Coroners Court of Queensland

Annual Report 2016-17

Brisbane Magistrates Court
363 George Street
Brisbane

PO Box 1649
Brisbane QLD 4001
DX 943

PH +61 7 3247 9017
FX +61 7 3109 9617

www.courts.qld.gov.au

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The Honourable Yvette D'Ath MP
Attorney-General and Minister for Justice
Leader of the House
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

I enclose a report on the operation of the *Coroners Act 2003* for the period 1 July 2016 to 30 June 2017.

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

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

The Guidelines issued under section 14 of the Act are publicly available and can be accessed at http://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/resources-and-legislation.

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

Yours sincerely

Terry Ryan
State Coroner

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Warning

Some content in this report may be distressing to some readers.

Aboriginal and Torres Strait Islander peoples are warned that this document contains the names of deceased persons.

State Coroner's overview

This Annual Report provides an overview of the work of the Queensland coronial system during 2016–17. During this financial year there were 5,587 deaths reported to coroners.

This represents an increase of 300 deaths over the previous reporting period, and is the largest number of deaths reported since the *Coroners Act 2003* commenced. There has been a 17% increase in the number of deaths reported over the past five years. The number of finalisations was slightly lower than in 2015–16, with 5,014 matters cleared. This figure represents the second largest number of matters cleared in the Court's history.

The coronial registrar continued to manage a high volume of less complex matters routinely reported to coroners, enabling other coroners to focus on more complex investigations and inquests.

I extend my thanks to my colleagues, and all who work within the Court, for their diligent approach to the timely management and finalisation of investigations into reportable deaths.

The Court strives to ensure that deaths are not subject to long and invasive investigations unless required. The Court is mindful of the need to balance the interests of bereaved families with the requirement for a thorough investigation in appropriate cases. Delay can often be attributed to factors outside the control of the Court, including the requirement for specialist investigations such as neuropathology, and cases awaiting the finalisation of criminal charges in other courts.

As noted in previous annual reports, the complexity of matters requiring coronial investigation is increasing as less complex matters are triaged out of the system. For example, health care related deaths may involve a range of medical specialities managing a patient over a short period of time.

I extend my appreciation to the counsel assisting and support staff within the Court who have worked with coroners over the past year in reviewing these complex matters. In particular, where matters proceed to inquest, counsel have assisted in the skilful presentation of evidence to help develop recommendations to prevent deaths in similar circumstances.

This year saw the first full year of operation of the Domestic and Family Violence Death Review and Advisory Board. The Board produced a number of significant case reviews, together with its first Annual Report. I also extend my appreciation to the members of the Board and the staff within the Domestic and Family Violence Death Review Unit, who support the Board as well as coroners in the challenging investigation of these deaths.

In May 2017, the Queensland Government announced that funds had been allocated to the Caxton Legal Service and the Townsville Community Legal Service to deliver a state wide Coronial Assistance Legal Service for three years to 30 June 2020. This initiative is welcomed by the Court and will see legal advice and representation offered to grieving families in the coronial process, including representation at inquest.

Previously, the interests of families have often been unrepresented in significant matters involving complex and contentious issues where other agencies are legally represented with funding from the State. This initiative may go some way towards correcting that imbalance.

The Court struggled with an unstable information technology platform during the year, resulting in delays for administrative staff and coroners alike. While these issues have been addressed to some extent, the Court would benefit from a shared information technology platform with the Queensland Police Service (QPS) and Queensland Health to enable information to be transferred without laborious manual data entry being required within the court. Analogous systems already exist in the Magistrates Courts' criminal and civil jurisdictions.

An organisational review of the Court's administrative structures in 2013 saw the centralisation of a number of administrative functions in the Court's Brisbane registry.

Ongoing concerns about inefficient administrative processes, and the capacity of staff to manage significantly increased workloads, saw a further organisational review commissioned during 2017. The purpose of this review is to examine systems and practices within the Court. The outcomes of this review are expected in early 2018.

As noted in previous Annual Reports, the Court relies heavily on our partners in Queensland Health Forensic and Scientific Services to deliver coronial services. Having regard to the pending retirements of several regional forensic pathologists, and challenges associated with recruiting pathologists to regional centres, a review was commenced during 2017 into the delivery of forensic pathology services in Queensland.

It is anticipated that this will result in advice being provided to the Queensland Government about a sustainable model for the provision of forensic pathology services in early 2018.

The Queensland coronial system

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

In general terms, reportable deaths include:

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

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

Recent years have seen a significant increase in demand for coronial services state-wide with reported deaths increasing from 3,514 in 2007–08 to 5,587 in 2016–17 – a 60 per cent increase in deaths reported.

This increase is a result of a number of factors including increased awareness of coronial reporting obligations and legislative changes to the types of deaths that are required to be reported to a coroner. Even so, deaths investigated by coroners make up only a small percentage of all deaths in the community. The 5,587 deaths reported to Queensland coroners represent only 17.7 percent of the 31,491 deaths registered in Queensland in 2016–17.

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

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

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

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

State Coroner

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

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

The State Coroner also chairs the Domestic and Family Violence Death Review and Advisory Board[1].

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

During 2016–17, the State Coroner conducted inquests into 10 deaths and finalised 73 investigations without proceeding to inquest.

The State Coroner also has a review function under the Coroners Act in respect of decisions about whether a death is reportable, whether an inquest should be held and whether an inquest or non-inquest investigation should be reopened. During 2016–17, the State Coroner received 22 applications for review and finalised 23 matters of this nature.

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

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

The State Coroner's Guidelines can be accessed at: http://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/resources-and-legislation.

[1] The Board is established as an independent body under the Coroners Act 2003 to enhance the systemic review of domestic and family violence related deaths. Information about the Board and its functions can be found at http://www.courts.qld.gov.au/courts/coroners-court/review-of-deaths-from-domestic-and-family-violence

Deputy State Coroner

Mr John Lock was appointed as a full-time coroner in January 2008. In July 2013, Mr Lock was appointed to the position of Deputy State Coroner for a period of five years. Along with the State Coroner, the Deputy State Coroner may investigate deaths in custody and deaths happening in the course of or as a result of police operations. The Deputy State Coroner acts as the State Coroner, as required.

In 2016–17, the Deputy State Coroner finalised 318 investigations including 10 following an inquest.

Brisbane Coroners

Ms Christine Clements was appointed as Brisbane Coroner in July 2013 after holding the position of Deputy State Coroner for 10 years.

In 2016–17, Ms Clements finalised 400 investigations including 1 following an inquest.

Mr John Hutton was appointed as a coroner in August 2008.

In 2016–17, Mr Hutton finalised 275 investigations including 1 following an inquest.

Northern Coroner

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

In 2016–17, 723 deaths were reported in the region and 637 matters were finalised. This represents a 19.5 per cent increase in the number of deaths reported in this region (up from 605 deaths reported in 2015–16).

South Eastern Coroner

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

In 2016–17, 811 deaths were reported in the region and 700 matters were finalised including 191 deaths finalised by the registrar and deputy registrar and four deaths finalised by inquest.

This represents a 1.1 per cent increase in the number of deaths reported in this region (up from 802 deaths in 2015–16).

Central Coroner

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

In 2016–17, 689 deaths were reported in the region and 646 matters were finalised including 72 finalised by the registrar and deputy registrar and three following an inquest. This represents an 8.8 per cent increase in the number of deaths reported in this region (up from 633 deaths reported in 2015–16).

Coronial Registrar

The coronial registrar based in Brisbane, **Ms Ainslie Kirkegaard**, is responsible for triaging deaths reported directly by doctors, aged care facilities, residential care services and funeral directors, and also provides telephone advice to clinicians during business hours. The coronial registrar's role operates State-wide. In the coronial registrar's absence, this function was managed by a deputy registrar, **Dr Don Buchanan**, on secondment from the Department of Health Clinical Forensic Medicine Unit.

In 2016–17, 1,957 deaths were reported to the registrar and deputy registrar, representing 35 per cent of the total number of deaths reported State-wide. Between them, the registrar and deputy registrar finalised 2,070 of the 5,020 matters (41.2 per cent) during the reporting period.

Coroners Court of Queensland

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

As at 30 June 2017, the CCoQ under the leadership of A/Director Julie Webber comprised of 50 staff members with 43 based in Brisbane, two in the Northern Coroner's office in Cairns, two in the South Eastern Coroner's office in Southport and three in the Central Coroner's office in Mackay.

Measuring coronial performance and outcomes

The performance measures for the coronial jurisdiction align with the national benchmarking standards outlined in the Report on Government Services; which provides information on the equity, effectiveness and efficiency of government services in Australia.

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

Clearance rates

In 2016–17, 5,587 deaths were reported state wide. Compared to the total numbers of deaths reported in 2015–16, this represents an overall increase of 5.66 per cent of 'lodgements'.

In 2016–17, coroners finalised 5,014 matters achieving a clearance rate of 89 per cent. In previous years, the clearance rate has reached the SDS target of 100 per cent. However, with further increases in lodgements and increasing complexity of cases, the clearance rate has decreased significantly.

Many matters reported to coroners are, following review of medical records and circumstances of death, found to be not reportable or reportable but not requiring autopsy and further investigation. During 2016–17, of the 5,014 deaths finalised, 1,813 were found not to be reportable within the meaning of s. 8(3) of the Coroners Act.

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

Pending cases and backlog indicator

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

There has been a notable increase in the overall number of pending cases during the reporting period (2,684 up from 2,127 as at 30 June 2016) and an increase in the backlog indicator from 13.6 per cent to 16.6 per cent.

As at 30 June 2017, 445 or 16 per cent of pending matters were more than 24 months old. This figure exceeds the national benchmarking target of 0 per cent

largely due to the increasing number of lodgements and the more rigorous investigation required under the Coroners Act. The finalisation of a coronial investigation also depends on the completion of autopsy, toxicology and police reports. Dependent on the circumstances of the death, coroners may also be required to await the outcome of other expert investigations and criminal proceedings.

Funeral Assistance

The *Burials Assistance Act 1965* requires the Department of Justice and Attorney-General to organise a simple burial or cremation of any deceased person whose estate cannot cover the funeral costs and whose relatives and friends cannot arrange or pay for their funeral in the interests of public health.

This service is called Funeral Assistance. CCoQ manages this scheme throughout the state. During 2016–17, 389 applications for funeral assistance were approved state-wide at a cost of $940,599. CCoQ recovered $329,769 from the estates of the deceased. This amounts to 35.06 per cent of total expenditure.

Table 1: Overall performance for 2016–17

	Brisbane	Northern	Central	South Eastern	Total
Number of deaths reported to Coroner	3364	723	689	811	5587
Number of Coronial Cases finalised	3037	637	642	698	5014
Inquest held	*23*	*0*	*3*	*4*	*30*
No inquest held	*3014*	*637*	*639*	*694*	*4984*
Number of Coronial Cases pending	1457	510	277	440	2684
Less than or equal to 12 months old	*962*	*274*	*186*	*271*	*1693*
Greater than 12 and less than or equal to 24 months old	*289*	*126*	*45*	*86*	*546*
Greater than 24 months old	*206*	*110*	*46*	*83*	*445*

Table 2: Number of deaths reported by type

	Brisbane	Northern	Central	South Eastern	Total
Suspected death (missing person)	8	6	9	3	26
Death in custody	16	0	0	0	16
Death as a result of police operations	14	0	0	1	15
Death in care	72	10	2	8	92
Health care related death	1027	138	200	154	1519
Suspicious circumstances	9	10	5	3	27
Violent or unnatural	1228	302	276	340	2146
Death certificate not issued and not likely to issue	984	256	198	298	1736
Unknown persons	76	0	0	3	79
Total	3365	722	690	810	5587

Table 3: Performance statistics 2012–2017

Year	Cases reported	Percent change	Cases finalised	Clearance rate	Backlog	Inquests held
2011–12	4461	1%	4771	106.9%	14%	81
2012–13	4762	6.7%	4999	105.0%	10.2%	66
2013–14	4682	-1.7%	4909	104.8%	12%	49
2014–15	4962	6.0%	4638	93.5%	11.9%	78
2015–16	5287	6.5%	5313	100.5%	13.6%	49
2016–17	5587	5.7%	5014	89.7%	16.6%	30

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

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

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

Queensland Police Service Coronial Support Unit (QPS CSU)

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

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

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

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

Key initiatives undertaken by QPS CSU during 2016–17, include:

- continuation and support of a temporary Detective Senior Sergeant position attached to the Domestic and Family Violence Death Review Unit located in the Coroners Court of Queensland
- the development of policies and increased stakeholder engagement that aims to improve responses to deaths on inbound flights
- continued stakeholder engagement with Queensland Rail
- preparations for responses during Commonwealth Games 2018
- engagement with CCoQ in the new undertaker contract process
- membership on the Serious Workplace Incidents Interagency Group
- creation of an 'application' to allow police officers to create a form 1 on a mobile device at the scene providing more detailed and timely reporting
- introduction, access and training of the Forensic Register to Queensland Health professionals
- continued consultation with stakeholders and implementation of policy to ensure a more efficient response to hospital calls for service

- ongoing commitment to the implementation of the National Missing Persons Victim System (NMPVS) to facilitate improved opportunities for early identification in the DVI process.
- continued training of QPS DVI officers trained in all phases of the DVI process.
- 9 month trial of a Human Remains Recovery Team (HRRT) where assistance is provided at scenes of traumatic deaths in the recovery of human remains.
- in consultation with CCoQ, introduced a revised system of coronial case management.

