding Program

The CCQ registry engaged the services of an external provider to develop induction and onboarding resources to support the introduction of new staff to the coronial jurisdiction. Resources include a new employee e-book detailing the court's vision and culture, onboarding checklists for managers and a series of 'Your Day' guides for positions in the court. These guides offer prospective employees a snapshot of a typical day's work.

CCQ Standalone Website

In early September 2023 the new standalone website at www.coronerscourt.qld.gov.au was launched, marking the culmination of a two-year period of research, development, consultation, and technical build time. The project was instigated in response to the Queensland Audit Office's 2018 report *Delivering Coronial Services*, which identified opportunities to better communicate the public value of the coronial system through sharing information about systemic learnings and death prevention, including from the Domestic and Family Violence Death Review and Advisory Board.[4] The CCQ website now offers a family-focused, accessible and consistent platform for providing information about the coronial process to families legal and health professionals.

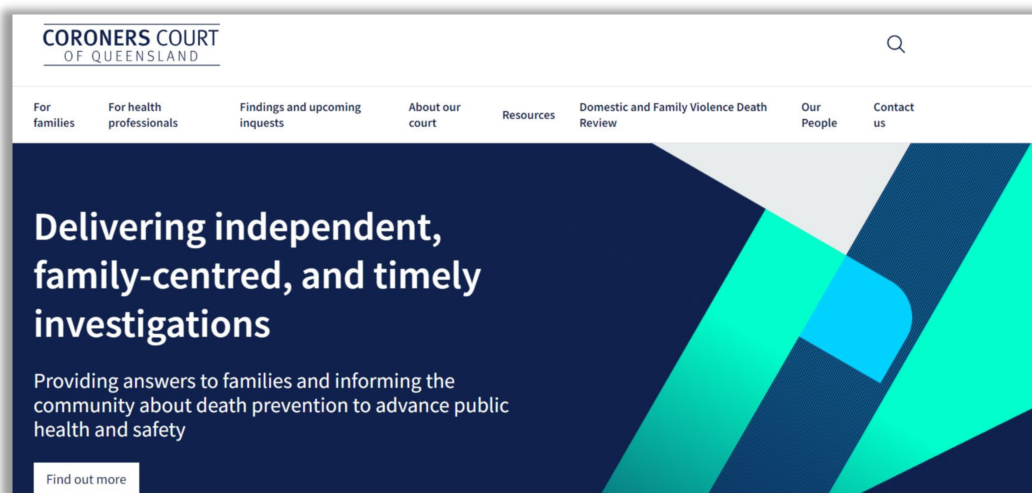


Image 2 *– Coroners Court of Queensland website landing page.*

[4] Delivering Coronial Services Report 6: 2018–19, https://www.qao.qld.gov.au/reports-resources/delivering-coronial-services.

Coronial Boundary Realignment

The appointment of additional coroners to the court prompted a review of the coronial reporting boundaries to ensure the equitable distribution of caseloads among coroners. After extensive consultation with police and coroners, and the transfer of autopsy services from Cairns to Townsville, boundary adjustments were implemented in March 2024.

Medical Practitioner Report of a Death to a Coroner (Form 1A and Form 9) Electronic Cause of Death Certificate Project

CCQ continued to work with the Registry of Births, Deaths, and Marriages to enhance the useability of its online portal and increase its uptake among doctors across the state, including pathologists working in the coronial system. The below figure shows the number of Form 9 cause of death certificates processed by form type.

Following last year's annual report, CCQ collaborated with Forensic Medicine Queensland to streamline *Form 1A – Medical practitioner report of a death to a coroner*. The revised version simplifies reporting instructions, enhances guidance on case reportability, restructures the form for clarity, emphasises doctor-family communication responsibilities, and directs families to the court for concerns. The updated Form 1A was completed on 1 July 2024.

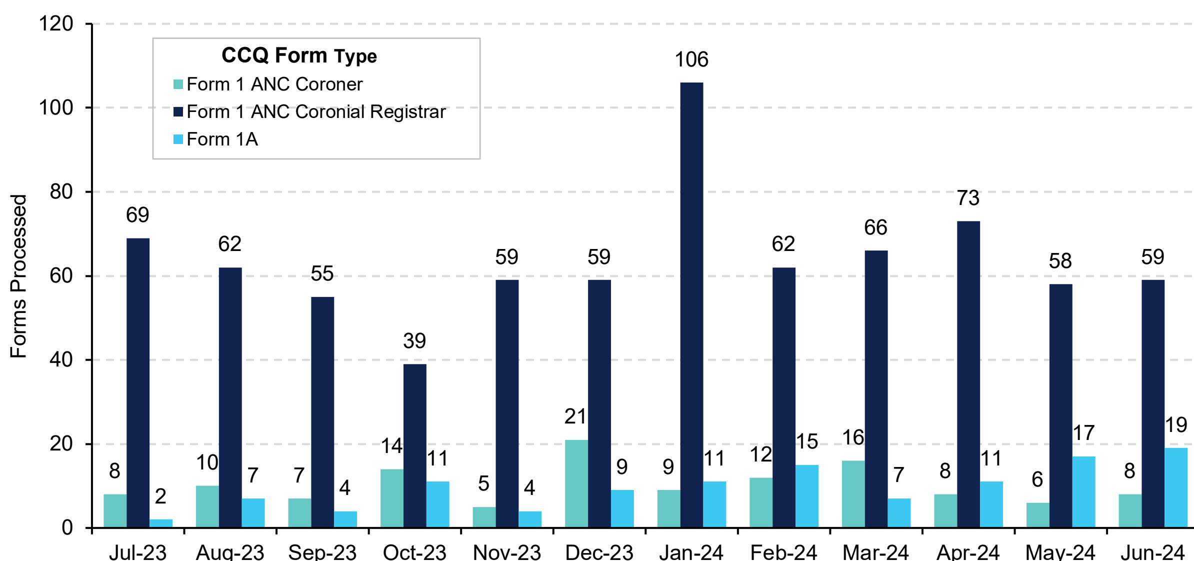


Figure 1 *– Form 9s processed by CCQ by form type.*

National Coronial Information Service (NCIS)

In July 2023, the CCQ registry assumed responsibility for coding cases into the NCIS, an online repository of coronial data for Australia and New Zealand. The team underwent extensive training, including thorough review of coding manuals spanning over 500 pages. Coding into the NCIS involves a meticulous process where team members analyse case details, select pertinent information, and input comprehensive data about deaths into the online database. Depending on complexity, each case may take between 15 to 60 minutes to code.

The team's tasks included addressing a substantial backlog of coding and optimising processes in Queensland. This involved discontinuing the previous coding system, Local Case Management System (LCMS), in favour of direct coding into the NCIS as cases were finalised in CCMS. Additionally, the team enhanced data fields to facilitate automatic transfer of information from CCMS to NCIS, thereby reducing manual data entry.

CCQ led the implementation of these initiatives with NCIS, achieving notable results in the first full month of dedicated coding efforts in September 2023. The initiative saw a remarkable 342.1 per cent increase in the number of Queensland cases closed in NCIS, totalling 1039 cases for the month. On average, the team closed approximately 49 cases per day and 246 cases per week, meeting the NCIS's case closure threshold of 80 per cent. During the reporting period 8,094 of cases were coded into the NCIS[5].

[5] Data supplied by the National Coronial Information System.

Farewell

During the reporting period, Magistrate Nerida Wilson and Magistrate Kerrie O'Callaghan returned to the general magistracy.

Nerida Wilson

Magistrate Wilson was appointed as the Northern Coroner in 2017 and served the Far North region until she returned to the general magistracy in September 2023. Prior to her appointment as a Magistrate in 2015, Magistrate Wilson served as an Australian Federal Police Officer from 1987 until 1995, thereafter completing her degree and practising as a solicitor and barrister.

During her time with the Coroners Court, Magistrate Wilson expertly investigated almost 1500 coronial matters encompassing a wide range of deaths owing to the vast regional catchment area she was responsible for. She demonstrated particular sensitivity towards the families of the deceased in her investigations, findings and at inquest. Over the course of her tenure Magistrate Wilson presided over several high-profile inquests attracting community and media interest nationwide.

The diverse range of matters investigated at inquest over the years included the multiple skydiving fatalities in 2019, the tragic baby death of James 'Bubba James' Tabuai due to a non-accidental skull fracture, the passing of 13-year-old Master Pini, a resident of a youth facility who died in a motor vehicle accident after accessing his carer's car keys, and the inquiry surrounding the disappearance of Jayden Penno-Tompsett during a road trip in 2017.

The inquiry into the tragic passing of 17-year-old Holly Winta Brown highlighted the significance of a coronial inquest in enhancing the safety of Queenslanders. Holly lost her life in 2015 while camping at the Laura Rodeo and Race grounds during an annual horse event. At the time, there were no emergency medical services available on the grounds, nor were there formal guidelines and protocols for event planning or risk assessment. Magistrate Wilson's inquiry led to a call for a standardised approach to deliver out-of-hospital emergency medical responses at mass gathering events, with the protocol to be named in Holly's memory.

The Lockhart River inquest examined circumstances leading to the deaths of the pilot and four persons onboard a Cessna aircraft which impacted Quintell Beach near Lockhart River after a number of missed approaches combined with poor visibility. Magistrate Wilson made six recommendations and found it was probable that had a terrain warning system been installed the accident would not have occurred.

Magistrate Wilson presided over a number of historical cases directed by the Attorney-General, including the re-opened inquiry into the deaths at sea of Enid Hyde and Norman Hyde near Yarrabah close to the 50th anniversary of the tragedy. The inquest was to re-examine the events of 1972 and the inquest held in 1973 to determine what occurred despite the difficulty with historical inquests where it was noted the 'only people who know the truth are all deceased'. The inquest into the highly publicised shooting death of Gwen Grover in 1983, which was held 38 years after the death following family advocacy, resulted in a new police investigation and an intensive review of her last 24 hours.

Toward the end of her time with CCQ, Magistrate Wilson delivered findings into the 'RHD Doomadgee Cluster' deaths of Betty, Ms Sandy, and Kaya. The inquest examined the deaths of three Aboriginal women who lived in the remote community of Doomadgee and died within 12 months of each other from complications of Rheumatic Heart Disease. The inquest received nationwide media attention. Magistrate Wilson determined there was a serious systemic failure across all of the relevant health services and facilities in Doomadgee that led to the deaths. The inquest resulted in 19 recommendations including for the health services involved and the state

health department to consider adopting a risk matrix for identifying, measuring, and monitoring institutional racism within public hospitals.

Magistrate Wilson acknowledged the cultural significance of hearing evidence 'On Country' with the inquest opening at Doomadgee, which saw significant attendance by the community. On behalf of the family and ancestors, a tribal warrior song and dance was held in appreciation of her conduct and recognition of her as a 'warrior' to the family. The Queensland Government accepted all recommendations for action.

Kerrie O'Callaghan

Magistrate O'Callaghan commenced with the Coroners Court on 5 December 2022 as a specialist coroner focusing on domestic and family violence and child related deaths. Magistrate O'Callaghan's appointment was on a temporary basis resulting from funding in the 2022–23 State Budget. Her experience includes arbitration and mediation, dispute resolution and litigation. She was appointed as a Magistrate in October 2017 and previously sat at the Southport and Dalby Magistrates Courts. Magistrate O'Callaghan was a Member and Senior Member of Tribunals from 1993 to 2017, including a Senior Member of the Queensland Civil and Administrative Tribunal from 2009 to 2017.

During her 12-month tenure with the court, Magistrate O'Callaghan dedicated considerable attention to the intricate and highly distressing cases of deaths associated with domestic violence. At inquest, Magistrate O'Callaghan took carriage of the multiple fatality car incident resulting in the tragic deaths of Charmaine McLeod and her four children. The two-week hearing in 2023 scrutinised the adequacy of responses by the police, health, and child protection agencies concerning Charmaine's complaints of domestic violence, child abuse, and the mental health care and treatment provided to her.

Prior to her departure from the court, Magistrate O'Callaghan delivered her findings of inquest into the suspected death of Tina Greer who went missing in 2012. Tina had recently ended her relationship with her partner, Leslie Sharman, the last person to see her alive. Tina's disappearance was treated as a homicide from the outset and the matter finalised without inquest. Tina's daughter appealed for an inquest to be held which was directed by the State Coroner with support from the Attorney-General. Despite intensive investigation and evidence at inquest, Magistrate O'Callaghan was unable to determine how or where Tina died but recommended that the Department of Child Safety, Seniors, and Disability Services require all staff to complete mandatory face-to-face training on domestic and family violence informed practice.

Reforming our Coronial System

Coronial Services System Delivery Framework 2021–2025

The *Coronial Services System Delivery Framework 2021–2025*[6] (the Framework) is the overarching strategic charter for agencies delivering coronial services. Our shared vision is for coronial services that partner to deliver independent, family-centred and timely investigations. The Framework reflects the joint commitment of agencies to a single coronial system which is interconnected and interdependent, working together through shared principles and responsibilities. Our shared priorities guiding the transformation of coronial services include:

- Family-centred coronial services
- Consistent statewide coronial services
- Sustainable and dynamic coronial system
- A whole of system approach to coronial services delivery
- Enhanced public value of the coronial system.

Coronial System Board

The Coronial System Board (the Board) assists the State Coroner with his role in coordinating and administering the coronial system under the Act. The Board provides strategic direction, enhanced partner collaboration, innovation and performance, and progresses programs of work in alignment with the Framework. The Board leads Queensland's coronial system transformation through greater coordination and planning to deliver family-centred services. Chaired by the State Coroner with the Deputy State Coroner as Deputy Chair, membership consists of senior leaders from the DJAG, QH and QPS.

In 2024, the Board refreshed and updated governance coronial system arrangements. The Board dissolved the Coronial System Coordination Group, updated membership of the Board and established two new sub-committees made up of partner agency representatives to work on initiatives to assist the Board in the key areas of performance and reform.

The Board and members of the Coronial System Coordination Group met nine times during the reporting period.

The Board held a successful Summit Day in October 2023 to address the problem statement: 'How can partner agencies efficiently and effectively deliver sustainable, trauma-informed, end-to-end coronial services to meet existing and future demand?'. The Board also held a workshop to determine areas of reform focus including improving services across the system, raising responsiveness and capacity, and delivering timely outcomes for families.

During the reporting period, partner agencies implemented responses to remaining recommendations identified in the Queensland Audit Office's 2018 report *Delivering Coronial Services* and the Board agreed that all recommendations were fully implemented. The reform activity driven by the QAO recommendations is now part of coronial system business as usual activity.

[6] Coronial Services System Delivery Framework, https://www.coronerscourt.qld.gov.au/__data/assets/pdf_file/0006/805785/23072001-coronial-system-board-coronial-system-framework-final.pdf

Performance and Operations Sub-Committee

The Performance and Operations Sub-Committee first met in June 2024. This sub-committee oversees and monitors coronial system operational performance, and its functions include:

- identifying and developing solutions to operational issues, including joint-agency responses to feedback and concerns
- managing cases through the coronial system
- implementing and driving the Backlog Reduction Strategy, and
- driving system improvements.

Coronial System Reform Sub-Committee

The Coronial System Reform sub-committee first met in June 2024. This sub-committee continues the work of the cross-agency Coronial Services Reform Program team to bring system wide reform to the service delivery model. Reform is directed towards ensuring a more transparent, accountable, effective and coordinated coronial system and improving the timely finalisation of matters through realising efficiencies in integrated operations.

Secretariat functions and responsibilities for the Board moved in 2024 to sit within the new Coronial Services Practice Prevention and Reform team within the CCQ registry.

Coronial Performance

Coronial performance in Queensland is assessed against national benchmarking standards outlined in the Report on Government Services.[7] Performance is evaluated based on a **clearance rate** and a **backlog indicator**.

The **clearance rate** provides insight into the court's efficiency in handling cases promptly. It is measured by comparing the number of cases lodged to those finalised.

The **backlog** assesses the 'age' of a pending case on 30 June each year against specific benchmarks.

External factors can influence the clearance rate and backlog, such as fluctuation in lodgments rates, shifts in court operational procedures, case complexity and matters awaiting finalisation of other investigations or court proceedings.

Reported Deaths

Not every death in Queensland needs to be reported. Only deaths triggered by specific incidents, where the cause is unknown or involving vulnerable individuals are considered reportable and undergo investigation. Of the **38,080**[8] **deaths that occurred in Queensland** during the reporting period **6,071** were reported to the Coroners Court for investigation, representing 16 per cent of all deaths in Queensland. Once a report of a death is received by CCQ, further analysis occurs to determine whether the matter meets the statutory definition of a reportable death.

