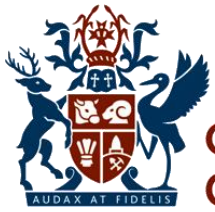


QUEENSLAND COURTS

Coroners Court of Queensland

Annual Report 2017-18

Dear Attorney-General
In accordance with section 77 of the *Coroners Act 2003*, I am pleased to present the Coroners Court of Queensland's Annual Report for the year ended 30 June 2018.

Terry Ryan
State Coroner
26 February 2019

Contents

Warning

Some content in this report may be distressing to readers.

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

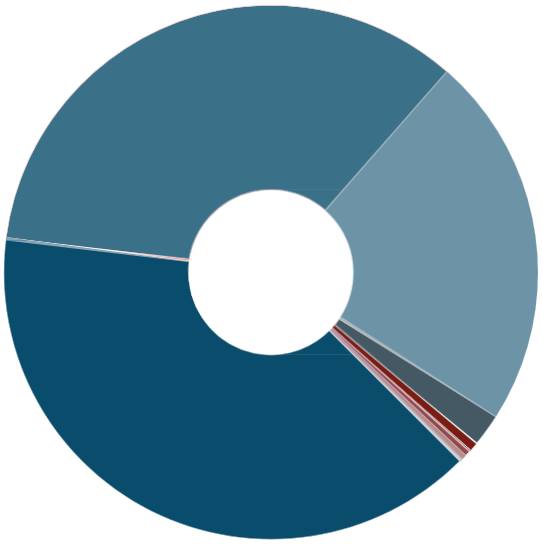
Our performance in a nutshell

5,812
Cases reported

5,618
Cases finalised

96.66%
Clearance rate

Death types



- Violent or unnatural 39.6%
- Death certificate not issued and not likely to issue 34.4%
- Health care related death 22.6%
- Death in care 2%
- Suspicious circumstances 0.6%
- Death in custody 0.33%
- Unknown persons 0.3%
- Suspected death (missing person) 0.2%
- Death as a result of police operations 0.01% [1]

Timeframes

166

Average number of days to finalise

Recommendations

52
Inquests held

100
Recommendations made

19
Implemented

14
Not accepted

3
Accepted in part

64
Under consideration /in progress

Information requests on finalised matters

2242 Requests for documents

37 Miscellaneous research enquiries

7 Genuine researchers applications approved

[1] The performance data for the Coroners Court of Queensland was revised in October 2018. Any variation of figures published in the Report on Government Services (RoGS) is a result of the data revision.

State Coroner's overview

The 2017-18 financial year has been a time of significant change within the Coroners Court of Queensland (CCQ), which has responded to the largest number of deaths reported since the *Coroners Act 2003* commenced. There were 5,812 deaths reported to coroners - an increase of 225 deaths over the 2016-17 financial year.

During 2017-18 the court cleared 5,618 matters, which was also the largest number of matters cleared in the court's history. There has been a 24% increase in the number of deaths reported over the past five years.

It was pleasing to see that despite the increasing workload the court achieved an improved clearance rate of 96.66%[2]. If the number of deaths reported to the court had remained stable, the clearance rate would have been over 100%. I gratefully acknowledge the assistance provided by the Department of Justice and Attorney-General in the provision of a number of temporary administrative staff to help manage the court's increasing workload in 2017-18.

While these figures are intended to be measures of the court's efficiency, it is important to acknowledge that each reportable death represents a tragic loss of life for the families concerned. Each death needs to be responded to in a compassionate way by all those who work within the coronial system, recognising the unique circumstances of the deceased person and their loved ones.

I am privileged to work with coroners and court staff who are committed to responding to and investigating each death that is reported thoroughly, fairly and sensitively. The court acknowledges that the efficient finalisation of investigations always needs to be accompanied by a response to the specific needs of each bereaved family at their time of loss.