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

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

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

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

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

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

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

Department of Justice and Attorney General Communication Services Branch

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

The Department's Communication Services Branch assists journalists and media representatives seeking to prepare balanced reports about coronial matters and CCoQ's activities. CCoQ responds to information requests and media enquiries in order to promote fair and accurate reporting.
In the 2016–17 reporting period, the Communication Services Branch received 121 media enquiries. These enquiries included requests for witness lists, inquest dates, access to files, inquest findings and investigation updates.

Relationships with other agencies

A coronial investigation may be one of a range of investigative or system responses to a reportable death. The circumstances of a death may also invoke scrutiny by Commonwealth and State entities including the Australian Transport Safety Bureau, Civil Aviation Safety Authority, Australian Defence Force, police, Ombudsman, aged care and health regulatory agencies or workplace health and safety or specific industry regulators.

While the focus of each entity's investigation will differ, there is often some overlap between the coroner's role and that of other investigative agencies. The State Coroner has entered into arrangements with a range of government entities to clarify their respective roles and responsibilities when investigating a reportable death. More information about these arrangements is available from the State Coroner's Guidelines, Chapter 11, Memoranda of Understanding[2].

[2] *Guidelines Chapter 11 Memoranda of Understanding*

Innovation in coronial practice

The first decade of the operation of the Coroners Act saw Queensland establish a modern, coordinated and accountable coronial system now regarded as one of the more progressive coronial jurisdictions in Australasia. This system features a range of innovations implemented over this time to manage the steady growth in demand for coronial services.

In 2016–17, the CCoQ, QPS and QHFSS continued to work proactively and collaboratively to identify opportunities to refine and develop the system to manage future demand.

The ongoing role of the Coronial Registrar

The registrar holds appointment under the Coroners Act and operates under a delegation from the State Coroner.

When established in 2012, the registrar's role was to investigate apparent natural causes deaths reported to police under section 8(1)(e) of the Act; to authorise the issue of cause of death certificates for reportable deaths under s. 12(2)(b) of the Act and to determine whether a death referred to the coroner under s. 26(5) of the Act is reportable. In practice, this involves directing the investigation of apparent natural causes deaths reported to police because a death certificate has not been issued; reviewing deaths reported directly by medical practitioners (using the 'Form 1A' process) or funeral directors; and providing telephone advice to clinicians during business hours about whether or not a death is reportable. These deaths represent the high volume, less complex range of matters routinely reported to coroners.

However, the scope of the registrar's role changed over the course of 2016-17. Initially the registrar's reporting catchment covered greater Brisbane, Sunshine Coast (north to Gympie) and South West Queensland (west to Cunnamulla). In August 2016, in an effort to alleviate the South Eastern Coroner's increasing caseload, the registrar's reporting catchment was expanded to include the South Eastern region (Logan-Beaudesert and the Gold Coast).

It quickly became apparent that the increased workload resulting from this catchment adjustment was unsustainable for a single registrar. To address this, the registrar's role was readjusted so that from 1 January 2017, the registrar managed all telephone enquiries and deaths reported by the Form 1A process or funeral directors in greater Brisbane, Sunshine Coast, South East, South West and Central Queensland regions (the Northern Coroner retained management of these matters by request). From 1 January 2017, the management of all new apparent natural causes death investigation reverted to the Brisbane and South Eastern coroners.

In September 2017, it is planned that the registrar will take on responsibility for telephone enquiries and deaths reported by the Form 1A process or funeral directors in the Northern reporting catchment. This further readjustment will achieve a consistent State-wide approach to the management of these matters.

To accommodate the impact of these readjustments, the bulk of the registrar's pending apparent natural causes files will be reallocated between the Brisbane coroners.

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

During the reporting period, 1,957 deaths were reported to the registrar, representing 35 per cent of the total deaths reported State-wide.

Between them the registrar and deputy registrar finalised 2,070 matters within the reporting period. This represents 41.2 per cent of the total 5,014 matters finalised State-wide.

The table below shows the steadily increasing demand on the registrar since the role was established in January 2012.

Table 4: Deaths managed by Coronial Registrar, 2012-13 to 2016-17

	Total deaths reported state wide	Total deaths reported into Brisbane	Total deaths finalised by Registrar
2012–13	4762	2708	1265
2013–14	4682	2795	1537
2014–15	4962	2991	1466
2015–16	5287	3247	1931
2016–17	5587	3364	2070 (state wide)

Apparent natural causes deaths

During 2016-17, 1,500 police reports of apparent natural causes deaths were received State-wide, representing 46 per cent of the total number of deaths reported to Queensland coroners by police. These deaths are reported because a cause of death certificate has not been issued and is unlikely to be issued.

As noted above, this aspect of the registrar's role was briefly expanded beyond the greater Brisbane-Sunshine Coast-South West Queensland reporting catchment to include the South Eastern region over the period August-December 2016.

From 1 January 2017, coroners continued to triage these deaths, with input from forensic pathologists, coronial nurses, forensic medicine officers and coronial counsellors, resulting in 514 of the total apparent natural causes deaths (34 per cent) being appropriately diverted from the coronial system with the issue of a cause of death certificate.

The table below shows the breakdown of cause of death certificates issued by reporting catchment.

Table 5: Number of cause of death certificates issued by region in 2016-17

Coronial reporting catchment	Total number of deaths reported by police	Total number of apparent natural causes deaths reported to police	Percentage of certificates issued
Brisbane	1,683	815 (48.4%)	359 (44.0%)
Northern	478	214 (44.8%)	40 (18.7%)
Central	534	192 (36.0%)	4 (2.1%)
South Eastern	552	279 (50.5%)	111 (39.8%)
	3,247	1,500 (46.2%)	514 (34.3%)

Limited availability of post-mortem CT scanning outside the coronial mortuaries in Brisbane and on the Gold Coast and conservative attitudes by regional pathologists about their role in issuing certificates are key factors impacting on the issuing of cause of death certificates in regional cases.

The role of the coronial nurses, based at the Brisbane mortuary, in collating medical history information and speaking with treating clinicians contributes significantly to achieving the issuing of cause of death certificates in apparent natural causes deaths.

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

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

In practice, these cost savings have continued to help offset the costs of increasing demand on the coronial system.

Consideration is currently being given to measures to enhance the use of triaging processes to reduce autopsy rates for apparent natural causes deaths outside Southeast Queensland.

Initiatives to streamline apparent natural causes death investigations

During the reporting period, the registrar also developed and implemented a streamlined approach to the management of apparent natural causes death investigations.

While proactive triaging of apparent natural causes deaths can and does avoid unnecessary autopsies, there will still be cases where preliminary investigation will not yield sufficient information to support the issue of a cause of death certificate, or it is clear from the outset that an autopsy is necessary to establish a cause of death.

Experience has shown that for the majority of the apparent natural causes deaths that proceed to autopsy, the medical cause of death is the only issue warranting coronial involvement. The initial police investigation has already confirmed there are

no suspicious circumstances and the circumstances in which the person died do not require further coronial investigation.

For these cases, the new streamlined investigation process works to position the coroner to make findings once the forensic pathologist has determined the cause of death. In these circumstances, the coroner will issue short-form non-narrative findings.

The guidelines for use of non-narrative findings for a natural causes death require the coroner to be satisfied that other than the fact that a cause of death certificate had not been issued for the death, the death was otherwise not reportable under the Coroners Act. These guidelines recommend that coroners still make narrative findings for sudden unexpected child deaths including sudden infant death syndrome (SIDS) or where the circumstances of the death need to be explained more fully.

In many of these cases, as the cause of death is determined at autopsy the coroner can make formal findings and finalise the coronial investigation within days of the death. This initiative has helped achieve much more timely completion of less complex investigations.

Deaths reported by Form 1A or funeral directors

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

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

Table 6: Number of Form 1A's by region

Coronial reporting catchment	Deaths reported via Form 1A
Brisbane	818 (down from 877)
Northern	106 (up from 92)
Central	62 (up from 61)
South Eastern	155 (down from 210)
TOTAL	1,141 (down from 1,240)

The number of deaths reported by the Form 1A process represent approximately 20.4% of the total deaths reported during the reporting period (down from 23.4% in 2015-16).

Form 1A reviews are a highly effective triage process which involves collating and reviewing all relevant medical records with the assistance of a forensic medicine officer and liaising with family members with the assistance of a coronial counsellor, where required.

If satisfied there is no need for further coronial involvement, the death certificate will be authorised and the coronial process ends.

In most cases, the Form 1A investigation can be completed within 24-48 hours of the death being reported and without the deceased person's body having to be moved from the hospital mortuary. During 2016–17, the Form 1A process diverted all but 54 deaths reported to the registrar from full coronial investigation.

Table 7 shows the significant increase in the health sector's use of the Form 1A process for potentially reportable deaths since 2007–08 – effectively almost quadrupling the state-wide usage of this process over the past decade.

Deaths reported directly by funeral directors are managed by the registrar using the same process. In 2016–17, 34 deaths were reported by funeral directors.

Table 7: Number of Form 1A's state-wide and in Brisbane

Financial year	Form 1As State-wide	Form 1As Brisbane
2007–08	314	223
2008–09	423	295
2009–10	732	482
2010–11	880	514
2011–12	1043	571
2012–13	1044	699
2013–14	1003	721
2014–15	1101	767
2015–16	1240	877
2016–17	1141	818

Telephone advice for clinicians

The registrar works closely with hospitals to educate clinicians about their coronial reporting obligations and actively encourage doctors to seek advice about the reportability of the death before they issue a cause of death certificate. This interface provides an important opportunity to filter out not reportable deaths and to triage reportable deaths were a cause of death certificate may be authorised under section 12(2)(b) of the Coroners Act (i.e. via the Form 1A process).

The registrar provides telephone advice to clinicians State-wide about whether a death is reportable. In 2016-17, 986 deaths were reported in this way and determined to be not reportable. This represents 17.6 per cent of the total number of deaths reported State wide.

Table 8: Distribution of telephone enquiries by region

Coronial reporting catchment	Deaths reported by phone call – deemed not reportable
Brisbane	696
Northern	124
Central	81
South Eastern	85
TOTAL	986

Clinical education and death prevention activities

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

While the registrar role was established primarily as an efficiency mechanism to ease the burden of increasing demand on coronial resources, the role has demonstrated a valuable contribution to general death prevention.

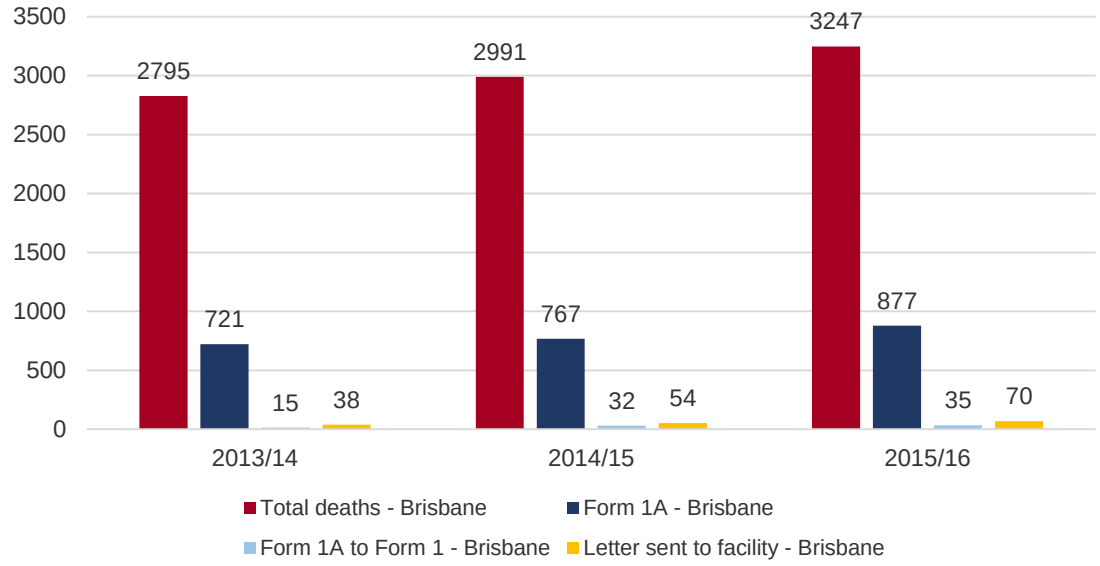
The Form 1A process can and does contribute to future death prevention even when deaths are diverted from full coronial investigation by identifying potential patient safety issues, which although not considered contributory to the death reported and not warranting further coronial investigation, otherwise merit further examination by the health service where the issues arose. In these cases, the registrar formally notifies the relevant health service executive of the potential issue and recommends formal clinical review.