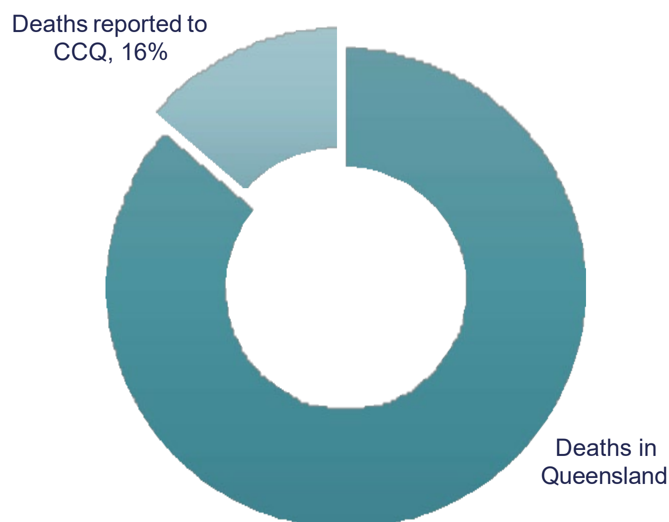


***Figure 2** – Deaths reported in Queensland and percentage reported to CCQ.*

[7] Report on Government Services, Report on Government Services - Productivity Commission (pc.gov.au).
[8] Figure provided by the Registry of Births, Deaths and Marriages.

Clearance Rate

Since 2019–20 there has been a general upward trend in the number of cases reported to the court, culminating in a peak during 2022–23 when the court registered its highest number of lodgements. The latest reporting period showed a 7 per cent decrease compared to the previous year.

The court improved its clearance rate by 8.54 per cent, compared to 2022–23, to 99.74 per cent. Of the 6,055 lodgements finalised, 4,987 (82 per cent) were finalised within 12 months.

These trends indicate ongoing efforts by the court to manage and resolve cases in a timely way.

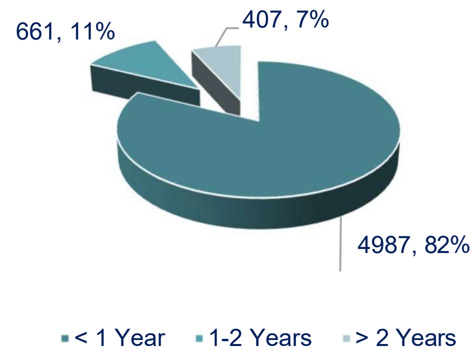


***Figure 3** – Finalisation of lodgments, by case age.*

Year	Cases lodged	Per cent change	Cases finalised	Clearance rate	Backlog	Inquests Finalised[9]	Cases finalised at inquest[10]
2023–24	6,071	-7.03%	6,055	99.74%	17.54%	23	31
2022–23	6,530	8%	5,999	91.9%	17.7%	20	24
2021–22	6,044	5.78%	6,115	101.2%	14.82%	27	35
2020–21	5,714	1.47%	5,845	102.29%	14.18%	26	27
2019–20	5,631	-2.86%	5,744	102.02%	14.81%	28	48
2018–19	5,797	-0.26%	5,860	101.09%	17.58%	29	29
2017–18	5,812	4.02%	5,618	96.66%	18.43%	40	52
2016–17	5,587	5.67%	5,014	89.7%	16.6%	28	30

***Table 1** – Performance Summary 2016–17 to 2023–24.*

Backlog Indicator – Pending Cases

Coroners are aware that delays in finalising coronial matters can cause unnecessary distress for families. However, finalising a coronial investigation can be dependent on completion of other investigative processes (for example, the completion of autopsy, toxicology, and police reports). Coroners may also await outcomes of criminal proceedings before finalising the coronial investigation.

CCQ has worked with partner agencies (QPS and QH) to embed and implement the Coronial System Backlog Reduction Strategy. Implementing the strategy has included increasing the number of coroners, updating the Coronial System Board's terms of reference, establishing the Performance and Operations sub-committee to drive implementation of the strategy, developing cross-agency status reports and increasing resources for the CCQ registry.

[9] Figure refers to inquests finalised, not the number of deaths investigated at inquest. An inquest can be held into multiple deaths.
[10] The inquests finalised and deaths finalised at inquest have been revised following data validation in 2023-24.

The CCQ backlog indicator percentage decreased slightly from the previous year to 17.54 per cent (or 503 cases) from 17.7 per cent (or 502 cases) in 2022–23. The total number of lodgements pending for this reporting period was 2,867, a slight increase from 2,833 in 2022–23.

A breakdown of the 2,867 lodgements pending by case age as of 30 June 2024 is depicted below.

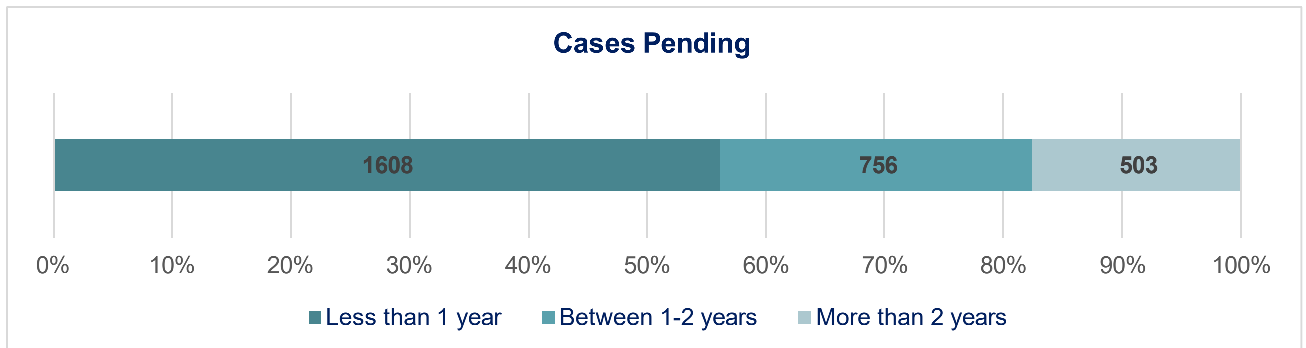


***Figure 4** – Cases pending as at 30 June 2024.*

Reportable Type

Section 8(3) of the Act defines the types of deaths reportable to a coroner for investigation. The number of deaths reported to CCQ within each category are shown in the table below.

Category of death	2023–24	2022–23	Per cent change
Suspected death (missing person)	12	23	- 47.83%
Death in custody	25	29	-13.79%
Death as a result of police operation	8	14	- 42.86%
Death in care	145	144	0.69%
Health care related death	475	481	-1.25%
Suspicious circumstances	12	17	-29.41%
Violent or unnatural	2,794	2,871	-2.68%
Death certificate not issued and not likely to issue	2,584	2,987	-13.49%
Unknown persons	16	10	60%

***Table 2** – Deaths reported statewide by primary reportable type 2023-24 compared to 2022–23.*[11]

[11] The total *Reportable Type* may be different from *the total number of cases lodged*, as multiple *Reportable Types* may be selected on a case in the CCMS.

Deaths by Coronial Region

CCQ receives reports of deaths across the state, which are categorised based on where the death occurred into one of four registry (coronial boundary) locations. The figures below represent the performance per location from the previous year. It is important to note that the State Coroner, Deputy State Coroner and Coronial Registrars receive reports of deaths statewide.

Deaths reported by coronial region	Brisbane 2023–24	Brisbane 2022–23	Northern 2023–24	Northern 2022–23	Central 2023–24	Central 2022–23	Southern 2023–24	Southern 2022–23
Number of deaths reported for investigation	**4,120**	4,387	**651**	687	**621**	673	**679**	783
Number of coronial cases finalised	**4,062**	4,101	**696**	585	**700**	644	**597**	669
Number of coronial cases pending	**1,697**	1,626	**479**	519	**275**	355	**416**	333
Coronial cases pending - *Greater than 24 months old*	**308**	285	**76**	110	**57**	56	**62**	51

***Table 3** – Regional performance 2022–23 to 2023–24.*

Not Reportable Matters

Many matters reported to CCQ are found to be not reportable as the death does not meet the definition of a reportable death under section 8(3) of the Act.

Of the deaths finalised during the reporting period **2,530 were determined to be not reportable** matters. These matters are included in the court's lodgement figures as significant work is involved in determining whether these matters are reportable or whether a death certificate can be authorised. This work can involve reviewing medical records, discussing the death with treating clinicians and family members and obtaining advice from FMQ.

Review applications

The State Coroner has a review function under the Act with respect to coroners' 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 the reporting period, the **State Coroner received 28 applications for review of a coroner's decision and finalised 17 matters**.

How Deaths are Reported

CCQ receives reports of deaths from police (via Form 1) and medical practitioners (via Form 1A). CCQ also receives 'Other' reports of deaths for review and investigation. These can include phone calls from medical practitioners, funeral directors, or aged care facilities, family members, missing person reports/advice, child death advice and notifications from the NDIS.

Initiating Form / Report	2023–24	2022–23	Per cent change
Form 1 – Police Report of a death	3,187	3,495	-8.81%
Form 1A – Medical practitioner report of a death	1,140	1,359	-16.11%
Phone call	1,588	1,461	8.70%
Other	58	76	-23.68%
Cause of Death Certificate	33	47	-29.79%
Child Death Advice Report	21	14	50%
Concerns	21	35	- 40%
QP608	14	23	-39.13%
NDIS Notification	9	25	-64%

***Table 4** – Initiating report of death for 2022–23 and 2023–24.*

Of the 6,071 cases reported to the court, 97 per cent were reported by police, medical practitioners and via phone calls to determine whether a death is reportable.

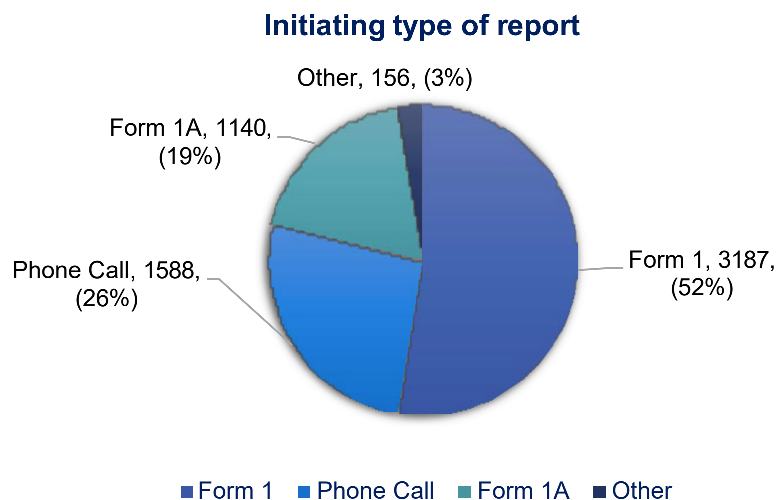


***Figure 5** – Initiating type of report for 2023–24.*

Death Type – Suspected Suicides

Suspected suicides continue to be one of the leading preventable causes of death in Queensland. In 2023-24, there were 784 suspected suicides reported to the court for investigation. Of these:

- 607 cases were men, accounting for approximately 77.4 per cent of the total.[12]
- 177 cases were women, making up about 22.6 per cent of the total.
- 50 cases were persons who identified as Aboriginal or Torres Strait Islander.

During the reporting period, the court continued to provide coronial investigation data and investigation documents to agencies to inform service responses and early intervention activities as well as support research into the development of suicide prevention policy and planning and suicide monitoring surveillance systems and projects.

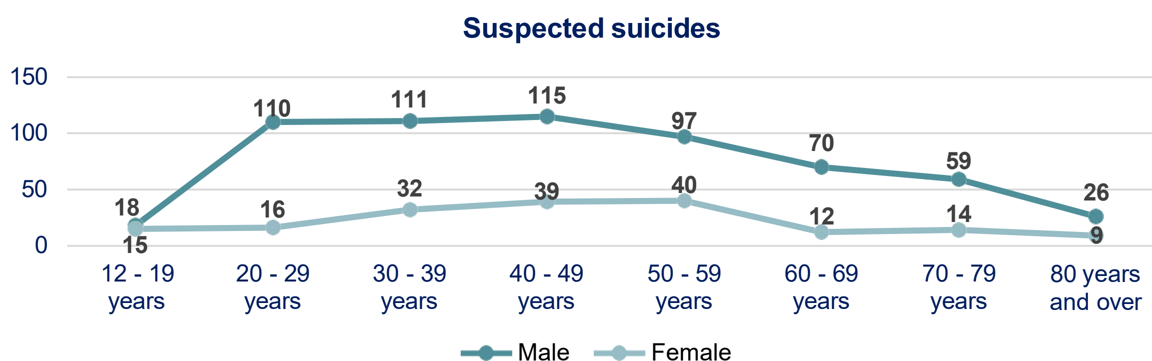


Figure 6 – Suspected suicides reported by age groups – male and female.

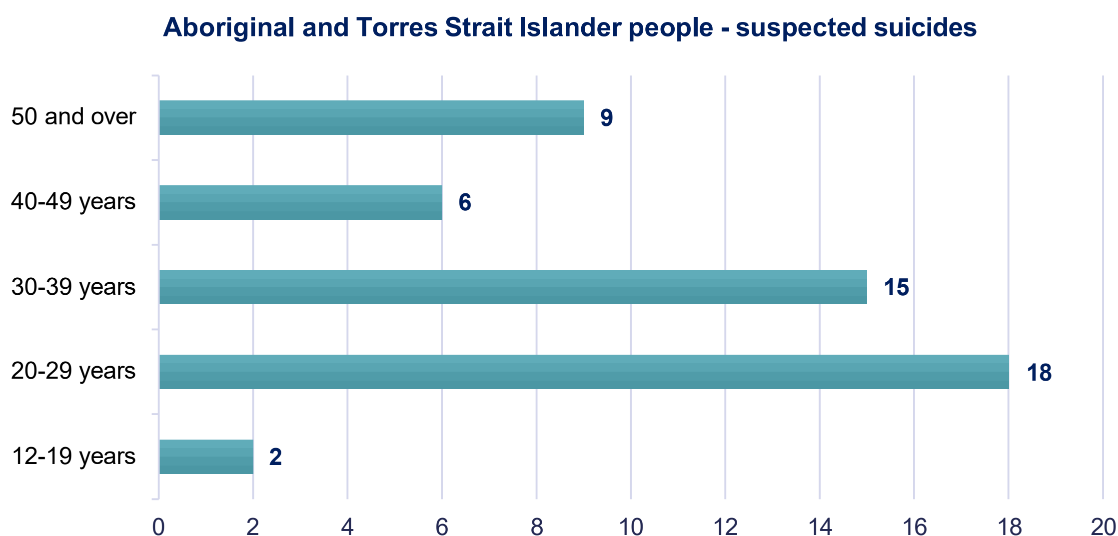


Figure 7 – Suspected suicides for Aboriginal and Torres Strait Islander people, by age group (male and female combined).

[12] For one male reported suspected suicide case, the age was unknown at the time of reporting.

Inquests

An inquest serves as the public face of the coronial process, being an open court proceeding that examines the events preceding a death. Inquests offer families insight into the circumstances surrounding the passing and offer transparency to the public regarding the death. Importantly, an inquest empowers coroners with legal authority to make comments and recommendations aimed at preventing or reducing deaths in similar circumstances in future. Each year only a small number of matters, less than one per cent of deaths reported to the court, progress to inquest.

Inquests

The Act requires that certain deaths are investigated at inquest, including those occurring in custody, in care or in the course of police operations, where there are issues about the care or police involvement. Inquests may also be held at the direction of the Attorney-General or District Court. A coroner may also convene an inquest if satisfied it is in the public interest, including whether drawing attention to the matter may prevent similar deaths in future.

During the reporting period CCQ finalised inquests into the deaths of **31 persons with 23 inquest findings** in comparison to previous reporting period with inquests into 24 persons with 20 inquest findings completed.[13] This figure does not account for the number of inquests that were opened or had ongoing hearings by coroners during the reporting period.

Inquest Categories

During 2023-24 period approximately 56 per cent of inquests finalised were classified as mandatory inquests required by the Act. About 39 per cent of inquests were conducted in the public interest. Additionally, one inquest finalised in the reporting period was directed by the Attorney-General, concerning the matter of Sharron Phillips.

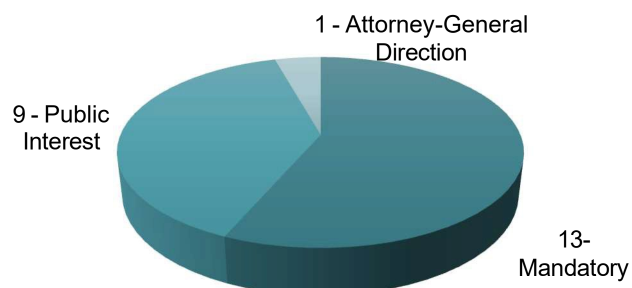


***Figure 8** – Inquests finalised by category.*

Counsel Assisting

Coroners are supported by in-house Legal Officers (referred to as Counsel Assisting). CCQ has developed a team of specialised Counsel Assisting with backgrounds ranging from Legal Aid, the Director of Public Prosecutions, mental health and child protection. This allows CCQ to reduce costs by briefing out to members of the private bar only as required, in line with equitable briefing practices. This may occur, for example, in order to acknowledge the unique nature of technical investigations involving air crashes, mining accidents, or matters involving the passing of Aboriginal and Torres Strait Islander people in remote Indigenous communities. During 2023–24, in-house Counsel Assisting conducted all but six inquests finalised in the reporting period.

[13] One inquest may include multiple deceased.