Organisational Reviews

In January 2018, the Department of Justice and Attorney-General was provided with the report it had commissioned on the Organisational Structure and Workforce Climate Review for the Coroners Court of Queensland. This report was completed by Workplace Edge, an independent consulting firm. The report examined existing systems, management and reporting relationships, as well as the business and operating environment.

The Workplace Edge report acknowledged that court staff and coroners are committed to working very hard to make a difference to internal and external 'customers' in the investigation of reportable deaths, and in making recommendations which contribute to reducing the number of preventable deaths. The report highlighted that the court

[2] See footnote 5

continues to face challenges affecting its performance, including the ongoing increase in the number of deaths with no corresponding increase in staff, and increasing community and stakeholder awareness and expectations regarding the coronial process. The report also identified issues with organisational culture and structure.

The report contained 42 recommendations, of which 36 were accepted by the Department in whole or in principle. The implementation of those recommendations continues under the auspices of a Change Management Steering Committee which includes the Executive Director of the Magistrates Courts Service and the State Coroner.

Included among the recommendations was the implementation of a team based model across the court, including the redirection of staff to regional offices to support regional coroners. This model ensures that consistent staff follow a file from the time a death is reported to the conclusion of the investigation.

Importantly, the report acknowledged that repeated exposure to distressed persons, and the confronting materials which are associated with many deaths, may have adverse effects on court staff. The report recommended that the court provide appropriate levels of support for staff by way of supervision opportunities, additional counselling outside the employee assistance program and resilience training. The court has responded by providing vicarious trauma and compassion fatigue training to staff, in addition to access to the services of the Department's employee assistance provider.

In addition to the Workplace Edge Review, during 2018 the Queensland Audit Office conducted an audit of the delivery of coronial services. The QAO assessed whether agencies are effective and efficient in supporting coroners in investigating and helping to prevent deaths. As part of the audit the QAO examined whether agencies in the coronial system provide adequate support to bereaved families, have efficient and effective processes and systems for delivering coronial services and plan effectively to deliver sustainable coronial services.

The QAO's Report was finalised and tabled in the Queensland Parliament in October 2018. The QAO Report concluded that "Queensland's coronial system is under stress and is not effectively and efficiently supporting coroners or families. If left unaddressed, structural and system issues, will further erode its ability to provide services beyond the short-term."

The QAO Report made seven recommendations, which have since been accepted by the Department of Justice and Attorney-General, the Queensland Police Service and Queensland Health, to address coronial system governance and process issues. I look forward to working with the Government in the implementation of those recommendations.

As highlighted in the QAO Report the work of the Coroners Court requires a very high level of collaboration between the Court and our partner agencies in the Queensland Police Service and Forensic and Scientific Services in Queensland Health. Notwithstanding the concerns identified by the QAO, the Court appreciates the good will and the high level of support from our partner agencies, and the relationships we have forged with them over many years. The Court would simply not be able to function without the support provided by the QPS and QHFSS to coroners and families.

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 5,812 in 2017–18 – a 65.4 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 5,812 deaths reported to Queensland coroners represent only 17.9 percent of the 32,329 deaths registered in Queensland in 2017–18.

The coroner's statutory role is to establish the identity of the deceased, when, where and how 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.

Our Coroners

The State Coroner, **Mr Terry Ryan**, was appointed on 5 July 2013. 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 must consult with the Chief Magistrate before issuing any directions or guidelines. 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[3].

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.

In the reporting period there were two guidelines issued under section 14 of the Act. The first related to the expeditious disposal of certain property in possession of the Queensland Police Service. The second was directed at enhancing the timeliness of natural causes death investigations by the issuing of non-narrative findings.

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

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 2017-18, the State Coroner received 39 applications and finalised 15 matters of this nature.

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. 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.

[3] 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

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

Mr John Hutton was appointed as a coroner in August 2008. Mr Hutton retired on 3 November 2017.

Mr Graeme Lee was appointed as a Brisbane Coroner on 6 November 2017.

Mr Kevin Priestly held the position of Northern Coroner until 11 September 2017.