These notifications have generally been met with a positive response from the health sector yielding demonstrated action to address the issues with a view to reducing the risk of adverse health outcomes. Actions taken in response to registrar notifications to date have included education and training of staff, developing and reviewing clinical policies and procedures, implementing practice changes, counselling or retraining individual clinicians, reviewing resources (staffing, equipment) and implementing monitoring and review processes.

These achievements were showcased in a presentation to the Australian-Pacific Coroners Society Conference in Perth in November 2016: *Prevention in Practice.*[3]

[3] Co-presented by Ainslie Kirkegaard, Coronial Registrar and Dr Adam Griffin, Director, Clinical Forensic Medicine Unit, Department of Health http://www.asiapacificcoroners.org/past-conferences/2016/

Figure 1: Form 1A outcomes, Brisbane, 2013-14 to 2015-16



Ongoing challenges

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

However, reallocation of the apparent natural causes death triaging and investigations to coroners has increased their caseloads and impacts on their capacity to progress more complex investigations and inquests. It is one of the factors affecting the clearance rate for 2016-17.

This could be alleviated with a second coronial registrar to manage the apparent natural causes deaths. The current registrar position has also exceeded capacity and a second registrar is needed if the efficiencies that this role brings are to be realised across the South Eastern, Central and Northern regions.

While the existing registrar role was established within existing resources, additional funding will be required to support a second registrar and their support staff if the efficiencies that the registrar role bring are to be realised State-wide.

Exploration of more innovative use of information technology to facilitate the transmission of and access to medical records is also needed to further enhance the efficiency of registrar work.

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

Forensic pathology services

During 2016–17, the State Coroner and the CCoQ contributed to work being progressed by QHFSS to examine the future sustainability of its forensic pathology service.

Coronial autopsies are performed by QHFSS-employed forensic pathologists in Brisbane, Gold Coast, and Cairns only, with coronial autopsies undertaken in Toowoomba, Rockhampton and Townsville (and some at the Gold Coast and occasionally Cairns) performed by fee-for-service forensic pathologists approved under the Coroners Act. A fee structure for the performance of fee-for-service autopsies is prescribed by regulation under the Coroners Act.

The prescribed fee structure underwent comprehensive review during 2014–15 to move away from a flat-fee to an hourly-rate model.

For historical reasons (largely reflecting the antiquated forensic services delivery model in place prior to the commencement of the Coroners Act in December 2003 which involved the performance of coronial autopsies by regional Government Medical Officers and a much smaller team of qualified forensic pathologists), the CCoQ continues to manage the budget for fee-for-service autopsies.

In 2016–17, the CCoQ expended $590,845 on fee-for-service autopsies, a substantial increase of 11.16 per cent from 2015–16.

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

Data from 2011–12 to 2016–17 about autopsies is provided in Tables 9, 10 and 11.

Table 9: Percentage of orders for autopsy issued to number of reportable deaths

	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17
Deaths reported	4461	4762	4682	4962	5287	5587
Autopsies	2742	2733	2475	2542	2550	2730
Percentage	61.5	57.4	52.9	51.2	48.2	48.9

Table 10: Number of orders for autopsy issued by type of autopsy to be performed

	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17
External	544	629	717	679	769	856
Partial internal	639	795	598	597	533	583
Full internal	1559	1309	1160	1266	1248	1291
Total	2742	2733	2475	2542	2550	2730

Table 11: Percentage of orders for autopsy issued by type of autopsy to be performed

	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17
External	19.8	23.0	29.0	26.7	30.2	31.4
Partial internal	23.3	29.1	24.2	23.5	20.9	21.4
Full internal	56.9	47.9	46.9	49.8	48.9	47.3

During 2016–17, there was a small increase in the percentage of autopsies performed relative to the number of reported deaths overall.

This is in keeping with the tenor of the State Coroner's Guidelines, *Chapter 5 Preliminary investigations, autopsies and retained tissue* which encourages coroners to order the least invasive post-mortem examination necessary to inform the coroner's investigation[4]. These figures demonstrate that triaging processes continue to divert a significant number of cases away from unnecessary autopsy.

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

Achieving system efficiencies: rethinking and refocusing the application of coronial resources through policy and legislative change

There has been a significant growth in demand for coronial services since the enactment of the Coroners Act in 2003. From 2004–05 (the first full financial year of reporting under the new legislation) to 2016–17 reported deaths have increased by 83.6 per cent (5,587 up from 3,043 deaths).

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

In 2014, the CCoQ developed a discussion paper for the Department of Justice and Attorney-General outlining a range of possible policy and legislative changes to assist in achieving system efficiencies including whether:

- coroners should continue to have a role in investigating all mechanical fall-related deaths resulting from age or infirmity
- coroners should be required to make findings (other than relating to the medical cause of death) in all apparent natural causes deaths that proceed to coronial autopsy
- a mandatory inquest is necessary for all natural causes prisoner deaths in custody where there are no issues of concern
- to limit the current prohibition on holding an inquest once a person has been charged with an offence in respect of the death to indictable offences only.

As at 30 June 2017, these proposals were still under consideration.

[4] state-coroners-guidelines-chapter-5

The role of the coroner in preventing future deaths

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

Information gathered as part of the coronial investigation can also be used to inform a range of prevention initiatives by government agencies, academics and other relevant parties. This research and activities can be used to inform death prevention initiatives across a range of reportable death categories

Inquests

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

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

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

Inquests into the deaths of 30 persons were finalised during 2016–17 (outlined in Table 13).

As can be seen in Table 12, there has been a steady decrease in the number of inquests held since 2011–12. Factors contributing to this decline include the ongoing yearly increase in workload for coroners and the increasing complexity of inquests.

Table 12: Number of coronial inquests by year

Year	No of inquests
2011-12	81
2012-13	66
2013-14	49
2014-15	78
2015-16	43
2016-17	30

Each of the full time coroners is assisted by a legal officer. These legal officers are increasingly performing the role of counsel assisting and during 2016–17 assisted in inquests into the deaths of 26 persons. Having in house counsel assisting is beneficial as coroners are supported by lawyers with specialised skills and experience in the jurisdiction and inquest costs are kept to a minimum.

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

Table 13: Coronial Inquests held during 2016–17

Name	Coroner	Counsel	Type of death	Recommendations
Mickelo, Garnett Allan	Lock	In house	Death in custody, health care related	No
Talbot, James Patrick	Lock	In house	Health care related	No
Poxon, Simon James	Lock	In house	Workplace death	Yes
Smallwood, Gregory Bert	Ryan	In house	Death in custody, natural causes	No
Antonio, Rachel	O'Connell	In house	Suspected death	No referred to DPP
Clarke, David Michael	McDougall	Private	Home invasion, hospitalisation	No referred to DPP
McBride, Russell Peter	Ryan	In house	Death in custody, suicide	No
Plumb, Mark Anthony	Lock	In house	Health care related	No
Winbank, Leslie Geoffrey	Ryan	In house	Death in the course of a police operation, suicide, siege	No
Calder, Michael James	Lock	In house	Health care related	No
Walton, Christopher Jon	McDougall	In house	Awning collapse	Yes
Floyd, Leah Elizabeth	Lock	In house	Death in care, physical disability	No
Capps, Ruth	McDougall	In house	Motor vehicle accident, medical condition	Yes
ES	Lock	In house	Multiple drug toxicity, palliative care in community	Yes

Name	Coroner	Counsel	Type of death	Recommendations
Haimona, Elliot Arapita	Ryan	In house	Death in the course of a police operation, suicide, taser	No
Sloan, Dane Benjamin	Ryan	In house	Death in custody, hanging	Yes
Cowley-Perch, Donna	Hutton	In house	Suicide, pentobarbitone, vet clinic	Yes
Gordon, Leonard Raymond	Ryan	In house	Death in custody, prison assault	No
Paddon, Darrin Edward	Ryan	In house	Death in custody, natural causes	No
Trott, Leila Michelle	Lock	In house	Drowning, remote area retrievals	Yes
Jensen, Ian Christoffer and Kepui, Timothy Ponde	O'Connell	In house	Bicycle accidents	Yes
Coolwell, Bradley Karl	McDougall	Private	Mental and physical care in hospital	Yes
Biffin, Albert Eric	Clements	Private	Low care nursing home, incarcerated hernia	Yes
Turpin, Robert Noel	Ryan	In house	Death in course of police operation	Yes
Volke, M & Prasetyo, M	Ryan	In house	Death in custody suicide domestic violence	No
Mead, Gwendoline	Kirkegaard	Private	Colorectal surgery	Yes
Tonkin, Nixon	Lock	In house	Health care related death, obstetrics	Yes
Langley, Archer	Lock	In house	Health care related death, obstetrics	Yes

Monitoring responses to coronial recommendations

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

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

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

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

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

Access to coronial information

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

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

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

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

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

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

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

- Amanda Thompson, Sarah Morley & Andrew Griffiths – QHFSS Forensic Toxicology

The full list of researchers is outlined below in Appendix 1.

Systemic Death Review Initiatives

There is an increasing recognition among government, academics and the broader community that systemic analysis of different types of deaths may improve prevention efforts; particularly where research has shown the presence of similar patterns or trends prior to the death. Such analysis may also assist in the identification of any missed opportunities to intervene prior to the death/s or opportunities to prevent future deaths.

The Domestic and Family Violence Death Review Unit was originally established in 2011 within the CCoQ to provide expert advice and assistance to coroners in their investigation of domestic and family violence related homicides and suicides. Over time, this unit has continued to grow and expand to consider other types of reportable death categories, including the deaths of children who were known to child safety services prior to the death.

It also supports other death prevention activities within the CCoQ and provides advice on national and state policy and practice initiatives, as they relate to the coronial jurisdiction.

Domestic and Family Violence Deaths

As a result of recommendations from the Special Taskforce on Domestic and Family Violence Final Report, *Not Now, Not Ever: Putting an end to Domestic and Family Violence in Queensland (*2015) there have been a number of significant enhancements to the Queensland domestic and family violence death review process.

This includes additional resources allocated to the Unit so they are better equipped to support coroners in their investigations of these types of deaths, and the establishment of protocols to facilitate the sharing of data and information from this death review process with public sector agencies, non-government organisations and academics.[5]

[5] http://www.courts.qld.gov.au/__data/assets/pdf_file/0010/489169/ccq-dfv-research-and-data-sharing-protocol.pdf

In addition, in their final report, the Special Taskforce recommended the establishment of an independent multi-disciplinary Domestic and Family Violence Death Review and Advisory Board to undertake systemic reviews of these types of deaths.

In July 2016, the Attorney General appointed the State Coroner as Chair of the Board as well as other Members who were appointed based on their expertise and system knowledge. Members are a mixture of academic, government and non-government representatives.

With the establishment of the Board within this reporting period, the Unit now provide secretariat and research support to the State Coroner and the Board, as well as continuing to support coroners in their individual investigations of relevant reportable deaths.

In early 2017, Queensland also assumed the role of Chair of the Australian Domestic and Family Violence Death Review Network. The Network comprises representatives from those jurisdictions where domestic and family violence death review processes are established or being trialled. The Network has a range of aims, including to improve knowledge in relation to domestic and family violence deaths at a national level.

The Network are currently undertaking a significant amount of work to establish the first national dataset of intimate partner homicides that have occurred in the context of domestic and family violence in Australia.

In 2016-17, coroners have conducted inquests or published their findings into a number of deaths where domestic and family violence was considered as part of the investigation, as summarised in brief detail below.

Non-inquest findings – KH

KH was a 35 year old women when she died from injuries inflicted by her de-facto partner C during an assault on the evening of 20 January 2012. C and KH were consuming excessive amounts of alcohol, and C later alleged to police that KH had grabbed a knife, caused property damage and was ‘going off’. He stated further that he subsequently disarmed her and fatally cut her neck with the knife.