Media and Community Interest

Coronial inquests and coroners’ findings at inquest continue to attract significant attention from the media and the community. CCQ, in consultation with the Department’s Media Relations Unit, addressed **528 media queries in 2023–24**, a significant increase from 301 in the previous year. These queries related to updates on investigations, requests for non-publication orders, exhibit requests, witness lists and other general investigative updates.

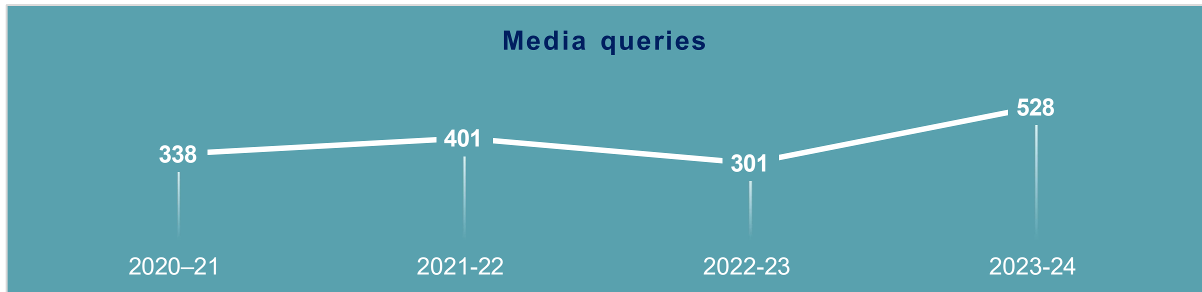


***Figure 9** – Media queries received from 2020–21 to 2023–24.*

Deceased name	Coroner	Inquest Category	Recommendations made	Keywords
Edgar Hugh Sandow (AKA Conlon)	State Coroner Ryan	Mandatory	Nil	Death in custody, natural causes
John Fredrick Schulte	State Coroner Ryan	Mandatory	Nil	Death in police operations, domestic violence
Thomas Edward Schwartz	Deputy State Coroner Gallagher	Mandatory	Nil	Death in custody, natural causes
Lockhart River Plane Crash No.2 Wayne Joseph Ganter, Mark Robert Rawlings, Henry Phillip Roebig, Wayne Anthony Brischke, Stuart Henry Russell Weavell	Coroner Wilson	Public Interest	Six	Controlled flight into terrain, plane crash
Leo Gareth Dodunski	Coroner MacKenzie	Public Interest	Two	Workplace health and safety incident, fatally struck by drill rig-machinery
AJO	State Coroner Ryan	Mandatory	Nil	Death in custody, hanging, suicide
GLT	State Coroner Ryan	Mandatory	Two	Domestic violence, death in custody, restraint, multifactorial cause of death, recognition of rapid deterioration by police officers
Herbert Charles Hilsley	State Coroner Ryan	Mandatory	Nil	Death in custody, natural causes
James Lewis Cummins	State Coroner Ryan	Mandatory	Nil	Death in custody, natural causes
Manmeet Sharma	State Coroner Ryan	Public Interest	Nil	Mental health, killing of a bus driver by mentally ill person
Omid Molayee	State Coroner Ryan	Mandatory	One	Death in custody, police shooting, self-immolation in vehicle
Jennifer Kohl	Coroner Lee	Public Interest	Four	International backpackers, farm equipment, ride on mower roll over
Tina Louise Greer	Coroner O'Callaghan	Public Interest	Four	Missing person, child safety, domestic and family violence
Aaliyah Te Paa, Rayvenna Coolwell Barefoot, Cayenne Robertson	State Coroner Ryan	Mandatory	Nil	Death in police operations, whether there was a pursuit
13-year-old boy	Coroner Lee	Public Interest	Six	Child death in care
Joshua William Klumper	Deputy State Coroner Gallagher	Public Interest	Nil	Suicide, hanging, youth, mental health, cannabis withdrawal, autism spectrum disorder
Samuel Timothy Brown	Deputy State Coroner Gallagher	Public Interest	Nil	Cause of head injury, competing expert opinions

Thompson James Harvey	State Coroner Ryan	Mandatory	Nil	Death in custody, domestic violence, hanging, substance misuse
Russell James Williams	State Coroner Ryan	Mandatory	Nil	Death in custody, remand prisoner, Safety Order, revocation of Safety Order, prison issued razor, suicide risk assessment
Sharron Phillips	State Coroner Ryan	Attorney-General Direction	Nil	Missing person, suspected death, reopened inquest, whether missing person is deceased, true crime podcast
Constance Watcho	Deputy State Coroner Gallagher	Public Interest	One	Missing person, death in suspicious circumstances
Lester Gilmore Shelton	Deputy State Coroner Gallagher	Mandatory	Nil	Natural causes, death in custody
Shiralee Deanne Tilberoo and Vlasta Wylucki	Deputy State Coroner Gallagher	Mandatory	5	Deaths in police watchhouses, family liaison, adequacy of care of prisoners and adequacy of prisoner inspections

***Table 5** – Inquest finalised during 2023–24 reporting period.*

Reducing Preventable Deaths

Responses to Coronial Recommendations

Responses to recommendations directed at the Queensland Government are published on the Queensland Courts website near the relevant inquest finding. These responses outline whether a recommendation is being considered, how it will be implemented or the rationale behind not supporting it. The Queensland Government endeavours to address coronial recommendations involving agencies by providing implementation updates until the recommendation is delivered or not supported. Some of the key responses made during the reporting period are listed below.

Brett Forte and Ricky Maddison – State Coroner Ryan

SC Brett Forte died after he was shot by Ricky Maddison following a police pursuit that ended in a confrontation. On 22 March 2024 the Queensland Police Service confirmed the establishment of six permanent District Duty Officer positions at Senior Sergeant level in the Darling Downs District and commencement of a pilot of a new QSearch tool to facilitate searches across all types of data and attachments held within the Queensland Police Records Information Management Exchange.

William George Grimes – State Coroner Ryan

Mr Grimes was tasered by police in an effort to stop him from setting himself of fire. On 22 March the Queensland Police Service established six permanent District Duty Officer positions at Senior Sergeant level in the Wide Bay District.

Tina Greer – Magistrate O'Callaghan

Ms Greer was reported missing in 2012 after ending her relationship with her partner who was the last person to see her alive. On 11 March 2024 the Department of Child Safety confirmed that all Child Safety Officers are required to attend face to face training and other foundational training, regarding domestic and family violence informed practices.

Lee Edward Parker – former Deputy State Coroner John Lock

Mr Parker died from smoke inhalation and effects of fire in an on-site bus that had been converted into a dwelling. As of 14 November 2023, a cross-agency working group to consider options for improving fire safety in moveable / alternative dwellings where people sleep was established. On 7 March 2024, the *Disaster Management and Other Legislation Amendment Bill 2024* came into force which provides requirements for smoke alarms in caravans and motorised caravans.

RHD Doomadgee Cluster – Magistrate Wilson

The RHD cluster involved three Aboriginal woman who lived in the same remote community and died within 12 months of one another. The Queensland Government confirmed it had accepted all recommendations which included assessment of gaps in service provision in Doomadgee and to develop a model of care which would effectively meet the needs of the community with regard to healthcare services. The Coroner also recommended a cultural leader/restorative expert be engaged to restore the trust between the community and health care providers in Doomadgee. As of 30 January 2024, all recommendations were under consideration or implemented.

Billy-Joh Watts – Coroner MacKenzie

Mr Watts was crushed by a falling pipe while a forklift was unloading a truck. On 10 October 2023, the Office of Industrial Relations confirmed the recommendation to review the Event Management procedure to facilitate sharing of information with other regulators where an inspector obtains information that may be relevant to enforcement of another Act has been completed and amended.

Non-Inquest Findings

The Act authorises coroners to publish non-inquest findings, known as chamber findings, when it is deemed in the public interest. This proactive publication may serve various purposes such as supporting initiatives to prevent deaths, increasing public awareness about preventable fatalities, correcting public misinformation, or informing regulators in specific professions and industries. Before publication, coroners must consult with the deceased's family to consider their views. In appropriate cases, findings can be anonymised. Additionally, the State Coroner's Guidelines provide that any individuals named in findings should be notified and provided an opportunity to respond before the findings are published.

During 2023–24 coroners published five non-inquest findings. The findings are accessible at the Coroners Court website - https://www.coronerscourt.qld.gov.au/findings-upcoming-inquests/search-findings.

Deceased name	Coroner	Keywords
Elaine Redmond	Coroner Roney	Fall, domestic accident (non-work related), subdural haemorrhage, Alzheimer's disease, anticoagulant therapy, hospital, medication error, Intracranial bleed, healthcare related.
Ms S	Coroner Bentley	Suicide, post-natal depression, lack of perinatal mental health beds, mother baby mental health inpatient treatment.
Mr G	Coroner Williams	Drowning, Crystal Cascades Waterhole, waterfall, safety signage.
Lenore	Coroner Kirkegaard	Health care related death, venous thromboembolism (VTE) risk assessment and management, standardised VTE risk assessment tool & practice, multidisciplinary safety net for VTE risk assessment and prophylaxis, rural and regional referral hospital.
Pilot	Coroner Lee	Aviation, recreational flying, drifters, low level flying, alcohol and drugs, non-compliance with regulatory framework.

***Table 6** – Non-inquest findings published during 2023–24 reporting period.*

Public Interest and Attorney-General Directed Inquests: Case Summaries

Section 28 of the Act authorises an inquest into a reportable death if a coroner investigating the death is satisfied it is in the public interest to do so. The 'public interest' is a discretionary consideration by a coroner. Some factors considered when assessing whether an inquest should be held include, but are not limited to, whether there is reasonable doubt about the cause or circumstances of the death, if there is a public interest in drawing attention to the death to prevent similar deaths in future, whether have previous inquests have dealt with similar deaths and made recommendations that have not been adopted or is there the potential for publicity from an inquest to generate new evidence. The Attorney-General can also direct that an inquest be held.

The following sections provides a summary of inquests finalised by coroners during the reporting period that were convened in the public interest or directed by the Attorney-General.

Wayne Joseph Ganter, Mark Robert Rawlings, Henry Phillip Roebig, Wayne Anthony Brischke, Stuart Henry Russell Weavell ('Lockhart River Plane Crash No. 2')

Coroner Wilson – 30 August 2023.

Circumstances of the Death

At 7.19am on 11 March 2020, a Cessna 404 aircraft departed Cairns en-route to Lockhart River. The five persons on board were Mr Stuart Weavell (the pilot), Mr Wayne Ganter, Mr Henry Roebig, Mr Wayne Brischke and Mr Mark Rawlings. The purpose of the flight was to convey personnel from Cairns to inspect the site of a school construction project, and to undertake a pest and termite inspection.

On approach into Lockhart River, the pilot encountered heavy rain and low visibility. The initial approach was missed.

While attempting a second approach to the runway, the aircraft descended below the minimum descent altitude, on a ground track 20 degrees left of the final approach track, before impacting with sand dunes at Quintell Beach, fatally injuring all on board.

The Inquest

The inquest hearing extended from 17 to 20 July 2023. Eleven witnesses were called and further written statements were received. The focus of the inquest was to identify and examine the circumstances that might explain the cause of the collision.

In addition to the matters arising under section 45(2) of the Act, the issues for investigation at inquest were: (1) the circumstances of the flight; (2) the level and adequacy of the pilot training of the pilot and his flying proficiency and experience in conducting RNAV (area navigation) GNSS (global satellite system) approaches; (3) whether the relevant air operator of the flight had in place appropriate safety management systems and adequate standard operating procedures in relation to the conduct of flights involving RNAV GNSS approach procedures; (4) whether the Civil Aviation Safety Authority adequately attended to the formulation of a regulatory policy in relation to the installation of a terrain avoidance and warning system ('TAWS') in piston engine aircraft; and, (6) any matters relevant to the prevention of similar accidents in the future.

Witnesses who gave evidence included qualified pilots with significant aviation experience, and qualified flight examiners who had undertaken various proficiency checks and other training directly with the pilot.

Findings and Comments

On the basis of the evidence it was concluded that (1) the collision with ground was the result of pilot error; (2) the pilot believed the aircraft was 1,000 feet higher than it actually was; (3) the pilot misread the altimeter, and possibly other instruments; and (4) the pilot's workload at the time was very high, taking into account the heavy rain, and lack of ground visibility, in the course of the instrument landing.

The evidence failed to demonstrate the reasons for an increase in airspeed, and rate of descent, in the 30 seconds prior to impact. Instrumentation capable of indicating altitude was fitted to aircraft of this type, but it could not be determined if that feature was engaged at the time. The aircraft was not fitted, and was not required to be fitted, with a Terrain Awareness Warning System. It was noted that there had been a previous multi-fatality collision with terrain at Lockhart River, which had been investigated by State Coroner Barnes in 2007. At this inquest, it was found that if a properly operating and fully-functional TAWS had been fitted, this earlier incident would probably not have occurred.

Recommendations
A number of recommendations were made, including that:

1. the Civil Aviation Safety Authority (CASA) implement legislation requiring TAWS in an expanded range of aircraft operations, which would include the in the circumstances of this case; and
2. CASA provide further information and advice about the hazards of conducting instrument approaches in relevant circumstances.

Gareth Leo Dodunski

Coroner MacKenzie – 31 August 2023.

Circumstances of the Death

Mr Gareth Dodunski was 21 years old when he died at the Fairview Mining Camp on 23 June 2013. He was working as a floorhand on a drill rig. Mr Dodunski died after being struck in the head by an item of drill rig machinery called an 'ST-80 Iron Roughneck tool' (ST-80).

At the time of this fatal incident, the Mr Dodunski was working with another crew member to attach a 'dog collar' to a section of the drill 'string' before the ST-80 was activated. Mr Dodunski and his co-worker were on opposite sides of the drill string and were meant to leave the ST-80 operating area before it was operated from an adjoining operating box. Tragically, the ST-80 was engaged while Mr Dodunski was still in the 'danger' zone of the ST-80. He died at the scene.

The incident that resulted in Mr Dodunski's death was the momentary inattention on the part of the driller when the ST-80 was activated, which struck the deceased causing his death.

The Inquest
In summary, the issues for the inquest were (1) the findings required by section 45 (2) of the Act; (2) the circumstances surrounding the death; (3) the adequacy of safety management systems both before and after Mr Dodunski's death; (4) the adequacy and timeliness of investigations conducted by police, work health and safety and petroleum and gas inspectorates; (5) actions that have been taken since this death to prevent deaths from happening in similar circumstances; and, (6) any matters relevant to the prevention of similar accidents in the future.

The inquest itself occupied seven hearing days, and oral evidence was provided by 18 witnesses who attended the inquest in person to give their evidence.

Findings and Comments
Coroner McKenzie determined that there had been some inadequacy of training, supervision, and oversight, but that none of those features had contributed to Mr Dodunski's death. The systems in place, however, had not been adequate to prevent or minimise the risk of death or injury relating to the operation of the ST-80.

There was no evidence that Mr Dodunski's death was caused by incompetence or gross negligence, as opposed to momentary error and inadvertence.

Recommendations
By the time the inquest was held, further safety and preventive reforms had been implemented which rendered further recommendations unnecessary.

Coroner MacKenzie did recommend that all work health and safety legislation in Queensland should be in one source document, to avoid confusion, and remove differing procedural requirements. In addition, investigators in the petroleum and gas sector should be accorded greater investigative authority, such as was already available within other workplace regulatory regimes.

Manmeet Sharma

State Coroner Ryan – 27 October 2023.

Circumstances of the Death

Mr Manmeet Sharma died from the effects of fire at the age of 29 years. Mr Sharma was the driver of a Brisbane City Council bus. On 28 October 2016, a passenger on Mr Sharma's bus ignited accelerant that had been tipped on Mr Sharma. The passenger was Mr Anthony O'Donohue. The ensuing fire put other passengers at imminent risk. A passing taxi driver, Mr Aguek Nyok, forced open the rear doors of the bus enabling other passengers to escape while other motorists attempted to extinguish the fire.

The Investigation

The coronial investigation identified that Mr O'Donohue had a mental health treatment history including a diagnosis of Delusional Disorder, Persecutory Type. He had a history of making threats to harm himself and others.

Mr O'Donohue accessed voluntary treatment in the community and had also been treated under an Involuntary Treatment Order (ITO). The ITO was revoked in late 2014, but he continued to receive treatment on a voluntary basis. His voluntary treatment then ceased in the context of resistance to treatment and rehabilitation or sharing information with his GP. He was still being prescribed appropriate medication and was regarded as being stable overall. He was considered to be 'low risk' at the time of being closed by his treatment provider.

Criminal proceedings against Mr O'Donohue were discontinued as a result of proceedings in the Mental Health Court. A non-revocable forensic order for 10 years was imposed.

An examination of the bus identified that there was a rapid escalation in the fire's development and Mr Sharma did not have time to escape.

The Inquest

The inquest was conducted over three days in June 2022. Oral evidence was taken, and a significant volume of material tendered about Mr O'Donohue's treatment and care.

Findings and Comments

The inquest concluded that the decision to revoke Mr O'Donohue's Involuntary Treatment Order (ITO) in 2014 was correct as he no longer met the clinical criteria.