Ms Nerida Wilson was appointed as the Northern Coroner on 11 September 2017. Deaths in the region from Thursday Island to Proserpine, north to the Papua New Guinea border and west to the Mount Isa district are reported to the Northern Coroner based in Cairns.

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

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

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.

Coroners Court of Queensland

The Coroners Court of Queensland 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 2018, the CCQ under the leadership of Director, Daniel Matthias, comprised of 54 staff members.

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 2017–18, 5,812 deaths were reported state wide. Compared to the total numbers of deaths reported in 2016–17, this represents an overall increase of 4.03 per cent of 'lodgements'.

In 2017–18, coroners finalised 5,618 matters achieving a clearance rate of 96.66 per cent[4]. In previous years, the clearance rate has reached the Service Delivery Standards (SDS) target of 100 per cent. Although the clearance rate has increased from 2016–17, with further increases in lodgements and increasing complexity of cases, the clearance rate is still below the SDS target.

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 2017–18, of the 5,618 deaths finalised, 1,850 were found not to be reportable within the meaning of s. 8(3) of the Coroners Act.

These matters are included in the lodgement figures on the basis that the coroner performs work in considering whether a death certificate can be authorised. This may involve obtaining medical records using the powers under the Coroners Act, discussing the matter with treating clinicians and obtaining advice from doctors at the Clinical Forensic Medicine Unit (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 investigations.

There has been a notable decrease in the overall number of pending cases during the reporting period (2,113 down from 2,684 as at 30 June 2017) but a further increase in the backlog indicator from 16.6 per cent to 18.4 per cent.

As at 30 June 2018, 383 or 18.4 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

[4] See footnote 5

circumstances of the death, coroners may also be required to await the outcome of other expert investigations and criminal proceedings.

Funeral Assistance

In the interests of public health 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.

This service is called Funeral Assistance. CCQ administers this scheme throughout the state. During 2017–18, 410 applications for funeral assistance were approved state-wide at a cost of $1,002,965. CCQ recovered $349,900, or 34.89 percent of this expenditure from the estates of the deceased.

Table 1: Overall performance for 2017–18

	Brisbane	Northern	Central	South Eastern	Total
Number of deaths reported to Coroner	3446	751	735	880	5812
Number of Coronial Cases finalised	3530	604	736	748	5618
Inquest held	*33*	*8*	*7*	*4*	*52*
Number of Coronial Cases pending	955	538	151	469	2113
Less than or equal to 12 months old	*621*	*334*	*92*	*266*	*1313*
Greater than 12 and less than or equal to 24 months old	*187*	*90*	*27*	*107*	*411*
Greater than 24 months old	*147*	*114*	*32*	*96*	*389*

Table 2: Number of deaths reported by type

	Brisbane	Northern	Central	South Eastern	Total
Suspected death (missing person)	4	4	2	1	11
Death in custody	19	0	0	0	19
Death as a result of police operations	6	0	0	0	6
Death in care	79	14	7	10	98
Health care related death	887	112	180	134	1325
Suspicious circumstances	9	17	4	4	34
Violent or unnatural	1291	318	300	394	2303
Death certificate not issued and not likely to issue	1145	282	242	329	1998
Unknown persons	7	3	0	8	18
Total	3446	751	735	880	5812

Table 3: Performance statistics 2012–2018 [5]

Year	Cases reported	Percent change	Cases finalised	Clearance rate	Backlog	Inquests held
2011–12	4461	1%	4771	106.9%	14%	81
2012–13	4762	6.74%	4999	105.0%	10.2%	66
2013–14	4682	-1.67%	4909	104.8%	12%	49
2014–15	4962	5.98%	4638	93.5%	11.9%	78
2015–16	5287	6.54%	5313	100.5%	13.6%	49
2016–17	5587	5.67%	5014	89.7%	16.6%	30
2017–18	5812	4.02%	5618	96.66%	18.43%	52

[5] The performance data for the Coroners Court of Queensland was revised in October 2018. Any variation of figures published in previous reports is a result of the data revision.