The coronial investigation identified that C exhibited a pattern of coercive controlling behaviour towards KH, including social isolation, belittling and threatening behaviour, restricting resources, as well as verbal abuse and physical violence.

KH told police after an assault in April 2010, where C had punched KH in the face, that C had begun physically assaulting her shortly after they commenced living together sometime in 2009. On this occasion, C was charged with assault occasioning grievous bodily harm and a police application for a domestic violence protection order was granted by the courts. Bail and protection order conditions prohibited C from contacting or approaching KH, however records indicate that contact continued between the couple over this intervening period, which came to the attention of police on at least two further occasions when KH sought to have the charges against C withdrawn.

KH’s body was discovered three days before C was due to appear in court in relation to the assault charge and subsequent charges which were initiated by police for breaching bail and protection order conditions.

In her findings, Coroner Clements noted the significant reform that had occurred in Queensland subsequent to KH's death that aimed to improve the safety and protection of victims of domestic and family violence as part of the Queensland Government's commitment to implementing recommendations from the Special Taskforce on Domestic and Family Violence Final Report.

Coroner Clements also noted that recent legislative amendments to remove the presumption of bail for high-risk offenders who commit relevant domestic and family violence offences may have influenced the outcome in this case had they been enacted at the time of KH's death.

As such, the coroner decided against holding an inquest, but published the findings from this case as a means to raise awareness of this death and to highlight the ongoing need for the community and all health, support, police and justice services to speak out and act against these forms of violence[6].

Inquest findings – Marcus Volke and Mayang Prasetyo

Marcus Volke and Mayang Prasetyo resided together in a unit complex in Teneriffe at the time of their deaths in October 2014. The couple were heard to be arguing loudly on the evening of 2 October 2014. The following day a foul smell was noted to be coming from the unit. Police were called after the unit manager noticed blood on the carpet and other damage. Upon police arrival, Marcus fled from the scene and police found Mayang's dismembered body inside the apartment. Shortly afterwards, Marcus was located deceased in a nearby street with significant self-inflicted injuries to his throat and wrists.

The nature of the relationship between Marcus and Mayang was unclear as, although the couple were married, it had been described by others as a business arrangement. The pair lived a transient lifestyle, reportedly travelled throughout Europe and Asia working within the sex industry, which limited the availability of reliable testimony to establish whether the couple were intimately involved. There was, however, evidence that their relationship was unstable and that Mayang had threatened to disclose to Marcus's family that he was a male escort if he tried to leave her. She was also known to monitor Marcus's social media usage and emails, including making contact with former partners by impersonating him online.

There was limited interaction with formal and informal support networks for either Mayang or Marcus in relation to domestic and family violence which may have afforded an opportunity to detect and respond to any prior indicators of risk in their relationship, and as such the State Coroner concluded there were no identifiable missed opportunities for intervention.

An inquest was conducted by the State Coroner on the basis that Marcus' death had occurred during police operations. A substantial focus of the inquest was the police response to the incident which is outlined in further detail on page 57 of this Annual Report. The State Coroner found that there were no grounds for criticism for police officers involved and they acted professionally and appropriately.

As part of his findings the State Coroner acknowledged that research demonstrates that there may be particular stressors and factors that are unique to the lesbian, gay,

[6] http://www.courts.qld.gov.au/__data/assets/pdf_file/0019/525214/nif-kh-20170620.pdf

bisexual, transgender, and intersex (LGBTI) community, and a lack of awareness of what domestic and family violence looks like in this context.

Given the Queensland Government's response to the Special Taskforce on Domestic and Family Violence Final Report and the *Domestic and Family Violence Prevention Strategy 2016-26* both acknowledge the particular needs of LGBTI people and identify a range of reforms that are currently being implemented; no further recommendations were made by the State Coroner during this Inquest[7].

Child protection deaths

In 2014, as part of reforms associated with the Queensland Child Protection Commission of Inquiry, the Coroners Court received an additional resource to provide expert advice and assistance to coroners in their investigations of children known to the child protection system prior to the death.

During 2016-17, the Coroners Court was invited to contribute to consultations regarding the child death review process in Queensland, which was subject to a recent review by the Queensland Family and Child Commission (QFCC). The QFCC considered the current operational model for conducting these types of deaths as well as contemporary evidence and interjurisdictional models as part of its final report, '*A systems review of individual agency findings following the death of a child*'[8].

The QFCC, in their findings, recognised the critical and valuable role of the coronial jurisdiction, including the Domestic and Family Violence Death Review Unit and the independent Domestic and Family Violence Death Review and Advisory Board, in the investigation and review of these types of deaths; and subsequently recommended that the Queensland Government consider a revised external and independent model for review the deaths of children known to the child protection system.

Deaths of children known to the child protection system are sometimes the most complex and require consideration of the interaction between a range of services, as outlined in the non-Inquest findings by the Deputy State Coroner below.

Non-inquest findings – C, a 14 year old child

C was a 14 year old girl who choked on food in the presence of her residential carers and later died in hospital. C had multiple disabilities including: foetal alcohol syndrome; autism; and, intellectual impairment and associated behaviour issues. C had been in care since she was three months old and at the time of her death was residing at a disability facility after multiple placements in foster care and other disability residences.

On 27 June 2015, C was on an outing with her carers who purchased fast food which was placed in the front of the car. C climbed over the seat and began eating the food which caused her to choke before collapsing. Resuscitation was commenced and QAS transported her to hospital. Tests revealed significant brain damage due to

[7] http://www.courts.qld.gov.au/__data/assets/pdf_file/0006/521277/cif-volke-mp-prasetyo-m-20170519.pdf

[8] Queensland Family and Child Commission. (2017). *A Systems Review of Individual Agency Findings Following the Death of a Child.* Brisbane: Author. https://www.qfcc.qld.gov.au/sites/default/files/For%20professionals/death-of-a-child-report-march-2017.pdf

impaired blood and oxygen supply. Two weeks later treatment was ceased and C died shortly after being removed from a ventilator machine on 9 July 2015.

The Department of Communities, Child Safety and Disability Services (DCCSDS) completed a Systems and Practice Review (SPR) as C was under a guardianship order at the time of her death. The SPR outlined a history of disadvantage for C and a multitude of challenges that she and her carers endeavoured to overcome. C was noted to have needs with regards to: physical health; child development; behaviour; as well as her relationship with her biological mother and other relationships.

Due to her physical limitations, C was mostly fed via a tube in her stomach, however had been beginning to eat orally prior to her death. An eating plan was in place, noting that as C tended to overfill her mouth and to eat too quickly she should be supervised to eat. The SPR suggested that in the circumstances, the issue arising in this case was not the implementation of the plan as the food was not intended for C.

In investigating this death, the Deputy State Coroner considered the Public Advocate's report '*Upholding the right to life and health: A review of deaths in care of people with disability in Queensland*.'[9]

The Deputy State Coroner noted that the need for interdisciplinary approaches involving relevant services had been identified as part of ongoing child safety reforms which was reiterated in the Public Advocate report. The Public Advocate report also identified the risks of choking for people with intellectual and cognitive impairments and called for greater understanding, training and support with regards to swallowing assessments and safe eating practices.

The Public Advocate reported that the availability of current, accessible health records to quickly and accurately assess both current and future client needs is an area requiring continuous focus and improvement.

The Deputy State Coroner considered whether this was an issue in this case but was unable to be determine if this contributed to detrimental outcomes for C or her subsequent death.

In his findings, the Deputy State Coroner concluded that the implementation of recommendations from the Public Advocate's report will improve the provision of care to children with complex disabilities in the care of residential facilities across the service system. Further, the Coroner reported not being able to identify any significant systemic shortcomings or missed opportunities for intervention with respect to the provision of care by the Department of Communities, Child Safety and Disability Services[10].

Suspected or apparent suicides

The CCoQ continues to contribute data and information to maintain the Queensland Suicide Register, established in 1990 and funded by the Queensland Government since this time.

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[9] Office of the Public Advocate (Qld). (2016). *Upholding the Right to Life and Health: A review of the deaths in care of people with disability in Queensland.* Brisbane: Queensland Government. http://www.justice.qld.gov.au/__data/assets/pdf_file/0008/460088/final-systemic-advocacy-report-deaths-in-care-of-people-with-disability-in-Queensland-February-2016.pdf

[10] http://www.courts.qld.gov.au/__data/assets/pdf_file/0005/484835/c-a-14-year-old-girl-non-inquest-findings.pdf

Managed by the Australian Institute of Suicide Research and Prevention, this Suicide Register was the first and is one of the most comprehensive databases of its kind in Australia and the Asia Pacific region. Data contained within the Register is used by government and academics to enhance their understanding of these types of deaths and inform prevention strategies and initiatives.

Led by the QPS CSU and supported by the Domestic and Family Violence Death Review Unit, Queensland managed the implementation of the National Police Form 1 project during this reporting period. This project aims to standardise and improve national reporting on suspected or apparent suicides.

The need for improvements in the national collection of suicide data and information has been subject to much consideration at a state and national level over the past decade; with increased recognition of the need for more accurate data to help us to better understand, and ultimately prevent, these types of deaths.

This was highlighted during the Senate Inquiry 'The Hidden Toll of Suicide' in 2010 which identified issues pertaining to the accuracy of suicide reporting in Australia and noted the consequences associated with underreporting, including in relation to our understanding of risk factors and the provision of services to those at risk[11]. As part of a range of recommendations designed to address these concerns, the Senate Committee recommended that all Australian Governments implement a standardised national police form for the collection of information regarding a death reported to a coroner (recommendation 4). Since this time, most jurisdictions have introduced, or are in the process of introducing, forms which contain these standardised items.

In April 2017, in collaboration with the QPS CSU and Suicide Prevention Australia to support the finalisation of this Project, the Domestic and Family Violence Death Review Unit conducted a comparison of all supplied State and Territory Police Report of Death to a Coroner forms.

From this comparison it was established that the majority of forms compared contained the minimum data required when reporting suspected and apparent suicide deaths to a Coroner. In a small number of jurisdictions, the form may have contained the minimum data or information required but the format did not easily allow for extraction and collection of statistics.

Following the National Coronial Suicide Prevention conference in May 2017, a working group was established to finalise this project. This work was ongoing as at 30 June 2017.

Deaths by suspected or apparent suicide remain one of the largest, non-natural causes death category reported to coroners each year. In 2016–17 they represented approximately 12 per cent of the total deaths reported to the office and they are at times some of the most complex. Often, multiple concerns are identified regarding a range of issues including the provision and management of mental health care or the interaction between various services in the provision of support or treatment prior to the death. Given the increasing volume and complexity of suicide investigations undertaken by coroners, there is a pressing need to equip them with access to timely, appropriately qualified and independent mental health expertise. By addressing this gap, coroners will be best placed to fulfil their fundamental general death prevention function, and in doing so, the Queensland coronial system will be vastly better

[11] Senate Standing Community on Community Affairs (2010) The hidden toll: suicide in Australia

positioned to inform and influence systemic mental health reform and suicide prevention.

Strengthening the coronial process with access to a specialist mental health death review process is consistent with the identification of suicide prevention as a stage one priority under the *Queensland Mental Health, Drug and Alcohol Strategic Plan 2014-2019*. This matter was raised by the Deputy State Coroner with the *Queensland Mental Health and Drug Advisory Council* in February 2017, who expressed concern with the lack of specialist advice to Coroners in relation to coronial investigations which examine mental health treatment.

The Council subsequently requested that the Queensland Mental Health Commission follow up with the Chief Psychiatrist, Queensland Health to explore how mental health advice could be reinstated to support the coronial process.[12]

Inquest findings – Robert Turpin

Robert Turpin was a 23 year old Aboriginal man who was found unresponsive by police and hanging in the bathroom at his mother's residence on 12 August 2015, after his intimate partner Tonee had called 000 alleging Robert had assaulted her and her younger sister. Robert and Tonee had been arguing for several days and Robert believed that she was going to leave him.

On the night of 11 August 2015, Robert, Tonee and others were drinking alcohol at his mother's residence where they both resided. Robert threatened to hang himself on three occasions during the course of the night and into the next morning. Tonee attempted to go to bed when Robert was 'being rough' with her and pushed her to the ground. Tonee's sister attempted to intervene and Robert also pushed her to the ground. Tonee told Robert she was going to call the police and he was observed to be '*jumping around…like trying to snap his neck'* before heading to the bathroom with a belt.

Robert had previously physically assaulted Tonee on at least two occasions which resulted in police intervention. Robert also demonstrated sexual jealousy when Tonee spoke with other males. A domestic violence protection order listing Robert as the respondent and Tonee as the aggrieved was in place at the time of death, as a result of previous physical assaults. An additional condition on the order specified that Robert was not to reside with Tonee, a condition which was breached at the time of the death. Tonee reported that both parties had nowhere else to go and she was trying to have the condition removed from the order. She reported being happy living with Robert and declared an intention to continue living with him.