The conclusion reached in the final risk assessment by Mr O'Donohue's treatment provider was affected by a lack of relevant clinical notes and Mr O'Donohue's own boundary setting during treatment. There was no way the treatment provider could have predicted Mr O'Donohue's attack on Mr Sharma. While being treated, the treatment and care provided to Mr O'Donohue by his treatment provider was considered reasonable. There was a missed opportunity for his treatment provider to engage directly with Mr O'Donohue's treating GP.

The inquest acknowledged the significant changes to Queensland's mental health system since Mr Sharma's death. The inquest also acknowledged practical and policy work being done by stakeholders to improve the safety of bus drivers.

Jennifer Kohl

Coroner Lee – 1 December 2023.

Circumstances of the Death
Jennifer Kohl, a 27-year-old German woman on a working holiday in Australia, was working on an avocado farm in Tamborine Mountain with her boyfriend, Paul Tunik.

On 8 December 2017, Ms Kohl and Mr Tunik were using a large ride-on mower with a low set trailer. At around 11am, Mr Tunik was driving the mower in a sloped and unused area of the property. Ms Kohl was sitting beside him on a mud guard. The mower rolled and Ms Kohl was trapped underneath.

Mr Tunik called 000 but there was a delay in emergency services attending the scene. Two passing motorists were flagged down but the three people were unable to lift the mower.

Ms Kohl was unresponsive when Queensland Ambulance Service (QAS) officers arrived. The mower was lifted off Ms Kohl with the assistance of Queensland Fire and Emergency Service (QFES) but Ms Kohl could not be revived.

The Investigation
The Queensland Police Service investigated, obtaining witness statements and other evidence. A mechanical inspection of the mower revealed several issues though none could be attributed as being the cause of the accident. A decision was made not to charge Mr Tunik.

Workplace Health and Safety inspectors investigated and initiated prosecutions against the farm operators, though the proceedings were ultimately discontinued as Mr Tunik did not attend court for the purpose of giving evidence.

Chamber findings were published on 3 December 2021 after the Office of Industrial Relations (OIR) advised that a criminal prosecution would not proceed. The coronial investigation was re-opened after an application was made on behalf of Ms Kohl’s mother for an inquest to be held.

As Ms Kohl was on a working holiday visa, information was obtained from the Department of Home Affairs (DHA) and OIR about the rights a young person on a working holiday has regarding workplace health and safety.

The Inquest
The inquest took place on 10 and 11 May 2023. Evidence was heard from seven witnesses, including the individuals who ran the farm. Mr Tunik had disengaged with the proceedings.

In addition to the findings required by section 45(2) of the Act the inquest also considered: what caused the mower to roll, the adequacy of safety measures, the appropriateness of the QAS emergency service dispatch, whether any delays in the attendance of emergency services, if avoided, would have changed the outcome and what measures are in place to safeguard international backpackers undertaking farm work.

Finding and Comments
Coroner Lee found that the mower rolled because it gathered speed after Mr Tunik drove it down the steep hill. It was determined it could not be slowed and Mr Tunik turned sharply causing the mower to roll. It was found that (1) the mower was to be used in specific areas for specific tasks; (2) the mower was suitable for the circumstances in which it was to be operated and that wheel weights were not necessary; (3) it could not be found that the absence of weighting and braking mechanisms contributed to the accident; (4) Mr Tunik provided inconsistent versions of events, repeatedly encouraged Ms Kohl to ride on the mower and it was the first time he had driven the mower on the unused area of the farm.

The workplace health and safety measures related to the mower were found to be appropriate, as was the dispatch of emergency services to the scene. The delay in the dispatch of emergency services could not have been prevented and, had it been possible, it was unlikely the tragic outcome could have been avoided.

Issues in relation to information provided to backpackers undertaking farm work were comprehensively addressed by information provided by OIR and DHA.

Recommendations

Coroner Lee recommended improving the information about workplace health and safety available to young people coming to Australia including, amongst others, DHA centralising information about workplace health and safety on a website and for the federal government to establish an evidence base for workplace health and safety risks specific to migrant workers.

Coroner Lee formed a reasonable suspicion that Mr Tunik committed an indictable offence and made a referral to the Office of the Director of Public Prosecutions.

Tina Louise Greer

Coroner O'Callaghan – 21 December 2023.

Circumstances of the Death

Tina Louise Greer was 32 years of age when she was reported missing on 21 January 2012. She had recently ended a relationship with her partner, Leslie Sharman. Ms Greer went missing after going to see Mr Sharman at his property on 18 January 2012. Mr Sharman was the last person to have seen Ms Greer alive.

The Investigation

The QPS conducted an extensive investigation into the disappearance and suspected homicide of Ms Greer. Initial investigations included an air and land search, telecommunication interceptions, gathering of over 100 witness statements, review of CCTV footage and seizure of vehicles for testing. Significant covert and forensic strategies were utilised. The Crime and Corruption Commission (CCC) conducted coercive hearings in 2012.

In 2018, Ms Greer's disappearance was reviewed by the QPS Homicide Investigation Unit and further investigations were to commence in early 2019; however, Mr Sharman was unexpectedly killed in a road accident.

The investigation continued with a focus on locating Ms Greer's body. Following a media release and a reward for information, further persons of interest were identified. A search was conducted of a rural property. No signs of Ms Greer were found. The CCC conducted further hearings in 2020, however, no fresh information was uncovered.

The Inquest

Chamber findings were initially delivered on 23 May 2020. Ms Greer's daughter then applied to the State Coroner for an inquest to be held into her mother's death. The application was granted.

The inquest was held over six days between 13 and 22 September 2023. A voluminous brief of evidence was tendered at the inquest. In addition to the findings required by the Act, a number of other issues were considered at the Inquest, including the adequacy of the QPS response to allegations of domestic and family violence perpetrated against Ms Greer by Mr Sharman; the adequacy of the QPS investigation into Ms Greer's disappearance and what improvement had been made by the QPS into investigating allegations of domestic and family violence and the disappearance of women who are suspected or known victims of domestic and family violence.

Findings and Comments

Coroner O'Callaghan found that there was sufficient evidence to find that Ms Greer was killed by Mr Sharman on or about 18 January 2012. The evidence confirmed the repeated incidents of physical violence and coercive and controlling behaviour that had been committed by Mr Sharman against Ms Greer. There was insufficient evidence for findings to be made about how and where Ms Greer died.

In relation to the adequacy of the QPS responses to the domestic and family violence committed by Mr Sharman against Ms Greer, the coroner found that there was a missed opportunity to offer Ms Greer support and referral to a domestic violence service, and to investigate the possession of firearms by Mr Sharman. Further, there was inadequate recording of domestic and family violence incidents in the QPS database and the responses of two investigating police officers to the incidents were also considered inadequate.

The coroner found that the police investigation into the disappearance of Ms Greer was prompt and extensive. Ms Greer was immediately considered a high-risk missing person and substantial police resources were expended. It was found that QPS had since made several improvements to investigate domestic and family violence, including the establishment of a Domestic and Family Violence and Vulnerable Persons Command and specialist training and courses to officers. Additional findings were made in relation to other issues considered by the coroner.

Recommendations

Three recommendations were made in relation to the QPS amending the Operational Procedures Manual. The first related to contact with the family, next of kin and informant in missing person cases. The second related to the appointment of a Family Liaison Officer for the missing person's family, and the third related to the reporting of missing persons cases to the National Public Register of Long Term Missing Persons. A recommendation related to mandatory face-to-face domestic and family violence informed practice for all staff was directed to the Department of Child Safety, Seniors and Disability Services.

Samuel Timothy Brown

Deputy State Coroner Gallagher – 7 March 2024.

Circumstances of the Death

The deceased, Samuel Timothy Brown, died on 26 November 2012, aged 20 years.

On the night of 24 November 2012, Mr Brown and a friend left a birthday party at Mermaid Waters where they consumed alcohol. They decided to walk to Broadbeach. Due to Mr Brown's level of intoxication, his friend left him sitting on the side of the road and continued walking to Broadbeach alone.

Early the following morning, Mr Brown was found alive but unconscious on the Gold Coast Highway at Mermaid Beach having sustained various injuries. He was transported to hospital where it was identified that he had sustained a severe fracture to the right base of the skull, and fractures to the right and left mandible and left cheekbone. He also had abrasions to the back of the right shoulder and underside of the left arm. A toxicology sample taken on admission identified Mr Brown had a blood alcohol content of 0.241. He died as a result of his injuries on 26 November 2012.

The Forensic Pathologist who performed the autopsy concluded that the overall pattern of injuries that Mr Brown sustained was suggestive of an impact with a vehicle.

The Investigation

The Queensland Police Service Forensic Crash Unit (FCU) investigated the circumstances of Mr Brown's death and considered that he 1) had been hit by a vehicle; 2) was the victim of an assault;

3) had sustained the injuries in a fall; or 4) sustained the injuries through some combination of the three.

The absence of indicators suggestive of a vehicle having collided with a person led investigators to discount this possibility. Similarly, there were reasons to conclude that no assault has occurred.

A 2015 prosecution of a taxi driver for an alleged 'hit and run' involving Mr Brown was discontinued.

The Inquest
The inquest was held in March 2018 and May 2018 where 26 witnesses were called. Differing opinions between medical experts raised the prospect of Mr Brown having been assaulted or involved in a collision with a motor vehicle. Specific contention arose with reference to an injury located under Mr Brown's chin. Given the conflict in that evidence, additional expert opinions were sought from two sources. Both experts considered that the injuries sustained by Mr Brown were consistent with an impact with a vehicle.

Findings and Comments
The constellation of injuries, when considered in the context of an oil mark to the shirt, were found to be consistent with impact with a vehicle, though the precise mechanism by which that collision occurred could not be determined. It was found that Mr Brown's death was caused by:

1(a) Head injury.

1(b) Motor vehicle collision (pedestrian).

No comments or recommendations were made.

Joshua William Klumper

Deputy State Coroner Gallagher – 7 March 2024.

Circumstances of the death

Joshua William Klumper (Josh) was 17 years of age when he was found hanging from a tree in bushland on 5 September 2017. Queensland Ambulance Service paramedics were successful in resuscitating Josh, and he died in the Gold Coast University Hospital (GCUH) ten days later from a brain injury as a result of the hanging.

Josh had a complex mental health history from about nine years of age. Josh had contact with public and private service providers including the Child and Youth Mental Health Service (CYMHS). On occasion, Josh exhibited reluctance or refusal to engage with mental health services. On 2 September 2017, Josh presented to the GCUH. He exhibited agitated behaviour as a result of cannabis withdrawal and unmet demands for medication.

The Investigation
A direction was issued to the QPS for a targeted investigation into Josh's death, including obtainment of mental health records in relation to Josh's presentation to the GCUH in September 2017. Further records were sought from several providers with whom Josh had engagement.

The Inquest
Chamber findings were initially delivered in this matter by Coroner McDougall on 10 June 2021.

Josh's mother applied for the investigation into her son's death to be reopened and an inquest held. The State Coroner granted the application, and the inquest was conducted on 26 and 27 April and 17 May 2023 with ten witnesses giving evidence.

In addition to the findings required by section 45(2) of the Act, the following issues were considered at the inquest:

1. Whether the decision to close Josh to the CYMHS in February 2017 was appropriate in the circumstances and made in accordance with relevant policies and procedures; and

2. Whether the treatment and care provided to John on 2 September 2017 was appropriate in the circumstances.

Findings and Comments
The Deputy State Coroner found that the evidence showed that Josh had a complex and entrenched mental health history.

It was found that the decision to close Josh to the CYMHS was appropriate in the circumstances. This was because Josh was engaged with a private provider and had accepted a referral to Headspace. It was noted that had CYMHS continued to provide treatment to Josh, there would have been unnecessary duplication in his care. However, it was also noted that a formal 'Transfer of Care plan' from CYMHS to the private provider and Headspace, which had not been done, would have been best practice.

The clinical decision making and conduct of the registered nurse who was involved with Josh on 2 September 2018 was appropriate, as was the care that was afforded by the RN to Josh.

Recommendations
The Deputy State Coroner considered the Root Cause Analysis that had been commissioned by the Gold Coast Hospital and Health Service following Josh's death. Six recommendations for service improvement had been made and updates had been provided as to their implementation. Accordingly, no further recommendations were made.

Sharron PHILLIPS

State Coroner Ryan – 20 May 2024.

Circumstances of death

Ms Sharron Phillips was 20 years old when she was reported missing by her mother to Goodna Police on the evening of 9 May 1986. Ms Phillips' vehicle was located, out of fuel, at Wacol by her family that afternoon. Ms Phillips' last known activity was a reverse charge call made from a public telephone at Wacol on 12:03am on 9 May 1986. Ms Phillips' body was never located, and no person/s were charged.

Investigation

The police commenced a homicide investigation on 9 May 1986 and an inquest was held on 19 January 1988. The original police investigation obtained over 160 statements, the results of forensic testing, audio recordings and photographic evidence. Following that inquest, Coroner Randall found that Ms Phillips had disappeared in suspicious circumstances, but there was no evidence upon which any person could be committed for trial.

In 2017, Police advised the State Coroner they had received information that Mr Raymond Mulvihill may be responsible for Ms Phillips' death. Mr Ian Seeley informed police that his adopted father, Mr Mulvihill, had confessed to murdering Ms Phillips before he died, and Mr Seeley told police he held information about the disappearance. Following 2020 amendments to enable an inquest conducted under repealed legislation to be reopened, the State Coroner reopened the inquest.

Inquest

An inquest was convened in Brisbane on 22 to 24 March 2021 to hear oral evidence from 12 witnesses. The focus of proceedings was examination of the evidence of Mr Seeley and to establish if Mr Mulvihill was responsible for Ms Phillips' disappearance. Consideration was given to the police investigation and response in verifying Mr Seeley's information. Police investigators concluded that if Mr Mulvihill had been alive, he would likely have been charged for the murder of Ms Phillips.

Findings and recommendations

The State Coroner found that Mr Seeley's evidence was crucial in determining any culpability or involvement of Mr Mulvihill and Mr Seeley in Ms Phillips' disappearance but, due to inconsistencies and lack of credibility in Mr Seeley's account, the evidence had not reached the requisite standard of proof. The State Coroner found that there was insufficient evidence to make a finding about Mr Mulvihill or Mr Seeley's involvement in Ms Phillips' disappearance.

The State Coroner found that he was satisfied Ms Phillips was deceased and that she had died in suspicious circumstances on or around 9 May 1986 in the vicinity of Wacol Station Road, Wacol, Queensland. The precise cause of death of Ms Phillips remains unknown. It was found that Ms Phillips' death was caused by person/s whose identity could not be determined.

The State Coroner recommended that Ms Phillips' case remain open with the Cold Case Investigation Team for timely investigation, review and monitoring of new information.

Aboriginal and Torres Strait Islander People: Case Summaries

The need for public scrutiny and accountability that requires all deaths in custody to be investigated by the State Coroner or the Deputy State Coroner arose out of the recommendations of the Royal Commission into Aboriginal Deaths in Custody. The following section provides a summary of the mandatory death in custody and directed inquests finalised during the period that involved the passing of Aboriginal and Torres Strait Islander people.

WARNING: *Aboriginal and Torres Strait Islander people are advised that the following section contains the names of people who have passed.*

Edgar Hugh Sandow (aka Conlon)

State Coroner Ryan – 5 July 2023.

Circumstances of the Passing

Mr Sandow had a significant medical history and was receiving treatment for his comorbidities. Mr Sandow was transferred to the Princess Alexandra Hospital on 12 July 2021 for routine haemodialysis. Fifteen minutes into the treatment he suffered an acute loss of consciousness and despite interventions he passed away days later.

The Investigation

The investigation into Mr Sandow's passing was led by the Corrective Services Investigation Unit, QPS. The State Coroner issued a direction for a targeted coronial investigation seeking medical records, information from the next of kin about any concerns and statements from relevant medical staff and custodial corrections officers. A coronial report was prepared and provided in July 2022. The report concluded there were no suspicious circumstances surrounding Mr Sandow's passing and that he had received appropriate care and treatment whilst in custody and the passing was not preventable.

The Inquest

The inquest was held at Brisbane on 17 May 2023. The brief of evidence was tendered at inquest, no witnesses were called, and Counsel Assisting made oral submissions. The issues for inquest were the findings required by section 45 (2) of the Act. The Aboriginal and Torres Strait Islander Legal Service (ATSILS) was granted leave to appear at inquest and made submissions in relation to possible recommendations to assist in preventing passings of elderly and terminally ill prisoners in a custodial setting.

Findings and Comments

The State Coroner found that Mr Sandow died on 17 July 2021, at the Princess Alexandra Hospital Secure Unit, as a result of: 1(a). End-stage renal disease; Other significant conditions: 2. Hypertension, ischaemic heart disease; diabetes mellitus.

Recommendations

The possible recommendations proposed by ATSILS were considered, however, having regard to information provided by Queensland Health the State Coroner determined that the circumstances of Mr Sandow's passing did not give rise to any further recommendations or comments.

Aaliyah Te Paa; Rayvenna Coolwell; Barefoot; and Cayenne Robertson

State Coroner Ryan – 15 February 2024.