Robert consumed alcohol and marijuana regularly and to excess, and had started using ice in the months before the death which was reportedly associated with him being more aggressive and moody.

An inquest was held as the death occurred during police operation, as attending officers reported not being aware of the suicide threat and did not immediately locate Robert upon arriving at the premises. The State Coroner ultimately concluded the death of Robert could not have been reasonably prevented by attending officers and his comments in relation to the police response are outlined in this Annual Report on page 56.

[12] The Meeting Communique is available here: https://www.qmhc.qld.gov.au/about/publications/browse/communiques/council-meeting-communique-17-february-2017

With respect to domestic and family violence, the inquest considered recommendation 86 of the Special Taskforce on Domestic and Family Violence report which relates to flexible and tailored responses to assist aggrieved persons stay safely in their homes.

The QPS also tendered information about current organisational reform activities relevant to this death, including the adoption of a proactive investigation and protection policy, the evaluation of their Protective Assessment Framework, and the roll-out of vulnerable persons training.

As such, no further recommendations were made by the State Coroner during this Inquest[13].

Deaths in care of people with a disability

The roles and responsibilities of coroners and their need for specialist advice and assistance when investigating deaths in care of people with a disability was recently recognised by the Office of the Public Advocate in their report, *Upholding the right to life and health: a review of the deaths in care of people with disability in Queensland* in early 2016.

The *Coroners Act 2003*, s. 8(3)(f) in conjunction with s. 9(1)(a), makes reportable the death of persons with a disability who lives in supported residential accommodation that is either a level 3 residential service under the *Residential Services (Accreditation) Act 2002* or a government operated or funded residential service. A level 3 accreditation is required if a residential service provides a personal care service.

These services provide varying degrees of personal support to residents ranging from the provision of meals and administration of medication, to full support with the activities of daily living. These deaths are reportable irrespective of the cause of death and whether the resident died somewhere other than the residential service, for example in hospital. This reflects the underlying policy objective of ensuring there is scrutiny of the care provided to residents of these services given their particular vulnerabilities.

The focus of a coronial investigation into a death in care (disability) is whether the circumstances of the death raise issues about the deceased's care that may have caused or contributed significantly to the death. The *Coroners Act 2003*, s. 27(1) (a) (ii), mandates an inquest if any such issues are identified.

In their Final Report, the Public Advocate made a number of recommendations in relation to the coronial investigation and systemic review of these types of deaths. This included that:

- the State Coroner should be required to report annually on deaths in care.
- coroners should be provided with further expert advice in relation to health and support issues for people with intellectual and cognitive impairments.
- there should be enhanced education and awareness raising about reporting requirements in relation to the deaths of people with a disability in care.
- an appropriate agency should be resourced and tasked to carry out regular systemic reviews of people with a disability who have died in care in

[13] http://www.courts.qld.gov.au/__data/assets/pdf_file/0007/519298/cif-turpin-rn-20170504.pdf

Queensland, with a report detailing the outcomes of these reviews to be tabled in Parliament at least biennially.

Taking into account the findings of the Public Advocate's report, data in relation to deaths in care are reported during 2016–17 financial year within this Annual Report. In addition to concerns raised by the Public Advocate with respect to the identification and reporting of these types of deaths, with the transition to the National Disability Insurance Scheme consideration is currently being given as to how to identify deaths in care, as current identification is predominantly place-based.

It is certainly the case, as discussed elsewhere in this report and previous Annual Reports, that with the ever-increasing number of deaths reported to the Coroners Court, and the increased complexity of investigations, now, more than ever, coroners need additional assistance in investigating those reportable deaths that require consideration of the actions of complex systems and the roles of individual entities in the provision of support to vulnerable persons.

Having regard to the findings of the Office of the Public Advocate report, and in recognition of this need across a range of reportable death categories, the State Coroner directed that an expert panel review process be trialled to examine the health care management of persons whose deaths have been reported to the coroner as a death in care (disability). This trial utilized the existing capacity of the Domestic and Family Violence Death Review Unit to apply the principles of systemic death review processes to this different type of death. As an independent panel, assistance was generously provided by Dr Adam Griffin, Director, Clinical Forensic Medicine Unit, Queensland Health, who acted as Chair for the Panel. The other experts included: Dr Katherine Robinson, Clinical Forensic Medicine Unit; Professor Nick Lennox, Director, Queensland Centre for Intellectual and Developmental Disability, University of Queensland; Professor Harry McConnell, School of Medicine, Griffith University; Dr Paul White, Consultant Physician of Psychiatry; and, Dr Caroline Ceron, Psychiatric Registrar.

These experts were required to review eleven (apparent) natural causes deaths in care of people who were residents in supported residential accommodation, in which potential concerns were identified with the adequacy of their health care management prior to the death.

The purpose of this Panel was to provide advice and make recommendations regarding:

- the health care management of the persons prior to the death, including whether the care provided was appropriate, and whether any of these deaths could reasonably be considered to have been preventable; and
- the identification of any gaps, or potential opportunities for improvement, in the health care management and personal care or support of people with a disability with complex needs in care, including where multiple care providers were involved.

In summary, common issues were identified across the cases by the Experts in the following areas:

- governing legislation and regulation with respect to the provision of personal care and support within Level 3 residential care facilities, with a specific focus on opportunities for improvement to the existing regulatory frameworks and standards; staff training and experience; eligibility screening and assessment; transition processes to higher care facilities; and health care practitioner

awareness of Level 3 residential care facilities which may have impacted on appropriate treatment and discharge planning
- the clinical management and care provided prior to the death including the quality of clinical records and decision-making; the importance of ensuring annual health assessments are conducted with this population; the need to ensure intellectual disabilities and cognitive impairments are appropriately screened, assessed and managed; the role and responsibility of general practitioners in coordinating care within the community; adherence to clinical management guidelines for the treatment of schizophrenia; as well as, the use of advanced health care directives as a means to take into account a person's ongoing care and support needs for this cohort, where consent may be difficult to obtain by practitioners.

Though not relevant to the circumstances of the deaths, the Panel also considered it appropriate to recommend the continuation of this initiative within the CCoQ, highlighting the volume of information and files available for consideration and review that would otherwise not be available outside of this jurisdiction and the need for a continued systemic focus on these types of deaths. At the time of publication, the recommendations made by the Panel were subject to the consideration of the investigating coroners and the Coronial Registrar

Inquest findings- Leah Elizabeth Floyd

Leah Elizabeth Floyd was born on 12 August 1965 and was 48 years of age at the time of her death on 10 October 2013 at the Nambour General Hospital.

On 8 August 2012, Ms Floyd suffered a fall from a balcony. She was said to be grossly intoxicated at the time. The fall resulted in tetraplegia associated with spinal fractures, for which she underwent operative procedures. She was then admitted to the Princess Alexandra Hospital Spinal Injuries Unit (PAHSIU) on 28 August 2012 and discharged from there almost a year later on 8 August 2013.

As a result of her long term hospitalisation, in July 2013 Ms Floyd developed pressure wounds on her elbows and sacrum. The sacral pressure wounds were noted to be healing before her discharge from the PAHSIU, although there were some pressure areas on her elbows at the time of discharge. She also suffered from ongoing depression and anxiety. It is important to acknowledge, that notwithstanding these conditions and her physical disability, Ms Floyd at all times after discharge had the mental capacity to make her own decisions about her finances and health needs.

Ms Floyd moved to Musgrave Drive, Yandina Creek to be supported by BE Lifestyle Ltd. BE Lifestyle is a community-based non-government organisation and provided a supported accommodation service with funding provided by the Department of Communities, Child Safety and Disability Services (Disability Services). BE Lifestyle did not provide nursing or medical care and arrangements were made for Ms Floyd to receive wound care and treatment from Blue Care Nursing Service.

Ms Floyd was in the care of BE Lifestyle from 26 August 2013 until she was taken to Nambour Hospital on 5 September 2013. BE Lifestyle raised concerns that Ms Floyd may have suicidal ideations and requested she undergo a psychiatric assessment. Ms Floyd was not consulted by BE Lifestyle or the referring GP about her transfer to hospital.

Although it was considered almost immediately that Ms Floyd was not suicidal or mentally unwell and could be discharged, Ms Floyd remained in Nambour Hospital

for approximately two weeks. During this time she was reviewed on three occasions by a psychiatrist. The psychiatrist formed the view that whilst Ms Floyd possibly had borderline personality disorder, which can be associated with self-harm, as well as anxiety issues, her overall risk for suicide and self-harm was low and she did not otherwise require inpatient psychiatric care.

Ms Floyd was discharged from Nambour Hospital on 19 September 2013 and returned to the care of BE Lifestyle. BE Lifestyle had asked Disability Services for Ms Floyd to be placed elsewhere, as it was concerned it could not meet her physical and mental health care needs. Arrangements were being made by Disability Services to find alternative supportive accommodation and in the meantime Ms Floyd remained at BE Lifestyle. Her pressure areas continued to be monitored by Blue Care and nurses from the PAH Transitional Rehabilitation Program team also assisted.

Ms Floyd was admitted to Nambour Hospital on the 6 October 2013, with a short history of low fever and intermittent coughing. Ms Floyd had delayed agreeing to be admitted until after she had completed a pre-arranged contact meeting with her children. By that time it is apparent she was quite unwell. The sacral pressure area was noted to have progressed to a large ulcer and she had developed a urinary tract infection. On 7 October she had an episode of low blood pressure, the cause of which was unclear. Sepsis was considered to be the most likely cause even though she had been treated for the local and more generalised infections that had been noted.

Despite medical management Ms Floyd progressed to develop respiratory failure and died on 10 October 2013. Dr Jenkins of Nambour Hospital issued a cause of death certificate indicating respiratory failure due to the development of sepsis following from an infected sacral wound, with urinary tract infection and tetraplegia contributing factors.

Ms Floyd died having been in community care for a total of only 29 days. After her discharge from PAHSIU she received care and support from a number of government (Queensland Health and in particular the PAH Transitional Rehabilitation Program (TRP) and Nambour Hospital and Disability Services) and non-government (BE Lifestyle, Blue Care and her GP) services.

Ms Floyd's death was reported to the Coroners Court as there was some concern about the specific wound care and that sepsis may have caused her death and/or that the management of the pressure ulcers may have contributed to this. As well, given the funding and accommodation arrangements, and Ms Floyd's physical disabilities, Ms Floyd's death met the criteria of a Death in Care.

Concerns

Concerns were raised by Ms Floyd's mother, as well as BE Lifestyle, regarding the appropriateness of BE Lifestyle to meet Ms Floyd's complicated medical and mental health needs. There was concern expressed about Ms Floyd being discharged from the PAH and Nambour Hospitals to BE Lifestyle and a concern that there was a reliance on BE Lifestyle to provide medical care.

Ms Floyd's husband also expressed concern about the care that was provided at BE Lifestyle including pressure wound care and the decision to have Ms Floyd admitted to Nambour Hospital for a mental health assessment.

There was evidence that BE Lifestyle had made several approaches to Disability Services attempting to have Ms Floyd placed elsewhere, stating they could not meet her care needs and that this was placing Ms Floyd, other residents, and staff at risk.

BE Lifestyle also raised concerns regarding Leah's alleged refusal to accept medical treatment, and raised whether that refusal was made in order to end her own life.

It became evident that there was a complicated relationship between Ms Floyd and some family members and confusion on the part of BE Lifestyle as to the rights of patients to determine their own health needs when they had capacity.

Autopsy examination

An autopsy was conducted on 17 October 2013 by Professor Peter Ellis, forensic pathologist.

On the basis of autopsy examination including toxicology, microbiology, review of medical records (including summarisation by a Clinical Forensic physician as well as police information), it was the pathologist's opinion that death was due to sepsis following pulmonary and cutaneous infections. Other contributing factors were a recent urinary tract infection and tetraplegia, which had been present for some period.

Conclusions

Coroner Lock stated that in his experience in most health care related adverse events there are usually multifactorial issues at play and a combination of system and human errors. Poor communication, poor documentation and a lack of safeguards can result in poor decisions being made. Some of those factors are evident in this case and these resulted in a number of missed opportunities to diagnose the deterioration in condition being suffered by Ms Floyd.

It was abundantly clear to the Deputy State Coroner that the TRP provided an excellent support program for Ms Floyd and he was very impressed with the various team members' caring and professionalism and the proactive manner in which they supported Ms Floyd after discharge.

Coroner Lock was satisfied Disability Services appropriately responded to Ms Floyd's concerns and needs. BE Lifestyle was certified to be able to provide services and care to a person with Ms Floyd's complex needs. When it became apparent Ms Floyd had lost trust in the management of BE Lifestyle, Disability Services acted expeditiously to find alternative accommodation.

Blue Care acknowledged there could be improvements to their documentation and some decision making that may have provided Ms Floyd a better level of service. That said, it cannot be stated that there was any one decision or treatment option made by Blue Care nurses that was causal to Ms Floyd's death.

Coroner Lock agreed with the submission from Counsel Assisting that Blue Care had demonstrated a genuine concern to improve practices for the future, both at an individual and organisational level.

Comments and recommendations

Given the limited clinical governance framework evident at BE Lifestyle, Coroner Lock considered a recommendation that Disability Services consider auditing BE Lifestyle in relation to its compliance with the *Human Services Quality Standards*. As

BE Lifestyle was in liquidation and presumably not providing any more residential care services in Queensland, such consideration was unnecessary.

Coroner Lock accepted the submission on behalf of Blue Care and did not consider it necessary to make any further recommendation. This was particularly so in the context of Blue Care having engaged in its own robust internal review of its services in this case and implementing improvements that were identified and considered to be necessary.

Higher courts decisions relating to the coronial jurisdiction

Beale v O'Connell & Ors [2017] QSC 127

This decision concerned an application to the Supreme Court of Queensland for the judicial review of decisions of the Central Coroner in relation to the investigation into the death of Tracey Ann Beale, including the decision to hold an inquest. The application was dismissed by the Supreme Court.

In 2016, the Coroner ordered that an inquest be held to examine issues surrounding death of Ms Beale, who had died following a struggle with her husband in which he had applied a headlock. Criminal charges in relation to the death had been discontinued by the Director of Public Prosecutions. Ms Beale's husband sought to have the Coroner's decision to exercise his power under s 28 of the *Coroners Act 2003* to hold an inquest quashed.

It was found that satisfaction that it is in the public interest to hold an inquest is a condition precedent to the exercise of the power to hold an inquest, and that a coroner must decide whether or not he or she is satisfied in this regard. However, Justice Jackson found that the coroner was not obliged to afford Mr Beale an opportunity to be heard by way of natural justice before deciding to exercise the discretionary power to hold the inquest. He noted several reasons for this, including:

- the decision does not adversely affect the interest of anyone, except to the extent that it may affect reputation or is a step that may later adversely affect someone during the inquest process.
- a decision to hold an investigation by inquest is only an intermediate step in the process of an investigation that will necessarily result in the making of the required findings, if possible.
- the hearing of the inquest itself and the making of the required findings or comments are attended by rights of procedural fairness or natural justice under the hearing rule.
- the Act makes express provision for notice of and appearance by interested persons at the inquest, but makes no provision for notice of a decision whether to hold an inquest.

The Coroner had identified two possible subject areas for comment under s. 46 of the *Coroners Act*; whether there should be a change in the law as to when a death caused by vaso-vagal nerve stimulation constitutes an offence, and whether public awareness of the risk of death by vaso-vagal nerve stimulation should be raised. In this regard, Justice Jackson said that as a matter of the 'ordinary meaning of s. 45 and 46, read in the context of the Act, nothing precludes a coroner from deciding to hold an inquest so that an authorised comment or comments may be considered'.

The Court also found that s. 28 did not require the coroner to obtain all available and relevant documentary evidence relating to the death before exercising the power to decide to hold an inquest, including the depositions of the evidence from the committal hearing involving Mr Beale. Although it was open to the Coroner to take the committal depositions into account in deciding whether to proceed with an

inquest, not having done so did not amount to failure to take into account a mandatory relevant consideration.

With respect to the witnesses proposed to be called to give evidence at the inquest, the Court found that an error as to relevance of the proposed evidence was not a ground for judicial review of the Coroner's decision to order particular persons to attend to give evidence.

The Court also found that because the Coroners Court is not bound by the rules of evidence at an inquest, unreasonableness could not be measured by whether expert evidence was admissible at common law or under any legislative provision. The Court found that the relevant expertise of witnesses related to content and operation of laws in connection with domestic violence. Those witnesses were capable of assisting the coroner in considering whether comments should be made to prevent deaths from happening in similar circumstances and other related matters under s 46 of the *Coroners Act*. Such comments can only be made where the death is investigated at an inquest.

The Court also found that it was not necessary for the court to produce a statement of proposed evidence before a decision to require a witness to attend an inquisitorial proceeding such as an inquest could be made.

Schaeffer v Ryan [2017] QDC 120

This decision involved an application to the District Court by the deceased's daughters under s. 30(6) of the *Coroners Act 2003* for an order that an inquest be held into the death of their father where the State Coroner had refused to hold an inquest. The application was dismissed by Judge Ryrie.

Mr Schaeffer had been admitted to the Princess Alexandra Hospital on 16 June 2016 for treatment that related to an infection of his left foot, and osteomyelitis with sepsis. After a prolonged period in the hospital, Mr Schaeffer passed away on 26 September 2016. This admission was against a background of a chronic history of left diabetic foot ulcer and osteomyelitis. Mr Schaeffer eventually underwent a left below knee amputation.

The relevant death certificate set out the cause of death, which was that Mr Schaeffer had died of sepsis of multifactorial aetiology, chest infection, right heel diabetes mellitus and urinary tract infection; refractory diarrhoea due to pancreatic insufficiency; and jejunal stricture.

After taking into account advice from Dr Lincoln of the Clinical Forensic Medicine Unit, the Deputy Registrar of the Coroners Court, Dr Buchanan, determined that Mr Schaeffer's death was a health care related death and was reportable under the *Coroners Act 2003*. This was on the basis that he had developed complications after surgery.

Dr Lincoln considered that the hospital discharge summary accurately reflected the significant events during Mr Schaeffer's admission at the PAH, and that the range of procedures were appropriately consented to. Dr Lincoln noted that Mr Schaeffer's multiple and complex medical problems presented considerable challenges for medical staff in diagnosis and management. However, Dr Lincoln was unable to identify any specific areas of concern in relation to his clinical care. During Mr Schaeffer's admission to hospital, his family utilised the "Ryan's Rule" process on four occasions.

Dr Buchanan was satisfied the death did not require further coronial investigation as he did not identify any concerns about the health care provided. He also found that a coronial autopsy was not required as the cause of death was known.

Judge Ryrie considered earlier decisions of the District Court in relation to applications under section 30. In particular, she noted that in *Lockwood v Barnes* [2011] QDC 84. Judge Dorney concluded that an inquest should be held where the views of the family or other significant members of the community, are such that an inquest is likely to assist to maintaining public confidence in the administration of justice. However, it will not be sufficient for the application to succeed based solely on the views of the family of the deceased.

Judge Ryrie also considered the decision of Judge Robertson in *Gentner v Barnes* [2009] QDC 307 where it was held that applications to the District Court for an inquest should be granted sparingly, and that regard should be had to the specialist nature of the Coroners Court, including resourcing issues.

Judge Ryrie noted that a common thread of the family's concern was that there was inadequate care and treatment provided to Mr Schaeffer during his prolonged admission, and the manner in which Ryan's Rule was responded to.

After considering Dr Lincoln's review of the medical file, Judge Ryrie was not satisfied that it was in the public interest for an inquest to be held. She noted that there was no uncertainty as to the cause of the death. Judge Ryrie also noted that this was also not a case where an inquest might lead to recommendations to prevent deaths in similar circumstances happening in the future. Neither was there sufficient uncertainty or conflict in the evidence to warrant the inquest process.

Deaths in custody and in the course of police operations

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

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

Elliot Arapita Haimona
(death in the course of police operation, taser deployment, suicide)

Elliot Haimona was a 23 year old New Zealand man who died on 28 January 2015 following self-inflicted injuries during the course of a police operation. On the evening before his death, Mr Haimona was visiting a friend at a Surfers Paradise motel complex. The Queensland Police Service (QPS) were called to the address after he refused an invitation to leave his friend's residence and then began stabbing himself in the head and neck.

Mr Haimona arrived in Australia in 2009, where he appears to have stayed in and around Surfers Paradise. It is likely that he was homeless for most of this time and had been living on the streets in the two years prior to his death.

Selwyn Yorke, an acquaintance of about 15 months was the last to see Mr Haimona. Mr Yorke recalled that Mr Haimona came unannounced to his unit just after 6:00pm on 27 January. The two men consumed some alcohol and shared cannabis cigarettes. During this time, another resident in the complex visited Mr Yorke's unit. He left about 9:00pm and did not consider the men were affected by alcohol or drugs and did not detect any bad feelings between the men.

At about 11:00pm Mr Yorke asked Mr Haimona to leave but got the impression that he did not want to go, allowing him to stay a little longer. At 11:30pm, Mr Yorke again asked Mr Haimona to leave and he began to walk outside, but then returned inside the unit to get a drink. Mr Haimona had a glass of water in the kitchen and then proceeded to walk out again, but stopped, turned, and walked back to the kitchen and grabbed a steak knife from the bench. Mr Haimona has then stabbed himself three times to the right side of the head with the knife.

Mr Yorke attempted to provide assistance to Mr Haimona by pushing a towel onto his neck however, a struggle ensued where the knife moved towards Mr Yorke. Mr Yorke has then exited the unit to contact QAS to attend. At 12:03am a first response crew arrived on scene shortly followed by QAS at 12:08am.

The officers entered the unit and saw Mr Haimona sitting upright at the end of the bed, holding a knife. The officers made a threat assessment; the senior officer drew his Taser, and the other officer, unclipped his firearm. The officers repeatedly called out to Mr Haimona to drop the knife, however Mr Haimona has resumed stabbing himself in the neck. The officer deployed his Taser which has caused Mr Haimona to drop the knife.

As the officers proceeded to handcuff Mr Haimona he regained movement and began to move toward the knife. A second Taser activation incapacitated Mr Haimona allowing him to be restrained and first aid commenced. QAS commenced treatment and he was transferred to the Gold Coast University Hospital where he was pronounced deceased at 0:15am on 28 January 2015.

Upon being notified of Mr Haimona's death, the QPS Ethical Standards Command (ESC) promptly attended and an investigation ensued. The investigation was informed by statements and recorded interviews all police officers involved, attending QAS staff, the other persons inside the residence in the lead up to the death, neighbours of the residence and Mr Haimona's next of kin. Relevant sections of the QPS Operational Procedures Manual and body worn camera footage were examined. Forensic analysis was conducted and photographs were taken.

A full internal autopsy examination was conducted which revealed the presence of a large number of stab wounds to Mr Haimona's head, neck and legs. There were at least 57 stab wounds to the neck that would have resulted in significant blood loss. The cause of death was confirmed as being from stab wounds to the neck.

The State Coroner accepted in his findings that the actions and decisions made by the attending police officers in the immediate lead up to Mr Haimona's death were appropriate and timely.

The State Coroner accepted the use of force option of the Taser was an appropriate choice. Mr Haimona's death could not have reasonably been prevented by the attending officers.

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

The State Coroner made no recommendations.

Darrin Edward Paddon
(death in custody, natural causes)

Darrin Edward Paddon was a 51 year old man who died on 16 March 2015 from natural causes whilst in the Secure Unit at the Princess Alexandra Hospital (PAH). At the time of his death, Mr Paddon was in custody at the Wolston Correctional Centre (WCC).

Mr Paddon had been imprisoned for most of his adult life and had an extensive history of significant cardiac and kidney disease which had multiple causes. His treating nephrologist at the PAH confirmed he commenced haemodialysis in 2003. Mr Paddon regularly attended the PAH for management of his multiple comorbidities with the frequency of transfers escalating in 2015.

On 8 March 2015, following a syncopal episode where he became dizzy and lost consciousness, he was admitted to the PAH where he underwent his usual haemodialysis and a blood transition. Arrangements were made for Mr Paddon to return to the PAH on 11 March 2015 for an endoscopy to investigate reported blood loss. Investigations on this date showed the presence of oesophageal varices, evidence of old blood staining the stomach and portal hypertensive gastropathy. His haemoglobin, white cell count and platelet count were all low.

Early in the morning of 13 March 2015, Mr Paddon complained of chest pain and headache, an ECG was performed. Medical staff noted he had reduced blood pressure, his haemoglobin was low, and there were new changes on the ECG suggestive of heart ischaemia. A code blue was called at 1330 hours after Mr Paddon was found unresponsive. He was successfully resuscitated.

The following day another code blue was called early in the morning, when he was found unresponsive and making a gurgling sound. He was again successfully resuscitated. Further changes were noted on an ECG suggesting a cardiac event. A cardiology registrar at the PAH documented the heart attack was thought to have been related to the gastrointestinal bleeding.