Circumstances of the Passings

Aaliyah Te Paa (aged 17), Cayenne Robertson (aged 14), Rayvenna Coolwell (aged 14), and ‘Barefoot’ (aged 13), died in Townsville on 7 June 2020, when the stolen vehicle they were travelling in collided with street signs and a traffic light pole. The driver of the vehicle, 14-year-old ‘QTS’, survived.

Two vehicles were stolen on 6 June 2020. The deceased children were passengers in one of those vehicles which, in the early hours of 7 June 2020, was observed to be driving erratically – speeding, doing burnouts, and beeping the horn. The QPS received reports of ‘hooning’ at around 4am, and patrol crews were notified.

At around 4:30am, after the vehicle had been observed travelling at excessive speed, driving on the wrong side of the road, and proceeding through red traffic lights, QTS failed to negotiate a roundabout and lost control of the vehicle, causing it to mount the curb, become airborne, and collide with street signs and a traffic light pole. When police arrived, the four passengers were deceased (having been ejected from the vehicle), and QTS was crawling out from the wreckage.

The Investigation

The QPS Ethical Standards Command investigated this incident as a death in police operation. The investigation concluded that there was no evidence to support a finding that any of the police units attempted to intercept or pursue the vehicle. Further, that there was no evidence to support any discipline referrals.

The Inquest

An inquest was held over two days, during which three issues were explored: (1) the findings required by section 45(2), (2) the adequacy and appropriateness of police actions on 7 June 2020, and (3) the adequacy of the QPS’ investigation.

Eight QPS witnesses gave evidence. The inquest heard evidence that the police vehicles did not activate lights and/or sirens and did not engage in a pursuit or attempted intercept. The vehicle’s occupants would, however, have been aware of the marked police vehicles and perceived that they were being chased.

Findings and Comments

The State Coroner was satisfied that police did not engage in a pursuit and, further, that all officers acted in accordance with the relevant QPS policies. QTS may have thought it was ‘an exciting game of cat and mouse’ and it was accepted that the children believed they were being ‘chased’ by police. However, this was a mistaken belief and one which ended in tragedy.

The Ethical Standards Command’s investigation was found to be comprehensive and professional. However, the families’ concerns about the delivery of the death notification in culturally appropriate ways were noted. The State Coroner acknowledged that this is a matter being addressed by the QPS.

In concluding his findings, the State Coroner commented on the issues associated with juveniles and motor vehicle offending. He recognised that there remained ongoing community debate about how to effectively respond to youth crime, and in that regard, noted the establishment of the Youth Justice Reform Select Committee.

Constance May WATCHO

Deputy State Coroner Stephanie Gallagher – 6 June 2024.

Circumstances of the Passing

Ms Constance May Watcho (aged 36) was last seen alive on 27 November 2017 in South Brisbane. When Ms Watcho had not been in contact with her family for an unusually long period, her brothers searched for her in Brisbane and eventually reported her missing on 8 February 2018. On 10 September 2018, Ms Watcho's skeletal remains were found in a bag at Kangaroo Point. At the time of her disappearance, Ms Watcho was in a relationship. They led an itinerant lifestyle and were often sleeping rough or couch-surfing. She had been released from custody four days before she was last seen.

The Investigation

Ms Watcho's brothers, Victor and Patrick, conducted their own inquiries in Brisbane before officially reporting her disappearance to the QPS on 8 February 2018. This led to the commencement by the QPS Missing Persons Unit of Operation Quebec Realism. Initial investigations revealed that Ms Watcho's bank accounts had been inactive since 27 November 2017 and she had not applied for further Centrelink assistance.

QPS Operation Quebec Graphics was launched following the discovery of the skeletal remains at Kangaroo Point. Ms Watcho was identified through dental records.

The police investigation was extensively resourced and involved canvassing a large number of witnesses, door knocking and CCTV footage review. A search warrant was executed at an address in Kangaroo Point. Covert policing methodologies were also employed. Despite these efforts, police were unable to determine the cause of death, any persons involved in her passing or confirm whether the location of her remains was the primary crime scene. Three persons of interest were identified, but no firm suspects were named. To encourage information from the public, a reward was offered for information leading to the apprehension and conviction of those responsible for Ms Watcho's murder, along with potential indemnity for accomplices who provide information. The case remained unresolved, with many questions unanswered about the circumstances of Ms Watcho's disappearance and passing.

The Inquest

An inquest was held at Brisbane on 5 to 9 September 2022, 15 and 16 December 2022 and 7 February 2023. A brief of evidence, which included the coronial investigation report, over 70 witness statements, audio and video exhibits, photographs and other materials gathered during the coronial investigation was tendered at the commencement of the inquest. The inquest heard oral evidence from 17 witnesses. The issues at inquest were the findings required by section 45(2) of the Act and the identity of any other persons involved in Ms Watcho's passing.

Findings and Comments

The Deputy State Coroner found that Ms Watcho's passing was suspicious due to the state and location of her remains. While the exact circumstances, location, and cause of her passing remained unknown, the evidence suggested that she likely died closer to when she went missing in November 2017 than when her remains were found in September 2018. Given the lack of compelling evidence and the weight of the available evidence, the Deputy State Coroner was unable to identify any person as a person who was involved in Ms Watcho's passing.

Recommendations

The Deputy State Coroner recommended that the police investigation remain open.

Shiralee Deanne TILBEROO and Vlasta WYLUCKI

Deputy State Coroner Stephanie Gallagher – 27 June 2024.

Circumstances of the Passings

Ms Vlasta Wylucki (aged 50) and Ms Shiralee Deanne Tilberoo, an indigenous woman (aged 49) both died of natural causes while in QPS watchhouses in 2018 and 2020, respectively. Despite the natural causes, both cases raised concerns about the level of care and supervision provided in the watchhouses, particularly as both women were experiencing substance withdrawal during the period in which they were in custody.

The cases were examined together due to their similarities, highlighting several common issues. These included inadequate supervision by watchhouse officers, who reported 'no problems detected' during checks when the women were visibly unwell or their condition could not be properly assessed. In Ms Tilberoo's case, there was also an 8-hour period overnight when she likely passed away unnoticed, further emphasising the need for improved monitoring practices in these facilities.

The Investigation

Both deaths were investigated by officers from the QPS Ethical Standards Command. The investigations considered the circumstances of each passing, whether watchhouse policies and procedures had been properly followed by QPS and watchhouse officers, and whether any officer had failed to comply with the relevant policies and procedures.

The Inquest

An inquest was held at Brisbane from 6 to 13 March 2023. The issues at inquest were the findings required by section 45(2) of the Act and the adequacy of watchhouse staff checks, clinical treatment provision, and QPS policies for prisoner supervision in both cases. For Ms Tilberoo's inquest there was an additional focus on the appropriateness of communication with next of kin and family following her passing, including death notification procedures and management of coronial investigations for indigenous persons who die in custody.

Findings and Comments

The Deputy State Coroner found that the physical checks conducted on Ms Tilberoo and Ms Wylucki were inadequate. The Deputy State Coroner found that the provision of clinical treatment in the watchhouses was inadequate due to the absence of 24/7 nursing services. The absence of such access was seen to be a systemic issue applicable to all prisoners in Queensland watchhouses. The Deputy State Coroner found that current QPS policies and procedures for supervising prisoners in watchhouses were appropriate, noting recent amendments to the Operational Procedures Manual in response to Ms Tilberoo's passing.

Recommendations

The Deputy State Coroner made five main recommendations. Those recommendations are that: consideration be given to amending legislation to reduce maximum watchhouse detention time to 72 hours; consideration be given to increasing resources for training officers who work in watchhouses; resources be provided to enable prisoners in watchhouses access to nursing and/or paramedical clinicians on a 24 hour and 7 days a week basis; initial health assessments are conducted by a Queensland Health clinician; and, additional funding be provided to non-government organisations whose core business is to support persons in custody.

Deaths in Custody and Deaths in Police Operations: Case Summaries

Reportable deaths include deaths in custody and deaths that happen in the course of or as a result of police operations.

The term ‘death in custody’ is defined in section 10 of the Act to include those who at the time of their death are in custody, trying to escape from custody or trying to avoid being placed into custody. ‘Custody’ is defined to mean detention under arrest or the authority of a court order or an act by a police officer or corrective services officer, court officers or other law enforcement personnel. An inquest is mandatory in these circumstances.

As per section 77(2)(b) of the Act the following contains a summary of the investigation, including the inquest into each death in custody finalised during the reporting period.

John Frederick Schulte

State Coroner Ryan – 7 August 2023.

Circumstances of the Death

Mr John Frederick Schulte (Mr Schulte), aged 37 years, died in Townsville on 25 December 2018 from a self-inflicted gunshot wound. His death occurred in the context of protracted domestic violence perpetrated by him against his ex-wife, Samantha Schulte, with whom he shared two children.

Mr Schulte was the registered owner of firearms which he used to threaten Mrs Schulte. At times, he also threatened to kill himself. Mrs Schulte reported these threats and her concerns about the firearms to the QPS on several occasions, including the day prior to Mr Schulte's death. No action was taken by the QPS.

On Christmas night, Mr Schulte sent photographs and a video to Mrs Schulte implying he intended to shoot himself. Police negotiators attended Mr Schulte's residence, however Mr Schulte shot himself approximately 15 minutes later, dying at the scene.

The Investigation

The QPS Ethical Standards Command investigated Mr Schulte's death, finding that the evidence supported misconduct allegations against four officers for failing to adequately investigate domestic and family violence and criminal allegations. It was recommended that one officer be referred for discipline action, and three officers receive refresher training.

A review of the police response was also conducted by the Domestic and Family Violence Death Review Unit. By virtue of that review, concerns were raised about the adequacy of the police response to (1) Mr Schulte's threats of self-harm/suicide, and (2) Ms Schulte's broader complaints of domestic violence.

The Inquest

A three-day inquest was held, during which issues including the police responses and communications, specialist domestic violence training for police, and the possibility of preventative changes to procedures or policies were explored.

The police officers involved in the events leading up to Mr Schulte's death, along with those involved in reviews of the police actions, gave evidence. There was an acceptance of police failures, and the court heard evidence about further education, resourcing, and training that had since been implemented. Mrs Schulte also gave evidence. Her courage in sharing her experiences, and her contribution to change were acknowledged.

Findings and Comments

The State Coroner ultimately found that the police response (and inaction) was entirely inappropriate. It was, however, acknowledged that the *'Hear her Voice'*, '*Not Now, Not Ever…'* and '*A Call for Change'* reports had since been published. The State Coroner therefore accepted the QPS' submission that policing of domestic and family violence is rapidly evolving and there were no further recommendations that could reasonably be made which have not already been addressed.

Thomas Edward Schwartz

Deputy Coroner Gallagher – 17 August 2023.

Circumstances of the death

Mr Thomas Schwartz was 64 years of age when he died at the Princess Alexandra Hospital. He was transferred from Wolston Correctional Centre where he was serving a custodial sentence for sexual offences against children.

Mr Schwartz suffered from fatty liver disease and was regularly reviewed and managed by gastroenterologist and staff specialists at the Princess Alexandra Hospital. The liver disease was of such severity that it was anticipated, in 2019, that he had one to two years to live.

Mr Schwartz was admitted to the Princess Alexandra Hospital from 23 November 2021 to 1 December 2021. During this admission, an Acute Resuscitation Plan was discussed with Mr Schwartz, and he made the decision that if an acute deterioration or critical event occurred, only ward-based based symptomatic care would be provided.

Early on 4 December 2021, Mr Schwartz was transferred to the Emergency Department at the Princess Alexandra Hospital due to worsening condition and fluid build-up in his abdomen. On 10 December 2021 a decision was made, in consultation with Mr Schwartz's family, to stop active care and only continue with comfort measures. On 22 December 2021, he entered the terminal phase of illness and was given palliative care.

The Investigation

An investigation was conducted by the QPS' Corrective Services Investigation Unit. Evidence obtained included witness statements from corrective services staff, nursing, and medical staff and medical records.

The Inquest

At the time of his death, Mr Schwartz was a prisoner under the Co*rrective Services Act 2006*. Mr Schwartz's death was a 'death in custody' and an inquest was required by the *Coroners Act 2003.* The inquest did not hear any oral testimony and all statements, medical records and material gathered during the investigation were tendered.

Findings and Comments

The Deputy State Coroner found that Mr Schwartz died from natural causes as a result of end stage liver disease due to Hepatitis C and non-alcoholic fatty liver disease. Mr Schwartz had been regularly admitted to the Princess Alexandra Hospital and reviewed by medical staff over the last two years of his life. It was found that he received regular, timely and appropriate medical care.

There was nothing that could have been done to prevent his death and there were no suspicious circumstances associated with his death.

No additional comments or recommendations were made.

AJO

State Coroner Ryan – 19 September 2023.

Circumstances of the Death

AJO was a 34-year-old man, found hanging, deceased in his secure cell at the Arthur Gorrie Correctional Centre on 20 June 2020. He had been transferred from the Toowoomba watchhouse to Arthur Gorrie Correctional Centre on 25 May 2020.

On 14 June 2020, AJO was moved to cell 24 in unit B3. He was the sole occupant of the cell which had exposed bars.

At approximately 4.36pm on 19 June 2020, prisoners in the unit were locked down for the night. AJO was last seen alive when the first head count was conducted at 8:08pm. Unit B3 was unstaffed from 6pm to 6am. The second head count was conducted at 4.36am on 20 June 2020. The Corrective Services Officer (CSO) noticed that the viewing window of AJO's cell was covered with brown paper.

Access to the cell was gained and AJO was observed hanging from bars by a makeshift ligature. The ligature was cut and CSOs commenced resuscitation efforts. Registered nurses and the Queensland Ambulance Service attended. AJO was declared life extinct at 5:03am.

The Investigation

AJO's death was investigated by the QPS and, in parallel, by Queensland Corrective Services. A search of the cell did not identify any suspicious circumstances. Investigators obtained AJO's prisoner records, medical records and obtained witness statements.

The Inquest

The inquest was held at Brisbane on 19 September 2023. The issues considered at the inquest were the findings required by section 45(2) of the Act and the appropriateness of the mental health assessment on AJO's admission to Arthur Gorrie Correctional Centre.

AJO had presented to the Adult Mental Health Unit at the Toowoomba Hospital as he had presented on at least four occasions between December 2007 and January 2011 in relation to dysthymia, self-inflicted wounds, personal relationship breakdown and suicidal ideations. AJO was known to Queensland Corrective Services and had previously served a term of imprisonment.

Upon being transferred to Arthur Gorrie Correctional Centre, an Immediate Risk Needs Assessment was conducted. AJO reported a previous suicide attempt.

On 25 May 2020, AJO was assessed by a psychologist. AJO reported no mental health conditions and that he was not currently medicated. He reported some depression and anxiety related symptomology. AJO was assessed as being at minimal risk of engaging in suicide or deliberate self-harm. At his request, AJO was placed in protective custody.

A review of telephone calls made by AJO between 29 May 2020 and 18 June 2020 did not identify any disclosures by AJO of suicidal ideation.

Findings and Comments
The State Coroner found there was no basis upon which prison staff or management could or should have formed a concern about risk of self-harm or suicide. In this instance, appropriate risk management processes to identify AJO's risk of suicide were applied.

The State Coroner noted that the removal of access to hanging points in prisons should continue to feature in suicide prevention strategies. No further recommendations were made.

GLT

State Coroner Ryan – 3 October 2023.

Circumstances of the Death
GLT was 46 years old when he passed away at the Rockhampton police watchhouse on 8 November 2019. GLT had been arrested by police for contravening a domestic violence order. He was escorted to a police vehicle without restraints but refused to get into the van. Police restrained GLT on the ground before he was placed into the 'pod' of the police van for transport to the watchhouse. Once at the watchhouse, police found GLT unresponsive.

The Investigation
The QPS Ethical Standards Command led the investigation into GLT's death. QPS Operational Training Services examined the use of force by police officers during GLT's arrest.

The Inquest
As GLT was in police custody time of his death, an inquest was mandatory. An inquest was held in Rockhampton on 5-7 September 2022. Matters considered at the inquest were the findings required by section 45 of the Act, whether the circumstances surrounding GLT's arrest complied with QPS policy and procedure, whether GLT condition was appropriately monitored, as well any preventative recommendations.

Findings and Comments
The State Coroner found that GLT had consumed methylamphetamine and had mental health and medical comorbidities. He was involved in an intense physical ground struggle with police while they attempted to restrain him. The exertion increased his risk of lethal arrhythmia. It was likely that the failure of police to recognise his clinical decline and deterioration contributed to his death.

The State Coroner recommended that police review the use of the terms 'excited delirium' and 'positional asphyxia' in QPS policy and procedure, in consultation with Queensland Ambulance Service, to ensure the terminology is accurate and reflects best practice. He also recommended that police introduce a mandatory requirement for police to provide radio confirmation of the health status of a person under arrest before they are transported.

James Lewis CUMMINS

State Coroner Ryan – 24 October 2023.

Circumstances of the Death
Mr Cummins was 41 years of age at the time of his death at the Townsville Correctional Centre. He had a history of chronic pain related to spinal stenosis and was prescribed medication to manage that pain. He also accessed illicit substances while incarcerated. On 2 September 2021, he was found unresponsive after collapsing in the prison's exercise yard. He was unable to be revived. It was found that Mr Cummins died as a result of a subarachnoid haemorrhage.

The Investigation
Mr Cummins' death was investigated by the QPS' Corrective Services Investigation Unit. The investigation concluded that there were no suspicious circumstances surrounding the death, and that Mr Cummins was provided with appropriate care and treatment while incarcerated.

The forensic pathologist conducted an autopsy consisting of an external and full internal examination of Mr Cummins' body and concluded that Mr Cummins died as a result of a subarachnoid haemorrhage.

The Inquest
The inquest was held at Brisbane on 24 October 2023.

The issues considered at the inquest were the findings required by section 45(2) of the Act and whether Mr Cummins had access to, and received, appropriate medical care while he was in custody.

Findings and Comments
The State Coroner found that Mr Cummins died from natural causes and that none of the prisoners, correctional or health care staff at the Townsville University Hospital or Townsville Correctional Centre caused or contributed to his death. There were no suspicious circumstances surrounding Mr Cummins' death.

The State Coroner was satisfied that Mr Cummins received appropriate health care and, in the circumstances, there were no comments or recommendation to be made pursuant to section 46 of the Act that would assist in preventing similar deaths in the future, or that otherwise related to public health or safety or the administration of justice.

Herbert Charles Hilsley

State Coroner Ryan – 20 October 2023.

Circumstances of the Death
Mr Hilsley died on 14 January 2022 while serving a term of imprisonment for sexual offences. He experienced several comorbidities. His health had steadily declined in the months preceding his death due to end stage chronic obstructive pulmonary disease, despite treatment. Mr Hilsley's application for exceptional circumstances parole was refused.

The Investigation
The investigation into Mr Hilsley's death was led by the QPS' Corrective Services Investigation Unit. A coronial report was prepared and provided in March 2023. The report concluded there were no suspicious circumstances surrounding Mr Hilsley's passing and that he had received appropriate care and treatment whilst in custody and the death was not preventable.

The Inquest
The inquest was held at Brisbane on 20 October 2023. The brief of evidence was tendered at inquest, no witnesses were called, and Counsel Assisting made oral submissions. The issues for inquest were the findings required by section 45(2) of the Act and whether Mr Hilsley had access to and received appropriate medical care while in custody.

Findings and Comments
The State Coroner found that Mr Hilsley died on 14 January 2022, at the Rockhampton Base Hospital, as a result of: 1(a) Pneumonia, due to or as a consequence of; 1(b) Emphysema (chronic obstructive pulmonary disease); Other significant conditions: 2. Ischaemic heart disease.

Recommendations
The State Coroner concluded that no comments or recommendations were required.

Russell James Williams

State Coroner Ryan – 30 April 2024.

Circumstances of the Death
Russell Williams was 51 years of age when he was found lying face down in the shower of cell 28 in unit S7 at the Capricornia Correctional Centre. There was a large amount of blood throughout his cell and a dismantled disposable razor blade located.

Mr Williams had a history of imprisonment. He was serving a life sentence and had been granted parole in 2012. On 29 January 2018, he was remanded in custody on two charges of murder dating from 1993. On arrival at the watchhouse, Mr Williams was asked questions relating to his health and denied having been treated for depression or having suicidal ideation. He commenced a hunger strike whilst in the watchhouse.

He was received into Capricornia Correctional Centre on 31 January 2018 where he continued the hunger strike. He was assessed as medium risk of self-harm by a provisional psychologist. On 6 May 2018, Mr Williams was placed on a temporary safety order and transferred to the Detention Unit. On 8 May 2018, a full safety order was put in place before it was cancelled on 14 May 2018. Mr Williams was returned to S7. A head count was undertaken at 8pm that night but there was no confirmation whether Mr Williams was sighted.

On 15 May 2018 at 5:05am, Mr Williams was found unresponsive in his cell. Despite assistance from corrective services officers and nursing staff, Mr Williams could not be revived.

The Investigation
The QPS' Corrective Services Investigation Unit investigated Mr Williams's death. The cell was examined and photographed, statements taken from senior staff, correctional officers, and inmates. Relevant records and CCTV footage were obtained.

The QPS investigator did not consider the death suspicious and was satisfied Mr Williams was alone in his cell at the time. Following the police investigation, the Office of the Chief Inspector appointed investigators to examine the circumstances of Mr Williams death. Ultimately, the Office of the Chief Inspector report identified a number of issues and it made eight recommendations. A copy of the Office of the Chief Inspector report was given to the State Coroner.

A full internal autopsy was conducted and confirmed the cause of death was incised wound to the right arm.

The Inquest

The primary issues for consideration, apart from the findings required by section 45 of the Act, was whether Mr Williams' intake assessment into custody was reasonable and appropriate; whether the making a cancellation of Mr Williams' temporary and full safety orders were reasonable and appropriate and whether the supervision of Mr Williams, upon his return to Unit S7, was reasonable and appropriate in the circumstances.

The inquest noted the Queensland Government's response to recommendations made following the 2019 findings on the deaths of Mr Appleton and Mr Malone relating to the availability of razor blades to prisoners within the first month of entry to prison.

Findings and Comments

After considering the responses from Capricornia Correctional Centre and Queensland Corrective Services to the recommendations from Office of the Chief Inspector report, the State Coroner was satisfied that no further recommendations should be made.

Thompson James Harvey

State Coroner Ryan – 13 May 2024.

Circumstances of Death

Mr Thompson James Harvey (Mr Harvey) was 33 years old when he passed away on 13 November 2017.

At the time of his death, Mr Harvey was remanded in custody at Capricornia Correctional Centre. Mr Harvey had a self-inflicted gunshot wound to his scalp that was treated in Mackay Hospital. This self-inflicted wound occurred following an altercation and pursuit by Police. Upon release from Mackay Hospital, Mr Harvey was arrested and taken into custody. Mr Harvey was transferred to Capricornia Correctional Centre and was initially under observation for opiate dependency and suicide risk. Mr Harvey was monitored hourly with safety precautions imposed to minimise the high risk of self-harm. These measures were reduced following clinical review on 9 November 2017.

On 13 November 2017, Mr Harvey was located deceased in his cell. A bed sheet had been used as a ligature. A suicide note was located.

The Investigation

The QPS' Corrective Services Investigation Unit undertook an investigation of Mr Harvey's death. The report completed by investigators was tendered at the inquest. Investigators obtained Mr Harvey's prison records, conducted interviews with other prisoners in his unit and obtained witness statements from corrective services staff including those who conducted risk assessments for Mr Harvey on his entry to prison.

The Inquest

An inquest was held in Brisbane on 19-20 April 2023. The issues for inquest were the findings required by section 45(2) of the Coroners Act and whether Mr Harvey's mental health was adequately assessed and monitored while he was in custody, and whether the care and supervision Mr Harvey received was adequate. There was also investigation of potential policy and procedure changes that could prevent similar deaths in custody. Queensland Corrective Services and Central Queensland Hospital and Health Service were granted leave to appear.

Findings and Comments

The State Coroner found that Mr Harvey died at the Capricornia Correctional Centre at Etna Creek, Queensland on 13 November 2017 and the cause of death was suicide caused by a neck compression ligature (hanging).

It was found that Mr Harvey's supervision and care in custody was sufficient notwithstanding missed opportunities for supervision, as well as a lack of documented risk assessment decision making and information sharing about Mr Harvey's individual suicide risks, history, and health needs.

The State Coroner found that, having regard to the recommendations made by Office of the Chief Inspector to Queensland Corrective Services and the response received to those recommendations, no further comment was required.

Lester Gilmore Shelton

Deputy State Coroner Gallagher – 10 June 2023

Circumstances of the death

Mr Lester Gilmore Shelton was 84-years old when he passed away at the Princess Alexandra Hospital on 4 October 2022.

At the time of his death, Mr Shelton was serving terms of imprisonment that were imposed by the District Court on 25 November 2020. Upon entry into custody, Mr Shelton was medically reviewed, and it was noted that he had extensive medical history and conditions. Mr Shelton was referred to a Medical Officer and chronic disease nurse.

Mr Shelton was admitted to the Princess Alexandra Hospital on eight occasions during his incarceration between 23 December 2020 and 14 July 2022. On 23 December 2020 during admission to the Princess Alexandra Hospital it was determined that Mr Shelton had terminal ileitis and a small bowel obstruction. On 20 April 2022 during admission to hospital, a planned colonoscopy procedure was cancelled due to Mr Shelton's increasing frailty and morbidity risk factors.

Mr Shelton was granted compassionate parole from Queensland Corrective Services custody on 30 June 2022; however, he was returned to custody on 1 July 2022 due to a lack of suitable living arrangements. On 14 July 2022, Mr Shelton was transferred to the Princess Alexandra Hospital for end-of-life care. He remained in hospital until his death.

The Investigation

The Corrective Services Investigation Unit, QPS undertook an investigation into Mr Shelton's death.

The Inquest

An inquest was held in Brisbane on 10 June 2024. No witnesses were called to give oral testimony. The inquest was heard in relation to the findings required by section 45 of the Act.

Findings and Comments

The Deputy State Coroner found that Mr Shelton passed away at the Princess Alexandra Hospital Secure Unit in Woolloongabba, Queensland on 4 October 2022 from natural causes. Mr Shelton's medical cause of death was determined to be a chronic bowel obstruction with other medical conditions including dementia, chronic obstructive pulmonary disease, diverticulitis, and terminal ileitis contributing to his death. Despite being incarcerated during the period of his terminal illness and death, it was found that Mr Shelton received health care that was adequate and appropriate and managed in consultation with his family.

There was no evidence of suspicious circumstances or that any person contributed to Mr Shelton's death. Given the cause and circumstances surrounding Mr Shelton's death, it was concluded that no further recommendations or comments were required.

Higher Court Decisions Relating to the Coronial Jurisdiction

If a coroner decides not to hold an inquest, a person may apply to the State Coroner or, if the coroner is the State Coroner, the District Court, for an order that an inquest be held. If the State Coroner declines the application, the person may apply to the District Court for an order that an inquest be held. Additionally, a person who is dissatisfied with an inquest finding may apply to the State Coroner or the District Court to set aside the finding. If a finding is set aside, the State Coroner or District Court may order than a new inquest is held.

The following section contains a summary of the decisions of higher courts relating handed down in relation to the coronial jurisdiction during the reporting period.

Morant v Ryan (The State Coroner) [2023] QCA 109

Morant v Terry Ryan (The State Coroner) [2023] HCASL 201

Ms Jennifer Morant died of carbon monoxide poisoning on 30 November 2014 in her car. Her husband, Mr Graham Morant, was convicted by a jury of counselling and aiding her suicide. Mr Angus Morant is the son of Mr Graham Morant and step-son of Ms Jennifer Morant.

On 30 July 2020 the Deputy State Coroner issued formal findings pursuant to section 45 of the Act following a coronial investigation. The Deputy State Coroner did not order that an inquest be held.

On 13 August 2021, Mr Angus Morant applied to the State Coroner for an order that an inquest be held. On 24 November 2021, the State Coroner determined that he was not persuaded that it was in the public interest for an inquest to be held and declined to hold an inquest.

Mr Morant then applied to the District Court for an order pursuant to section 30(6) of the Act that an inquest be held. The application, which was heard on 16 May 2022, was refused by Judge Loury KC in the District Court on 10 June 2022 on the basis that the Deputy State Coroner had already made findings with respect of the required matters, that an inquest would not achieve more than that, and therefore it was not in the public interest to hold an inquest.

Mr Morant then applied to the Queensland Court of Appeal against the decision of Judge Loury KC. That appeal was heard on 13 March 2023 and judgment was delivered on 26 May 2023. The Court of Appeal held that the determination whether something was in 'the public interest' was an exercise of discretion by a judicial officer. It was further held that the appellant would need to demonstrate the primary judge erred by having acted upon a wrong principle, mistook the facts, or allowed extraneous or irrelevant factors to guide or affect them.

Having considered the grounds of appeal contended by Mr Morant, the Court of Appeal found there had been no error by the primary judge and that the decision fell within the proper exercise of discretion.

Mr Morant then applied for special leave to appeal the decision of the Court of Appeal to the High Court of Australia. Special leave to appeal was refused on 7 December 2023.

Systemic Death Review Initiatives

Domestic and Family Violence Death Review Unit (DFVDRU)

The DFVDRU is based within CCQ and provides specialist advice and assistance to coroners in their investigations of domestic and family violence related homicides and suicides and the deaths of children who were known to the child protection system. Through analysing demographic characteristics, static and dynamic risk indicators, and lethality risk indicators, the DFVDRU identifies trends and patterns regarding domestic and family violence related homicides and suicides to assist in identifying opportunities for prevention.

Systemic death review processes have been established across jurisdictions to facilitate these types of deeper learnings.

In 2023–24, the DFVDRU completed 31 comprehensive case reviews to assist coroners in their investigations of domestic and family violence-related deaths and deaths of children known to the child protection system.

The DFVDRU maintains two comprehensive statistical databases:

- Queensland Domestic and Family Violence Homicide Database
- Queensland Domestic and Family Violence Suicide Database

Data held by the DFVDRU is shared with government and non-government sectors to inform policy and practice reforms. In addition, the DFVDRU supports other death prevention activities within CCQ and provides advice on national and state policy and practice initiatives as they relate to the coronial jurisdiction.

The DFVDRU is a founding member of the Australian Domestic and Family Violence Death Review Network (the Network) and continues to work closely with other death review mechanisms in Australia and undertake research in partnership with Australia's Network Research Organisation for Women's Safety (ANROWS).

This year, the partnership published an analysis of filicides in a domestic and family violence context that occurred between 2010 and 2018.[14] The findings from this report indicated that approximately three-quarters of all filicides between 2010 and 2018 occurred in a context of DFV. The research highlighted the highly gendered nature of filicide within a domestic and family violence context, as the majority of cases involved a male filicide offender. In most cases, the filicide offender was a biological parent, and resided with the filicide victim/s full-time at the time of the death. The data also showed a high prevalence of intimate partner violence history prior to the filicide. The high proportion of children who had experienced domestic and family violence prior to their death highlights the importance of recognising children as victims of domestic and family violence in their own right.

[14] Australian Domestic and Family Violence Death Review Network data report: Filicides in a domestic and family violence context 2010-2018 - https://www.anrows.org.au/publication/australian-domestic-and-family-violence-death-review-network-filicides/

Domestic and Family Violence Death Review and Advisory Board (the Board)

The DFVDRU provides secretariat support to the Board. The Board is an independent body established by the Act to undertake systemic reviews of domestic and family violence deaths in Queensland and make recommendations to the Queensland Government to improve legislation, policy and practice to prevent or reduce the likelihood of domestic and family violence deaths.

The establishment of the Board was a key recommendation of the Special Taskforce on Domestic and Family Violence in Queensland in their *Not Now, Not Ever* report.

The Board's functions include:

- reviewing domestic and family violence deaths in Queensland;
- analysing data and applying research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland;
- conducting or commissioning research to prevent or reduce the likelihood of domestic and family violence deaths;
- writing systemic reports into domestic and family violence deaths, identifying key learnings and elements of good practice in the prevention and reduction in the likelihood of domestic and family violence deaths in Queensland;
- making recommendations to the Minister about improving legislation, policies, practices, services, training, resources and communication to prevent or reduce the likelihood of domestic and family violence deaths in Queensland; and
- monitoring the implementation of the Board's recommendations.

In its 2022–23 Annual Report, the Board stated its intention to undertake a review and report on cases involving intimate partner sexual violence (IPSV) to further enhance understanding in this area. The Board, with the assistance of expert advisors, identified and reviewed cases involving sexual violence, alongside recent literature and cross-jurisdictional practice, to inform the development of recommendations.

This process identified 21 domestic and family violence homicide cases (involving 30 deaths) and 14 suicide cases (involving 20 deaths) where there was evidence of IPSV. Key findings and recommendations of this review can be found in the *Intimate Partner Sexual Violence Case Review: System Issue Report* on the Coroners Court of Queensland website at https://www.coronerscourt.qld.gov.au/dfvdrab/reports-research-and-data.

The DFVDRU is committed to engaging with the service system and community to share insights from the work of the Board that can enhance understanding of domestic and family violence, support best practice service delivery and collaboration, and inform efforts to eradicate domestic and family violence deaths.

Further information about the Board can be found in the Board's annual reports available on the Coroners Court of Queensland website.

Deaths in Care

The focus of a coronial investigation into a death in care is whether the circumstances of the death raise issues about the deceased's care that may have caused or contributed significantly to the death. Section 27(1)(a)(ii) of the Act mandates an inquest if any such issues are identified.

A 'death in care' is defined in section 9 of the Act and makes reportable the deaths of certain vulnerable people in the community, that is those with a disability or mental illness and children who are in certain types of care facilities or under certain types of care arrangements. These deaths are reportable irrespective of the cause of death or where the death occurred to reflect the underlying policy objective of ensuring there is scrutiny of the care provided to these people given their vulnerabilities.