A code blue was also called on 14 March 2015 after Mr Paddon was found unconscious. Examinations revealed no blood loss, however an ECG suggested further cardiac ischemia.

On 16 March 2015, a further code blue was called due to bradycardia (slow pulse) and low blood pressure. Mr Paddon was resuscitated with medication to increase his heart rate and adrenaline. Spontaneous circulation returned, however, he remained unresponsive. Following discussions with his mother, it was decided care would be directed towards keeping him comfortable. He was declared deceased at 1730 hours on 16 March 2015.

Upon being notified of Mr Paddon's death by the PAH, the Queensland Police Service, Corrective Services Investigation Unit attended and an investigation ensued. The investigation obtained Mr Paddon's correctional records and medical files from WCC and the PAH. The investigation was informed by statements from relevant health care professionals and Mr Paddon's mother. An autopsy was conducted which showed the cause of death to be from acute myocardial infarction due to or as a consequence of, coronary atherosclerosis. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

Evidence from the Clinical Forensic Medicine Unit was obtained surrounding the adequacy of Mr Paddon's medical care and treatment whilst in custody. The report noted some concerns surrounding the end stage cardiac and emergency management provided to Mr Paddon, however, overall did not consider that these would have altered the outcome as there were limited treatment options available at this time.

The State Coroner accepted that the medical care provided to Mr Paddon by staff at the WCC and PAH was adequate and appropriate. The State Coroner concluded that the death was from natural causes with no suspicious circumstances.

The State Coroner made no recommendations.

Gregory Bert Smallwood
(death in custody, natural causes)

Gregory Bert Smallwood was a 53 year old Indigenous man who died on 28 November 2014 after longstanding ischaemic heart disease and chronic obstructive airways disease. At the time of his death, Mr Smallwood was in custody at the Lotus Glen Correctional Centre (LGCC).

Mr Smallwood had an extensive medical history at the time of his incarceration in April 2013, including, morbid obesity, hypertension, diabetes, chronic obstructive pulmonary disease (COPD), schizophrenia and a history of substance abuse including methamphetamines and cannabis.

At the time of his incarceration, in April 2013, Mr Smallwood was noted to weigh 108 kilograms. He had normal observations, with his blood pressure, pulse rate and oxygen saturations all within normal limits. A further follow up appointment in May 2013 his doctor strongly recommended that he quit smoking and he was prescribed Champix to assist with withdrawal symptoms.

By July 2013, Mr Smallwood was still smoking between 15 – 30 cigarettes a day. However, by his next appointment date on 13 September 2013, Mr Smallwood had gone 26 days without smoking. He complained of some lower back pain and was given Panadol and Celebrex to manage the pain.

On 3 January 2014, he had complained of shortness of breath, especially at night. An ECG was conducted, which returned normal results. Further investigations were conducted, including

spirometry, a chest x-ray and an echocardiogram. His vital signs were essentially normal, though it was noted Mr Smallwood's weight was increasing.

At a review appointment on 16 January 2014 his doctor noted from the chest x-ray that he had a likely old, crush fracture and made a diagnosis of COPD. The results of spirometry testing showed Mr Smallwood's lung capacity was reduced, but the lung function was adequate.

From April 2014 his weight had increased to 129.1 kilograms and the focus changed to Mr Smallwood's weight gain and his smoking. He was told to limit carbohydrates and to exercise and mobilise more. In around May 2014, smoking was banned in the LGCC, so this resolved Mr Smallwood's smoking issue.

Despite regular advice from his doctors about diet and exercise, he progressively gained weight from 108 kilograms to over 140 kilograms. Mr Smallwood continued to be routinely medically reviewed and was last seen by his doctor, four days prior to his death.

At 3:05am on 28 November 2014, Mr Smallwood made an intercom call and stated 'I can't breathe, can't breathe'. A Code Blue (medical emergency) was called by the receiving officer.

Upon entry to the cell at 3:09am, first response officers noticed Mr Smallwood was not responding or breathing. As Mr Smallwood was being placed in the recovery position two registered nurses arrived and commenced CPR. At 3:15am, the Queensland Ambulance Service (QAS) was asked to attend. At 3:18am a call was made for the crash cart, which contained various emergency medical equipment like a defibrillator and oxygen tank.

At 3:34am paramedics from the QAS arrived on the scene, and CPR management was transferred to them. No signs of life returned at any stage, and Mr Smallwood was declared deceased at the scene at 4:11am.

Upon being notified of Mr Smallwood's death, the Queensland Police Service (QPS), Corrective Services Investigation Unit (CSIU) attended and an investigation ensued. The scene was secured and investigators obtained Mr Smallwood's correctional records and his medical files from LGCC. The investigation was informed by statements from relevant custodial officers at LGCC, fellow inmates, relevant medical personnel, as well as Mr Smallwood's brother. An autopsy was conducted which showed the cause of death to be from coronary atherosclerosis due to or as a consequence of chronic obstructive pulmonary disease and chronic cholecystitis.

Evidence from the Clinical Forensic Medicine Unit was obtained surrounding the adequacy of Mr Smallwood's medical care and treatment whilst in custody at LGCC. The report was not critical of the care but considered querying the location of the crash cart was appropriate due to a 13-minute delay between the initial Code Blue call and the arrival of the emergency crash cart. The State Coroner investigated the availability of the crash cart at the inquest.

The State Coroner was satisfied that the health care provided to Mr Smallwood during this time was adequate and appropriate. The State Coroner accepted the opinion that the delay in arrival of the crash cart and use of the defibrillator was unlikely to have altered the outcome

The State Coroner further accepted that there were no concerning or suspicious factors contributing to Mr Smallwood's demise. No third party caused or contributed to his death. The State Coroner was satisfied the matter was thoroughly and professionally investigated.

The State Coroner made no recommendations.

Leslie Geoffrey Winbank
(death in the course of police operation, suicide, firearms, siege)

Leslie Winbank was a 53 year old man who died at his home on 30 November 2014 from a self-inflicted gunshot wound to the head. Mr Winbank had been facing financial, relationship and health related stressors in the lead up to his death. Sadly, some of Mr Winbank's family were caught up in the events leading to his death. Following police arrival at the residence however, he allowed the occupants of the house to leave safely.

On the morning of 30 November 2014, Mr Winbank's wife woke to find her husband in the kitchen making a cup of tea. Mr Winbank's son and his girlfriend were also at the residence. Mrs Winbank told police she returned to her room after an unexpected exchange with Mr Winbank regarding some money. A short time later, Mrs Winbank recalls that Mr Winbank entered her bedroom, pointed a gun at her and demanded the return of the money. Mr Winbank has then pointed the gun at his own head and threatened to shoot himself.

Mrs Winbank was then joined by her son and his girlfriend who phoned the eldest child to explain was has happened. The eldest son has then contacted police at 7:34am to relay the events and advise his mother, brother and brother's girlfriend were hiding in a bedroom at the residence, as his father was armed with a hand gun and smashing property.

Police from Deception Bay were initially tasked to the job with units from other surrounding areas also responding. A temporary forward command post was established and officers were directed to form an inner cordon around the Winbank property.

At 8:06am Mr Winbank had a lengthy call with police communications, where he advised he was armed with a hand gun and that the others were in a bedroom. He disclosed to the call taker that he was in constant pain, with no quality of life and said "I think I want to finish it". Mr Winbank advised he was aware that police were near his property and that he would shoot any police officer that came into his home. Attempts were made for Mr Winbank to speak with his treating psychiatrist but the connection failed and he then declined to speak with him.

At 9:36am, Mr Winbank advised police the occupants could leave the house. At 9:58am the QPS call taker made arrangements with Mr Winbank to allow the occupants to leave safely and they did so without incident at 10:03am. Mr Winbank was then transferred to police negotiators who spoke with him at 10:25am and again at 10:43am at which time he appeared calm and a basic surrender plan was discussed with him.

At 12.56pm the last conversation with Mr Winbank took place, where he indicated he would 'be out in a minute'. It appears the call ended due to a loss of power to the handset being used by Mr Winbank. Police attempted to contact Mr Winbank using a long range audio device but there was no response. The Special Emergency Response Team (SERT) arrived on scene at 3:35pm to contain the situation and provide a safe platform for negotiations with Mr Winbank.

At 6:35pm, SERT officers deployed a tactical entry 'robot' to gain vision inside the house, it however, could not be manoeuvred into the house. Three SERT officers then approached the house at 7:13pm to deploy a smaller robot and saw Mr Winbank's legs, which were motionless. He was found lying on the ground beside a firearm with a significant wound to his head.

The circumstances leading to Mr Winbank's death were investigated by the QPS Internal Investigations Group (IIG). The investigation was informed by statements and recorded interviews with all police and SERT officers as well as involved family members. A forensic analysis of the scene, firearm and digital camera located in the lounge room was conducted.

Gunshot residue testing on Mr Winbank's body was also undertaken. An internal autopsy was conducted which confirmed the cause of death was a gunshot wound to the head.

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

The State Coroner was satisfied that the investigation conducted into the death by the IIG was appropriate and thorough.

The State Coroner made no recommendations.

Leonard Gordon
(death in custody, prison assault, supervision of prisoners)

Leonard Gordon was 22 years of age when he died at the Maryborough Correctional Centre (MCC) on 9 October 2012. His death was the result of a sudden, violent and unprovoked assault by another prisoner in the exercise yard of Unit S2, a protection unit within MCC.

The assault occurred while custodial corrections officers were searching cells within the unit. The assailant was a convicted murderer with a history of intimidating and assaulting other prisoners.

Tragically, Mr Gordon was just two days short of his date of release from a relatively short sentence of imprisonment. He had no history of violence within prison.

The immediate circumstances of Mr Gordon's death are clear as they were captured on CCTV. The offender was subsequently convicted of Mr Gordon's murder. These findings set out those circumstances and address the following issues:

- The adequacy of facilities and procedures in place at MCC for the placement of prisoners into protective custody;
- The availability within Queensland Prisons of items similar to the metal bar used to assault the deceased;
- The reasons a material report relating to the death from a member of MCC staff was not provided to investigating police;
- The adequacy of the supervision of prisoners at MCC when cell searches are being conducted; and
- Whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

Investigations were conducted into the circumstances leading to the death of Mr Gordon by the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) and the Office of the Chief Inspector (OCI).

The State Coroner was satisfied that the QPS investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The State Coroner had regard to the recommendations made in the report of the Office of the Chief inspector and the QCS response to those recommendations.

He also had regard to the relevant recommendations made in the Queensland Parole System Review Report and the Queensland Government's commitment to implement those recommendations.

The State Coroner did not consider that there were any further recommendations he could reasonably make to prevent a similar death from happening in the future.

Russell McBride
(death in custody, suicide, welfare checks, hanging points, CCTV)

On the morning of 26 March 2014 Russell McBride failed to emerge from his cell at Arthur Gorrie Correctional Centre (AGCC) and was found to be hanging from a towel rack. A prison officer had conducted a welfare check on all prisoners in Mr McBride's unit less than 30 minutes earlier.

At 52 years of age, Mr McBride had spent just six weeks on remand at AGCC. It was his first period of imprisonment. He was not considered to have an elevated risk of suicide when assessed by prison staff and a psychiatrist. Mr McBride was subsequently accommodated in one of the many cells at AGCC with readily available hanging points consisting of exposed bars above cell doors for ventilation and fixed towel racks.

An investigation into the circumstances leading to Mr McBride's death was conducted by Detective Senior Constable David Caruana from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

The State Coroner was satisfied the QPS investigation was thoroughly and professionally conducted and that all relevant material was accessed.

A separate investigation was conducted at the direction of the Queensland Corrective Services (QCS) Chief Inspector. A copy of the report into that investigation was provided and tendered at the inquest. The State Coroner found the investigation conducted on behalf of the Chief Inspector was thorough and the recommendations made valuable.

The State Coroner was satisfied that:

- no staff or prisoners at AGCC were involved in the death of Mr McBride.
- the efforts to revive Mr McBride when he was discovered hanging in his cell adhered to procedure.
- the procedures in place to identify whether Mr McBride was at risk of self-harm or suicide were adequate and were followed appropriately. The procedures worked to ensure that Mr McBride was referred to PMHS and received a prompt review by a psychiatrist, even though it might be said that this was a case of erring on the side of caution. I accept that there was no evidence available to any of the counsellors, nurses or other professionals who assessed Mr McBride to indicate that he was at unacceptable risk of self-harm.