During 2023–24, 145 'death in care' matters were reported to the court for investigation, compared to 144 in the previous year. As reflected below, the majority of deaths in care reported related to persons with a disability. The court collaborates closely with care providers and the National Disability Insurance Agency to obtain necessary materials for an independent review of the care given before death.

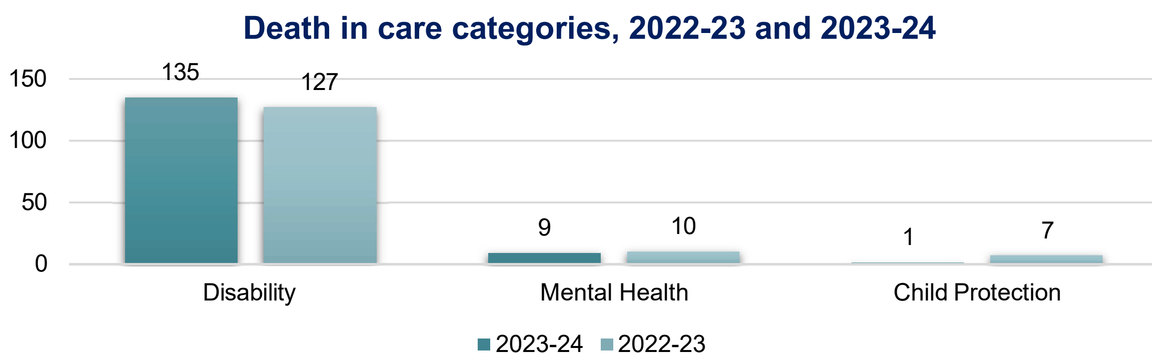


***Figure 9** – Death in care categories reported during 2022–23 and 2023–24 reporting period.*

Death in Care (Disability)

Of the 135 matters reported as a death of persons with disabilities in care, 124 were finalised during the reporting period. By the end of this period, 119 were determined to have resulted from natural causes, while 10 were attributed to domestic accidents or health care procedures and one was linked to interpersonal violence.

Death in Care (Involuntary Mental Health Treatment)

Of the nine deaths reported because the person died while subject to a treatment authority, six were from natural causes. The remaining three deaths raised issues relating to suicide risk, access to illicit drugs while on unsupervised leave and adequacy of health care.

Death in Care (Child Protection)

The one child death reported because the child was subject to orders made under the *Child Protection Act 1999* at the time of their death was a drowning / water related death.

During the reporting period Coroner Lee finalised the inquest into the death of a 13-year-old who drowned at Cedar Creek Falls while subject to an interim child protection order which placed the child in residential care operated by an external service provider. A summary of the inquest follows.

13-Year-Old Child

Coroner Lee – 26 February 2024.

Circumstances of Death

A 13-year-old child died while swimming in a rock pool at Cedar Creek Falls on 8 April 2021. He was taken to the falls for a swim by a youth worker with another child from his residential placement. The water at the Falls was turbulent and visibility was very poor. The 13-year-old child swam in the rock pool despite the youth worker being concerned about the conditions. The youth worker supervised the children swimming. The 13-year-old child moved into a deeper area of the rock pool, out of his depth and he could no longer swim. Despite efforts by the youth worker and a bystander, the 13-year-old child drowned.

The Inquest

At the time of his death, the 13-year-old child was in the custody of the Department of Child Safety, Seniors, and Disability Services ('the Department') under an interim Child Protection Order, making his death a 'death in care' pursuant to the Act. An inquest was held on 15 and 16 August 2023 and 13 October 2023 in Brisbane. The matters set out in section 45 of the Act were considered at the inquest. Other issues considered included: the circumstances of the death and, particularly, the chain of decision-making that led to the child's death; the adequacy of departmental policies relating to notice, consent, and supervision of children in the custody of the Department; issues related to the standard of care and any actions taken since the child's death which might prevent deaths from occurring in similar in the future.

Findings and Recommendations

Coroner Lee found the level of supervision and the actions of the youth worker to be appropriate in all the circumstances. Coroner Lee recommended that the Department standardise guidelines and risk assessment procedures and reporting for high-risk activities for children in care and ensure mandatory water awareness safety training was given to all out of home care service provider staff involved in children's care.

In relation to preventative measures, Coroner Lee also recommended that Queensland Parks and Wildlife Service and Partnerships (QPSWP): consider and action all accepted recommendations of a safety and risk assessment report completed by the Royal Life Saving Society of Australia; attempt to formalise information sharing arrangements with the Queensland Police Service in relation to deaths and serious injuries occurring in national parks; and, improve QPWSP reporting of high-risk conditions prevailing in national parks.

Coroner Lee further recommended that the Department of Environment and Science form a working group to consider policy improvements and solutions for serious incidents or deaths in QPSWP parks. These recommendations were made noting that QPWSP had already progressed the recommendations in part.

Coronial Registrars

The Coronial Registrars use a multidisciplinary approach to triage deaths reported to CCQ. This includes:

- **investigating apparent natural cause deaths reported by police** (via Form 1) because a death certificate has not been issued and is unlikely to be issued;
- **reviewing deaths reported directly by medical practitioners** via Form 1A seeking authority to issue a cause of death certificate for apparently reportable deaths;
- **reviewing deaths notified by funeral directors, disability service providers, families and other entities including the Office of the Health Ombudsman, the National Disability Insurance Scheme Quality and Safeguards Commission and the Queensland Ambulance Service** to determine whether they are reportable deaths requiring coronial investigation; and
- **providing telephone advice to clinicians** who seek advice about the reportability of the death before they issue a cause of death certificate. This provides an opportunity to filter out not-reportable deaths and to triage reportable deaths where a cause of death certificate may be authorised under section 12(2)(b) of the Act.

Since the Queensland Audit Office's 2018 report *Delivering Coronial Services*, several measures have been implemented to improve reporting for natural cause deaths and to divert not reportable deaths from entering the coronial system. These initiatives include:

- paramedics are encouraged to consult directly with the deceased's regular doctors to obtain a cause of death certificate;
- first response police officers now have 24/7 access to forensic physicians for advice on issuing death certificates;
- police only contact regular doctors during business hours to allow proper consideration for issuing death certificates;
- a dedicated triage role has been established within the QPS Coronial Support Unit to identify cases likely to receive a death certificate; and
- a pre-registration triage process has been set up for police-reported natural cause deaths, involving forensic physicians from Forensic Medicine Queensland to assist with death certificate issuance by consulting with doctors and families.

More Effective Triaging of Apparent Natural Cause Deaths

In 2023-24, general duties police officers proactively engaged with medical practitioners in the community and obtained 1,355 Cause of Death Certificates (CODCs). Police also worked with Forensic Medicine Queensland and obtained a further 509 CODCs meaning 1,864 deaths in total were diverted from the coronial system due to certificates not being issued.

CCQ continued to work with agencies to divert non-reportable deaths from the system, resulting in a decrease in the number of deaths managed through the Coronial Registrar triage pathway. **During the reporting period a total of 3,942[15] deaths were initially reported through and/or managed by Coronial Registrars**, representing 64.6 per cent of total deaths reported statewide. This is a decrease from the 4,507 deaths reported in 2022–23 to Coronial Registrars.

[15] This figure is from a total of 6,082 matters reported to the court. The total number of reportable deaths differs are multiple reportable types may be selected.

Forensic Pathology

Autopsy examinations can be a vital component in coronial investigations, yet their invasiveness, cost, and potential emotional impact on grieving families are major considerations. In line with the State Coroner's Guidelines, coroners are encouraged to prioritise the least invasive post-mortem examination necessary to inform their investigation.

Autopsies are performed by forensic pathologists employed by Forensic Pathology and Coronial Services (FPaCS).[16] Ensuring sustainability of forensic pathology services remains a key priority for CCQ in collaboration with FPaCS, aimed at providing Queensland with prompt and high-quality forensic pathology services. The implementation of the triaging process and the introduction of preliminary medical examinations are intended to redirect cases from unnecessary and invasive autopsies.

Preliminary investigations and examinations along with external medical examinations are minimally invasive procedures that may involve visually inspecting the body, reviewing medical records, performing a CT scan, or collecting samples like, hair, blood, and urine.

In 2023-24, the number of internal post-mortem examinations ordered declined from the previous year. Overall, there was an increase in reporting of examinations ordered, following the court enhancing its reporting capabilities to count orders for preliminary investigations and preliminary examinations.

The number of full and partial internal autopsies continued to decline from previous years, consistent with the purpose of amendments in the Act in 2020 to provide coroners with discretion to order less invasive post-mortem examinations.

	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023-24
Deaths reported	5,587	5,812	5,797	5,631	5,714	6,044	6,530	**6,071**
Examinations ordered[17]	2,730	2,629	2,476	2,353	2,095	1,524	1,380	**1,969**
Percentage	48.9%	45.23%	42.71%	41.78%	36.66%	25.22%	21.13%	**32.43%**

***Table 7** - Orders for examination issued for reportable deaths.*

Type of order (final)	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22	2022–23	2023–24
Full internal	1,291	1,032	765	800	520	551	571	**537**
Partial internal	583	630	614	498	762	677	638	**584**
External	856	967	1,049	1,008	319	296	171	**128**
Prelim Examination	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**445**
Prelim Investigation	N/A	N/A	N/A	N/A	N/A	N/A	N/A	**275**

***Table 8** - Number and type of examinations ordered for reportable deaths.*

[16] From July 2021, the budget and administration of coronial autopsies was transferred to Queensland Health for management.
[17] This figure refers to post-mortem examinations ordered and includes multiple orders for a deceased person.

Despite an overall increase in examination orders, the number of invasive examinations declined from 1,209 orders for full or partial internal examinations in 2022-23 to 1,121 internal examinations in 2023-24. There were 848 non-invasive examinations ordered in 2023-24, meaning that just under half (42 per cent) of all post-mortem examinations ordered were for non-invasive options.

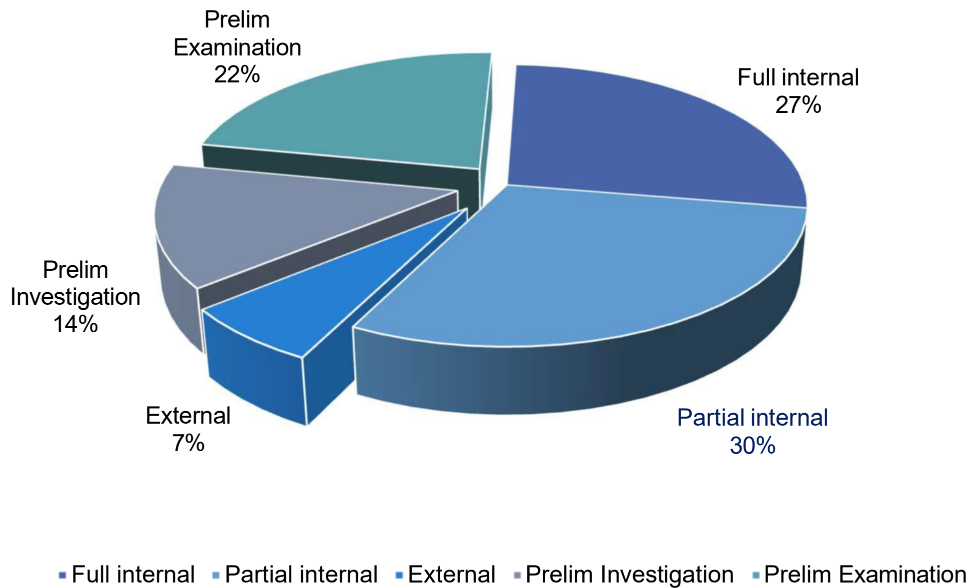


Figure 10 - *Type of examinations ordered for reportable deaths.*

Access to Coronial Information

The Act limits access to coronial investigation documents due to the highly sensitive and personal nature of the content. A coroner may only consent to release of records if they are satisfied the conditions of the Act are met. Consideration must be given to whether the applicant has sufficient interest in a document as well as the extent to which the document contains information that cannot be released, the conditions under which access may be given and whether release of the information is in the public interest.

Finalised information requests

Applications for access to records for non-research purposes require coronial consideration of factors including the privacy of the deceased and their family members, the openness and transparency of coronial processes, and the potential benefits to public health and safety. Applicants deemed to have sufficient interest may include the deceased's immediate family, a legal representative, health practitioner or insurer, as well as official public agencies or regulatory entities. Priority is given to applications submitted by family members as timely access to coronial records can support the bereaved and assist in progression of other legal or financial processes. Information requests and related queries are processed by CCQ's Information Release Team.

933

individual requests for documents and queries were received by CCQ during 2023–24.

Genuine Researchers

The coronial system is an important source of information for researchers and, in turn, academic analyses can be invaluable in assisting the jurisdiction's work in preventing future deaths. Scholarly investigation of reportable deaths is vitally important to improving public health and safety as research outcomes inform a broad array of issues. Completed research projects may inform publication of scientific articles in Australian and international journals, as well as provide outcomes of interest to multiple agencies and jurisdictions including emergency health care professionals, police, public health groups, drugs/therapeutic goods administration, legislators, clinicians, mental health support services and the domestic and family violence prevention sectors.

Generally, researchers may only access coronial documents once the investigation is finalised. 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.

Access to coronial records for research purposes requires the State Coroner to be satisfied the applicant is a genuine researcher and the information sought is reasonably necessary for the research. Assessment includes consideration of the applicant's qualifications, standing and reputation in the research community, whether the applicant has obtained relevant ethical approvals, the purpose of the research and how its outcomes are intended to be published and used. A wide range of individuals and organisations have been recognised as genuine researchers for the purpose of undertaking diverse research activities into areas including suicide prevention, road safety, fire fatalities, drowning deaths, scuba diving deaths, SIDS, building standards and the efficacy of the coronial system.

9
research projects approved.

The Act requires the names of persons given access to documents as genuine researchers to be noted in the annual report. The following genuine researchers were approved during the reporting period:

Griffith University - Ryan Lightfoot, Professor Silke Meyer, Professor Patrick O'Leary and Doctor Marika Guggisberg:

What individual factors and situational circumstances are associated with female-perpetrated intimate (ex)partner homicide and what implications do these raise for earlier intervention and prevention?

This doctoral thesis research within the Griffith Criminology Institute examines the life-course trajectories of female intimate partner violence victim-survivors to intimate partner homicide perpetrator. The project will undertake thematic analysis of coronial records to facilitate situational and contextual understanding and identify areas for further investigation. Analysis will focus on the forms of interpersonal and other types of violence women who kill their intimate partner have experienced and engaged in, as well as the contextual circumstances of a woman's use of interpersonal violence prior to using lethal violence, including help-seeking strategies, barriers to escape and the role of coercive control (particularly entrapment) in the use of lethal force against a current or former intimate partner. Research outcomes aim to identify opportunities for earlier intervention and prevention to contribute to improvements in policy and procedure around responses to women at risk of experiencing and or using lethal violence.

Department of Child Safety, Seniors and Disability Services:

Death in Care (Level 3 Supported Accommodation) coronial data requirements.

The Director-General of the Department of Child Safety, Seniors and Disability Services was approved under as a genuine researcher for the purposes of informing research into deaths in care and supporting work undertaken by the Department's Disability, Seniors and Carers division to build a broader systemic understanding of the complexity of the profile and support required for clients in Level 3 Supported Accommodation settings.

Queensland Health Forensic and Scientific Services – Forensic Pathologists Dr Rexson Tse, Dr Melissa Thompson and Dr Jack Garland:

Investigations into the relationship between heart weight, microscopic myocyte hypertrophy, macroscopic heart dimensions and their association with sudden cardiac death.

Cardiac hypertrophy can lead to sudden cardiac death and is commonly encountered in postmortem examination. However, the relationship between the range of hypertrophic features is not well understood. The study aims to aid in assessing myocyte hypertrophy by examining any association between myocyte cytoplasmic and nucleic features, along with macroscopic cardiac features relevant to age, gender, height and weight. The outcome is anticipated to enable a more comprehensive cardiac hypertrophy diagnosis and assist in establishing cause of death.

Queensland Health Forensic and Scientific Services – Forensic Pathologist Dr Jack Garland:

Association between cardiovascular disease and death by anaphylaxis: a twenty-year retrospective study in Queensland, Australia.

A twenty-year retrospective, this study aims to document the association of cardiovascular disease (and other significant pathologies) with fatal anaphylaxis to better understand why these allergic reactions can be survived in some circumstances and are fatal in others. The outcome of Dr Garland's research is expected to demonstrate cardiovascular disease as an associated risk factor for fatal anaphylaxis outcomes. This evidence will provide important epidemiological information of great relevance to the understanding of anaphylaxis and its physiological effects and assist in the diagnosis of whether a death is due to anaphylaxis in borderline cases.

Queensland Health Forensic and Scientific Services – Forensic Pathologist Dr Bianca Phillips:

Detections of nitazene type synthetic opioids in Queensland, Australia.

A continuously evolving group of synthetic opioid analgesics classed as novel psychoactive substances (NPS), nitazenes are characterised by very high potency and are not approved for the pharmaceutical market. The study aims to examine the emergence of these illicit drugs in Queensland for the purpose of contributing to the limited data currently available on nitazene blood concentrations and providing further research to assist in a better understanding of the global public health issues posed by NPS. Case studies will focus on the timeline of detections, the exact substance identified, blood concentrations, polydrug use and the age and gender profile. It is hoped the symptom and treatment data associated with hospital admissions can be compared to circumstances associated with coronial cases to assist in a better understanding of the potential harm and risk profiles presented by these compounds.