Garnett Allan Mickelo
(Death in custody, health care related, coronary atherosclerosis, recent stent angiography, adequacy of medical treatment, adequacy of observations in prison)

On 24 November 2012, Garnett Allan Mickelo, aged 48, was being housed in the Safety Unit at the Woodford Correctional Centre (WCC). He had recently returned to WCC after an admission to the Princess Alexandra Hospital (PAH) for cardiac treatment. He was checked and observed to be settled. Some hours later, he was again checked but noted to have no movement. A Code Blue was eventually called but no resuscitation was attempted. Mr Mickelo was subsequently declared deceased.

It is a well-recognised principle that the health care provided to prisoners should not be of a lesser standard than that provided to other members of the community. The evidence tendered at the inquest established the adequacy of the medical care provided to Mr Mickelo when measured against this benchmark.

The issues for the inquest were determined as follows:

- confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death
- consider whether any third party contributed to his death
- consider the adequacy of the cardiac care provided to the deceased during his admission to the PAH over 19-22 November 2012
- consider the adequacy of the management of the deceased's medication upon his discharge from the PAH on 22 November 2012, and his subsequent re-admission to WCC
- consider the adequacy of the health care provided to, and the observations of, the deceased in his cell at WCC over 22-24 November 2012.

An investigation into the circumstances leading to the death of Mr Mickelo was conducted by Detective Sergeant Brad Hallett from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

The Deputy State Coroner was satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed.

At the request of the Coroners Court of Queensland, the Clinical Forensic Medicine Unit (CFMU) provided an overall review of the medical care provided to Mr Mickelo whilst he was in custody. Expert reviews were obtained of the cardiac treatment at the PAH which was undertaken by Professor Darren Walters, Director of Cardiology at the Prince Charles Hospital and Dr Andrew Clarke, cardiac surgeon. During the course of the investigation a number of other medical opinions and statements were provided.

The Deputy State Coroner was satisfied that Mr Mickelo was given appropriate medical care by staff at the PAH. The majority of the evidence supported the view that reasonable decisions not outside of an appropriate standard of medical practice were made.

The Deputy State Coroner concluded that Mr Mickelo died from natural causes. He found that none of the corrective service officers or inmates at WCC caused or contributed to his death.

The Deputy State Coroner was satisfied that, where there were deficiencies in the care provided to Mr Mickelo whilst at WCC, these have been dealt with adequately.

Dane Benjamin Sloan
(Death in custody; hanging; maximum security unit; supervision of prisoners)

Dane Benjamin Sloan was 24 years of age when he was found hanged in the exercise yard attached to the Maximum Security Unit (MSU) of Brisbane Correctional Centre (BCC) on 2 October 2013. He died in hospital four days later, on 6 October 2013.

On the afternoon of 2 October 2013, Mr Sloan was escorted into the exercise yard of the 'B' Wing of the Maximum Security Unit (MSU). At the time he was not the subject of a formal observations regime, and he was considered not to be at risk of self-harm.

At around 2:46pm, Mr Sloan approached the chin-up bar, and stood on a medicine ball to help him reach the bar. He then removed a piece of sheeting from the rear of his shorts. He then fashioned the sheeting into a ligature, which he placed over the bar and his head. He then stepped off the medicine ball.

Almost 15 minutes later, a Correctional Officer entered a nearby officers' station and saw Mr Sloan hanged from the chin-up bar. A Code Yellow and a Code Blue were called, and entry was gained to the exercise yard. Officers continued into the exercise yard where they observed that Mr Sloan was unresponsive. He was cut down and paramedics from the Queensland Ambulance Service (QAS) attended. Mr Sloan was then transferred to the Princess Alexandra Hospital (PAH) for further management. However, he did not regain consciousness, and died on 6 October 2013 at 2:02pm.

The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) investigated the circumstances leading to Mr Sloan's death. Detective Senior Constable Donald Laird led the investigation and submitted a report which was tendered at the inquest.

The State Coroner was satisfied that the QPS investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The State Coroner adopted (where relevant) the findings of the investigation conducted on behalf of the QCS Chief Inspector (OCI Report). This report was tendered and referred to at the inquest.

The OCI report made a number of recommendations, including that QCS action matters arising from a Root Cause Analysis (RCA) that was conducted. That RCA was tendered at the inquest, and identified a level of complacency by staff at the BCC MSU as one of the root causes.

The State Coroner was satisfied that the RCA conducted by the OCI identified all relevant root causes relating to Mr Sloan's death. The OCI recommended that QCS action all matters arising from the RCA. The State Coroner heard evidence at the inquest about these matters from the General Manager, Custodial Operations – State Wide Operations for QCS, Mr Peter Shaddock.

Mr Shaddock's evidence was that the QCS Incident Oversight Committee had accepted the recommendations arising from the OCI report. Implementation of the recommendations was tracked via an 'Initial Directorate Response' form. This document outlined the issues in a general sense, and determined which part of QCS would be responsible for addressing the various matters identified. A copy of that form was tendered at the inquest.

The State Coroner recommended that in considering the replacement of current CCTV monitoring systems, QCS take into account the evidence heard during this inquest, with a view to ensuring that any new recording system clearly displays all relevant camera angles. Consideration should be given to potential hanging points within the cells and exercise yards in the MSU, and ensuring that the best available camera angle, with reference to the potential hanging points, can be fed clearly to the main control room monitors.

In relation to the evidence about working in the control room the State Coroner considered that it is likely that staff simply become fatigued, and lose focus, after looking at a large number of images on screens for an extended period of time. The State Coroner recommended that QCS explore the merits of a policy of more frequent rotations of officers through the control room as a way of minimising that risk.

Robert Turpin (death in the course of police operation, suicide, domestic violence, dissemination and interpretation of information to first response police)

Robert Turpin was a 23 year-old Aboriginal man who was found unresponsive at his mother's residence in Atherton on 12 August 2015. Police found him hanged in the bathroom following his partner calling 000 early that morning, alleging that Mr Turpin had assaulted her and her younger sister. Police initiated CPR while QAS were en route to the scene. Mr Turpin was initially taken to the Atherton Hospital and later flown to the Cairns Base Hospital Intensive Care Unit. He died eight days later on 20 August 2015.

At the time of Mr Turpin's death a Domestic and Family Violence Protection Order (DFVPO) was in place between him and his partner. One of the conditions of the DFVPO was that Mr Turpin not reside with his partner, a condition which was being breached at the time of his death. This factor became relevant to the State Coroner's consideration of Mr Turpin's death, as it was possible if his partner had not been staying with him, the conflict and escalation of violence which preceded the suicide might not have occurred.

On the morning of 12 August 2015, Mr Turpin's partner advised she went to have a shower and was joined by Mr Turpin, who said that he wanted to commit suicide. He had also expressed an intent to kill himself twice during the previous night. Mr Turpin's partner advised she responded to the effect that while he was loved and cared for, "it's just the silly things you do" that caused concern.

The circumstances leading to Mr Turpin's death was investigated by the QPS Ethical Standards Command. The ESC was not notified of Mr Turpin's death until 18-19 September 2015 as it was not initially identified as a death in the course of a police operation.

The investigation was informed by statements and records of interview with the police officers involved, attending QAS staff, persons inside the residence in the lead up to the death and Mr Turpin's next of kin. Medical records, call logs and body worn camera footage from the attending officers was examined. Forensic analysis was conducted and photographs of the residence taken. An external autopsy was conducted which confirmed the cause of death as being as consistent with hanging with alcohol and cannabis intoxication listed as other significant contributors.

The pathologist, Dr Botterill was asked to provide an opinion as to whether earlier police arrival and attendance upon Mr Turpin might have realistically made a difference to the level of hypoxic damage suffered. Dr Botterill gave evidence to the effect that it was extremely unlikely that anything police could have reasonably done after locating Mr Turpin would have saved his life.

The State Coroner was satisfied that the actions and decisions made by the attending police officers in the immediate lead up to Mr Turpin's death, based on the information available to them at the time, were appropriate and timely. The State Coroner was satisfied on the balance of probabilities that Mr Turpin's death could not have been reasonably prevented by the attending officers.

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

The State Coroner made no recommendations.

Marcus Peter Volke and Mayang Prasetyo (Death in custody, avoiding being placed in custody; suicide; domestic homicide)

Marcus Peter Volke and Mayang Prasetyo, an Indonesian citizen, were both 27 years of age and living together in a unit complex at Teneriffe at the time of their deaths, which occurred over the period 3 - 4 October 2014.

The couple had been heard arguing loudly in their unit over the evening of 2 October 2014. From the morning of 3 October 2014, other residents of the unit complex noticed a foul smell, which seemed to be coming from the couple's unit. During 3-4 October 2014, Mr Volke had purchased supplies from local stores including a large cooking pot, rubber gloves and various cleaning products. On 3 October 2014, he went to the Royal Brisbane and Women's Hospital (RBWH) to have a severe cut on his left hand treated.

By the evening of 4 October 2014, the smell emanating from the unit had become noticeably worse. Mr Volke called an electrician to repair a power outage which he attributed to an oven fault at his unit. This resulted in the unit managers being called, as the electrician required access to the main switchboard of the unit complex. While inside Mr Volke's unit, the unit manager noticed blood on the carpet and other damage, which led to the police being called.

Police officers arrived at the unit and spoke to Mr Volke outside in the hallway. Mr Volke indicated he did not know where Ms Prasetyo was. When police told Mr Volke they would need to enter the unit, he asked if he could have a moment to secure his dogs, which were currently running around inside. Police agreed to this request. Mr Volke re-entered the unit and locked the door behind him. He was subsequently seen by the unit manager running from the rear of the unit. A search ensued for Mr Volke, and involved officers on foot as well as members of the dog squad.

At the same time, police gained access to the locked unit and found Ms Prasetyo's dismembered body. Her feet were protruding from a large stockpot which was placed on the floor of the kitchen. Other body parts were found in a garbage bag contained in the washing machine.

Police located Mr Volke soon after in a nearby underground carpark with the help of police dogs. He was found inside an industrial bin with significant injuries to both sides of his throat and wrists. The Queensland Ambulance Service (QAS) was called, but the extent of his injuries meant that he could not be resuscitated.

An investigation into the circumstances leading to Mr Volke's death was conducted by Detective Sergeant Joshua Walsh from the Queensland Police Service Ethical Standards Command (ESC) Internal Investigations Group. A separate homicide investigation into the circumstances leading to Ms Prasetyo's death was conducted by Detective Sergeant Jack Savage from the Fortitude Valley Criminal Investigation Branch.

The State Coroner was satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed.

Mr Volke's death was reported as a death in custody under the *Coroners Act 2003*. He died while he was trying to avoid being put into custody. In those circumstances an inquest was mandatory. The focus of the inquest was the actions of the relevant police officers involved in the events leading up to the death of Mr Volke.

The State Coroner concluded that Mr Volke died from his own actions after inflicting multiple stab wounds to his neck within an industrial bin. He had run away from his unit when it became inevitable that police officers would discover Ms Prasetyo's remains within the unit. He also had incised wounds to both wrists that were self-inflicted inside the unit immediately after police officers attended. The State Coroner found that none of the police officers or other persons at the Teneriffe unit block caused or contributed to his death in any way.

The State Coroner was satisfied that the actions and decisions made by the attending police officers in the immediate lead up to Mr Volke's death were appropriate and timely. He was satisfied that the officers were justified in not forcing entry to the unit after they initially spoke with Mr Volke in the hallway. Mr Volke's death could not have reasonably been prevented by the attending officers.

The State Coroner was satisfied that the investigation conducted into Mr Volke's death by the Ethical Standards Command was appropriate, thorough, and covered all relevant areas of investigation. He was satisfied that the protocols established to investigate deaths in custody in accordance with the *Coroners Act 2003*, and Queensland Police Operational Procedures Manual were complied with.

In the circumstances, he did not consider there were any recommendations he could reasonably make to prevent similar deaths from occurring in the future.

Appendix 1: Register of approved genuine researchers 2016–17

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

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

Person/position	Organisation
Professor Robert (Robin) A Cooke	Independent Researcher
Dr Leo Nunnink & Professor Belinda Carpenter & Dr Nigel Stubbs	The Organ Tissue Donation Service
Lucinda Coates, Dr Katherine Haynes, Deidre Radford and Rebecca Darcy	Risk Frontiers - Bush Fire and Natural Hazards Cooperative Research Centre (BNHCRC) - Macquarie University
Dr Deborah Gilmour	Royal Brisbane and Women's Hospital
Professor Joseph Ibrahim	Monash University - Department of Forensic Medicine
Professor Jeremy Davis, Dr Kerry Armstrong, Assistant Commissioner Mike Keating and Ms Lisa Marie O'Donnell	Centre for Accident Research and Road Safety - CARRS-Q – (already approved but a new study)
Amanda Thompson, Sarah Morley & Andrew Griffiths	QHFSS – Forensic Toxicology