Queensland Health Forensic and Scientific Services, Public and Environmental Health – Dr Sanmarie Schlebusch, A/Professor Amy Jennison:

Meta-GP project extension to post-mortem sampling.

Funded by the Australian Government Medical Research Future Fund, the Meta-GP project aims to bring pathogen genomics to the bedside and enable personalised approaches to infectious disease management so that clinical and public health responses may be more rapidly and appropriately targeted. A collaboration of pathogen genomics and clinical infectious disease researchers working alongside peak laboratory regulatory bodies, the project will result in Australia having the first accredited, nationally accessible network of laboratories that can apply metagenomic approaches in patient care to rapidly detect, prevent and respond to infectious threats, including antimicrobial resistance.

Griffith Criminology Institute - Professor Silke Meyer, Dr Katie Hail-Jares, Professor Kate Fitz-Gibbon, Professor Ben Mathews, Ms Maria Atienzar Prieto and Ms Saniya Bedekar:

The role of domestic violence in youth suicide risk - identifying opportunities for earlier interventions.

A joint Griffith Institute of Criminology and Queensland Mental Health Commission research project, Principal Researcher Professor Meyer is leading a team of experts in a study to explore the links between domestic and family violence and how it may contribute to youth suicide. The project aims to better understand youth suicide risks and identify early intervention opportunities.

Queensland Health Forensic and Scientific Services – Forensic Pathologist Dr Jack Garland:

Risk factors for hypothermia in a warm climate: a twenty-year retrospective study in Queensland, Australia.

The study aims to document the association of significant pathologies (particularly cardiovascular disease) with fatal hypothermia, as well as to document the frequency of identified features of hypothermia. Research outcomes are expected to demonstrate the demographic of hypothermia deaths in Queensland is similar to that in other warm climates, and that there will be high rates of predisposing co-morbidities. This evidence will provide important epidemiological information relevant to understanding hypothermia's physiological effects and the associated intrinsic and extrinsic risk factors, as well as assist in determining the cause of death in borderline cases.

Queensland Health Forensic and Scientific Services – Forensic Pathologist Dr Rexon Tse:

Toxicological death in Gold Coast, Australia: a five-year retrospective study.

This 5-year retrospective study aims to characterise toxicological death at a local level in the Gold Coast, Australia. Toxicological death encompasses fatalities caused by exposure to a range of substances, including alcohol, various drugs and medications, toxic chemicals, fumes, and poisons. Current scientific literature regarding national and local studies into toxicological deaths focuses on deaths caused by alcohol, or a specific drug (or drug group). National and local research into toxicological death as a single category is very limited and further characterisation is expected to aid in identifying emerging substances, trends and provide data for resource allocation and public health planning.

CCQ Registry Structure

During the reporting period the CCQ registry underwent a restructure marked by the introduction of an Executive Director position with oversight of the CCQ registry and a new directorate leadership structure. The Executive Director CCQ reports to the Deputy Director-General, Courts and Tribunals.

Stream profile

The CCQ registry is comprised of various administrative and professional positions within streams that combine to support the full range of CCQ's functions.

Operations

Under the leadership of Director of Operations, the largest stream within the court registry oversees case management of coronial investigations and the progression of matters to inquest. Operations staff work closely with coroners and registrars and facilitate communication with families and other stakeholders throughout an investigation. Operations teams are based primarily in Brisbane, with regional teams supporting coroners based in Southport, Mackay and Cairns. Three Coronial Support Coordinators manage the operations teams and deal with complex matters. The Operations team is further supported by two managers, the Manager, Operations who oversees the wider Operations team and the Manager, Cultural Capability.

Legal Services

Led by the Director of Legal Services, in-house lawyers (known as Counsel Assisting) assist coroners in their investigations by providing advice on case files, preparing matters for inquest, as well as appearing as Counsel Assisting at inquests.

Coronial Services Practice, Prevention and Reform

Led by the Director, Coronial Services Practice, Prevention and Reform, the unit provides specialist advice and assistance to coroners in their investigation of DFV-related homicides and suicides, as well as deaths of children who were known to the child protection system. The unit provides secretariat support to the Domestic and Family Violence Death Review and Advisory Board and maintains databases of all DFV-related homicides and suicides that occur in Queensland. The unit also manages the Coronial System Board secretariat support, information release, data capability improvements and supports prevention functions and system reform activity.

Business Services

Business Services provides finance and human resources support across the registry, and also manages the government undertaker contracts and the Funeral Assistance Scheme on behalf of the Department of Justice and Attorney-General. Specialist human resources and wellbeing support is also delivered across the CCQ registry through a temporary position in the Business Services team. The team reports directly to the Executive Director.

Senior Leadership Team

The operation of the CCQ registry is overseen by a senior leadership structure consisting of the Director and Senior Managers in each stream. The group meets regularly to manage issues arising within the registry and business functions of the court. This includes identification of training and professional development needs of registry staff; workload management discussions and the progression of major reforms and major projects. The organisational structure of the CCQ registry is depicted below.

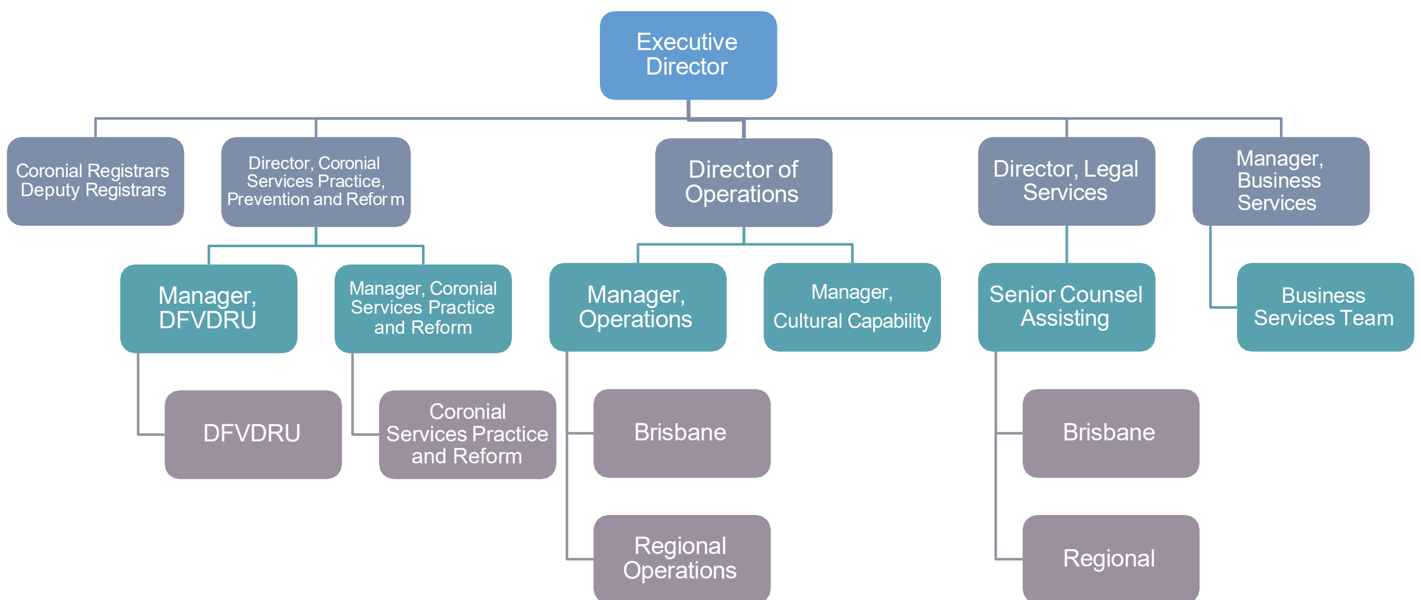


***Figure 11 -** Coroners Court of Queensland leadership.*

Funeral Assistance

The Department of Justice and Attorney-General (DJAG) can arrange for a simple burial or cremation service, where someone has died in Queensland and has no known relatives or friends who are willing or able to pay for a funeral or where the deceased person's assets cannot cover the costs. This is referred to as 'Funeral Assistance'.

Funeral Assistance Scheme applications, 2023–24.			
379 Applications approved	**$1,213,533** Statewide expenditure	**$178,027** Expenditure recovered	**14.67%** Expenditure recovered

In 2023–24 CCQ continued to administer the Funeral Assistance Scheme (the Scheme) on behalf of DJAG under the authority of the *Burials Assistance Act 1965*.

Funeral assistance is not a monetary grant and eligibility is based on set criteria that must be met by the relevant applicants. Applications can be made by individuals or agencies (such as police officers or social workers where there are no known or willing next of kin) and are submitted in person at courthouses across Queensland (including Regional Services Outlets). When an application is approved, CCQ authorises a simple funeral (burial or cremation) to be conducted by the Government Contracted Undertaker (GCU) in the Local Government Area boundary where the person died, and according to the deceased person's wishes (if known).

CCQ is responsible for the administration of the Scheme on behalf of DJAG, the budget, cost recovery activities, policy, procedure, strategic oversight and management and reporting. Appeals in respect of decisions are also dealt with by CCQ. Funeral costs may be recovered by DJAG, subject to conditions of section 4A of the *Burials Assistance Act 1965*. This can include recovery of monies from the deceased's bank account, money held by the Public Trustee of Queensland (PTQ), QPS, QH and other agencies as appropriate.

Under the Scheme, CCQ also authorises return to Country transfers for Aboriginal and Torres Strait Islander persons who have passed away outside of Community, to enable them to be laid at rest within their traditional homelands. The cost of this transfer is usually required to be covered by the individual applicant. However, individual applicants may now also apply for special consideration for a return to Country transfer to be funded under the Scheme if they cannot cover the cost of the transfer themselves. This special consideration is subject to additional delegate approval and may involve a longer application processing time. If approved, the return to Country transfer will be undertaken by an appropriate supplier as determined and contracted by DJAG. Funding will not be paid as a monetary grant to the applicant or as a reimbursement of any transfer costs incurred by the applicant outside of the approved arrangement.

In 2023–24, CCQ experienced a 1.83 per cent decrease in applications received from the previous year. Of these applications, 379 were approved which saw an increase in approved applications (318 approved in 2022-23) at a net cost of $1,035,505. This amount comprises total expenditure outlaid ($1,213,533) less the total monies recovered under the Scheme ($178,027).

In comparison to 2022-23, the cost recovery rate decreased to 14.67 per cent due to the increase in the applications in the second half of 2023-24, in respect of which recovery will occur in 2024-25. All revenue reported as cost recovery under the Scheme each year includes funds recovered against applications approved in previous financial years, as applicants may discover funds at a later time, or the PTQ may administer a deceased's estate that the Scheme has registered an interest in.

Government Contracted Undertakers

DJAG engages government contracted undertakers (GCUs) to undertake the provision of coronial services in Queensland. The current service combines the conveyance of deceased persons under the Act and the burial or cremation of deceased persons under the *Burials Assistance Act 1965*. CCQ administers the contracts on behalf of DJAG.

GCU conveyancing 2023–24

5,292	**$5,623,508.86**
Conveyances by GCUs	statewide expenditure on conveyances

The State Coroner is responsible for ensuring all reportable deaths are investigated. When a death is reported to the coroner, the deceased person must be conveyed by the GCU, at the direction of a QPS officer or a coroner, from the place of death to a facility such as the local hospital mortuary for a coronial investigation. Depending on the nature of the death and the local health resources available, the deceased person may be transported to another hospital or health facility for an examination, pathology test, or autopsy to be conducted.

GCUs are also responsible for conducting a simple funeral service where an application has been approved under the Funeral Assistance Scheme. From 1 February 2024, new SOA contracts commenced following a tender process. The new contracts include the requirement for GCU site visits under the CCQ Assurance Program. The assurance program is embedded in day-to-day performance management and relationship building with both new and existing CCQ Suppliers.

The total number of claims accepted for conveyance of deceased persons in Queensland in 2023–24 was 5,292 at a total expenditure of $5,623,508.

APPENDIX ONE

Reportable Death Types

Unknown identity

The death of a person with unknown identity (even if nothing is suspicious about the death) must be reported to a coroner.

Suspicious circumstances

Are generally where homicide is suspected or it's unclear whether another person has been involved. A coroner also has jurisdiction to investigate the suspected death of a 'missing person'. Suspected deaths are reported when there is reason to suspect the person is dead.

Violent or unnatural

Those caused by accident, suicide or homicide rather than a disease's natural progression i.e., car accidents, falls, drowning, drug overdoses, and industrial and domestic accidents. These deaths are reportable even if a delay occurs between the incident causing injury and the death, as long as the injury caused or contributed to the death and the person would not have died without the injury.

Death in custody

If the person died while in custody, escaping from custody or trying to avoid being put into custody. 'Custody' is defined broadly to capture detention under any state or federal legislation (with some limited exceptions) whether or not by police.

Death as a result of a police operation

Include those such as the death of an innocent bystander while police are attempting to detain a suspect or someone who commits suicide while police are present.

Death in care

Deaths of certain vulnerable people in the community (namely children under guardianship or in care, involuntary mental health patients, and people with disabilities with high support needs who lived in funded supported accommodation arrangements or receiving a relevant class of NDIS supports) are reportable deaths, whatever the cause of death may be or where it occurred.

Cause of death certificate is unlikely to be issued

Medical practitioners must issue a cause of death certificate if they can form an opinion as to the probable cause of death. If they cannot, they must report the death so the medical cause of death can be established.

Health care related

Broadly, this refers to a health procedure (i.e., dental, medical, surgical, diagnostic, or health-related such as anaesthetic or drug), or any care, treatment, advice, provided for the benefit of human health. These deaths include those due to a failure to treat or diagnose, and clinical or medication incidents and errors. A death is health care-related if both: health care, or failure to provide health care, caused or contributed to the death; and/or before the health care was provided, an independent person (qualified in health care) would not have expected the health care to cause or contribute to the death, or for the death to occur at that time.

APPENDIX TWO

Presentations by the Coronial Registrars

The Coronial Registrars continued their regular clinical education forums to a variety of stakeholders.

The below presentations were delivered in 2023–24:

- Australasian College of Legal Medicine (ACLM) Cause of Death Certificate Workshop QLD
- Sunshine Coast Hospital and Health Service - STEPP-2 PGY2+ education session
- Australian Catholic University
- Medical Education - Townsville Intern Teaching, Townsville University Hospital
- Redcliffe Hospital Grand Rounds
- Uniting Care - Cornubia
- Patient Safety and Quality Branch meeting Clinical Excellence
- Education sessions with Boards/Practitioners of various private residential aged care facilities

APPENDIX THREE

Presentations by the Domestic and Family Violence Death Review Unit

In addition to monitoring the implementation of the recommendations and producing an Annual Report, the Board, via the Domestic and Family Violence Death Review Unit, responds to requests from across the sector to deliver presentations to discuss the role and work of the Board in more detail.

The below presentations were delivered in 2023–24:

- Child Death Review Board Secretariat.
- Child Safety Systems and Practice Review team.
- Mt Gravatt Child Safety Service Centre.
- South-East Region DFV Champions Forum.
- Youth Justice Systems Quality Review and Supports team.
- Toowoomba Community Corrections.

APPENDIX FOUR

Glossary of common terms

ADFVDRN	Australian Domestic and Family Violence Death Review Network
ANC	Apparent Natural Causes death
ANROWS	Australia's National Research Organisation for Women's Safety
APCS	Asia Pacific Coroners Society
ATSILS	Aboriginal and Torres Strait Islander Legal Services
CCMS	Coroners Case Management System
CCQ	Coroners Court of Queensland
CCQ FAS	Coroners Court of Queensland Funeral Assistance Scheme
CFMU	Clinical Forensic Medicine Unit
CSB / The Group	Coronial System Board
CSCG	Coronial System Coordination Group
CSQ	Courts Services Queensland
CSSDF	Coronial Services System Delivery Framework 2021–2025
DFV	Domestic and Family Violence
DFVDRAB	Domestic and Family Violence Death Review and Advisory Board
DFVDRU	Domestic and Family Violence Death Review Unit
DJAG	Department of Justice and Attorney-General
FMO	Forensic Medicine Officers
Form 1	Form 1 – Police Report of a death to a coroner
Form 1A	Form 1A - Medical practitioner report of a death to a coroner
Form 9	Form 9 – Cause of death certificate
FPaCS	Forensic Pathology and Coronial Services (formerly QHFSS)
GCU	Government Contracted Undertakers
QAO	Queensland Audit Office
QH	Queensland Health
QHFSS	Queensland Health Forensic and Scientific Services
QPS	Queensland Police Service
QPS CSU	Queensland Police Services Coronial Support Unit
RBDM	Registry of Births, Deaths and Marriages
SOA	Standing Offer Arrangement
the Act	*Coroners Act 2003* (Qld)

CORONERS COURT
OF QUEENSLAND

QUEENSLAND
COURTS