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 Queensland 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 CCQ 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 QPS investigators and forensics, 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 QPS CSU. Their primary role is to ensure the 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 2017–18, 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 aiming to improve responses to deaths on inbound flights
- continued stakeholder engagement with Queensland Rail and Work Safe Queensland
- engagement with CCQ in the new undertaker contract process
- membership on the Serious Workplace Incidents Interagency Group
- mentoring first response officers on QLite being an 'application' to allow police officers to create a form 1 on a mobile device at the scene providing more detailed and timely reporting
- continued 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.
- coordinating a timely response to scenes of traumatic deaths in the recovery of human remains by the Human Remains Recovery Team (HRRT)
- assist in the review of the Coronial system conducted by the Queensland Audit Office
- in consultation with CCQ, 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 Queensland Health Forensic and Scientific Services (QHFSS) at Coopers Plains, Gold Coast University Hospital, Toowoomba Hospital, Rockhampton Hospital, Townsville Hospital and Cairns 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 CCQ, 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 CCQ 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 CCQ's activities. CCQ responds to information requests and media enquiries in order to promote fair and accurate reporting.

In the 2017–18 reporting period, the Communication Services Branch received 220 media enquiries, up from 121 in the preceding period. 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;
- Queensland Police Service and Australian Federal Police;
- Queensland Ombudsman and Commonwealth Ombudsman;
- aged care and health regulatory agencies;
- Workplace Health and Safety Queensland 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[6].

[6] *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 2017–18, the CCQ, 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 involved 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, the registrar took on responsibility for telephone enquiries and deaths reported by the Form 1A process or funeral directors in the Northern reporting catchment. This readjustment has achieved a consistent State-wide approach to the management of these matters.

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, 2,179 deaths were reported to the registrar, representing 37.5 per cent of the total deaths reported State-wide.

Between them the registrar and deputy registrar finalised 2,189 matters within the reporting period. This represents 37.66 per cent of the total 5,812 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 2017-18

	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)
2017–18	5812	3445	2189

Apparent natural causes deaths

During 2017-18, 1,489 police reports of apparent natural causes deaths were received State-wide, representing 45.7 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.

Coroners continued to triage these deaths, with input from forensic pathologists, coronial nurses, forensic medicine officers and coronial counsellors, resulting in 612 of the total apparent natural causes deaths being appropriately diverted from the coronial system with the issue of a cause of death certificate.

Limited availability of post-mortem CT scanning outside the coronial mortuaries in Brisbane and on the Gold Coast and conservative attitudes by some 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 a streamlined approach to the management of apparent natural causes death investigations, which was implemented following amendments to the State Coroner's Guidelines.

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 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 5: Number of Form 1A's by region

Coronial reporting catchment	Deaths reported via Form 1A
Brisbane	893 (up from 818)
Northern	134 (up from 106)
Central	107 (up from 62)
South Eastern	197 (up from 155)
TOTAL	1,331 (up from 1,141)

The number of deaths reported by the Form 1A process represent approximately 23% of the total deaths reported during the reporting period (up from 20.4% in 2016-17).

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.

Table 6 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 2017–18, 40 deaths were reported by funeral directors.

Table 6: 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
2017–18	1331	893

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 non-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 2017-18, 969 deaths were reported in this way and determined to be not reportable. This represents 16.7 per cent of the total number of deaths reported state wide.

Table 7: Distribution of telephone enquiries by region

Coronial reporting catchment	Deaths reported by phone call – deemed not reportable
Brisbane	734
Northern	103
Central	77
South Eastern	55
TOTAL	969

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.

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.

The current registrar position has exceeded capacity and a second registrar is needed if the efficiencies that this role brings are to be realised state-wide. While the existing registrar role was established within existing resources, additional funding will be required to support a second registrar and their support staff.

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 and coronial work in general.

Forensic pathology services

During 2017–18, the State Coroner and the CCQ 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 CCQ continues to manage the budget for fee-for-service autopsies.

In 2017–18, the CCQ expended $520,074 on fee-for-service autopsies.

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 2017–18 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*	*2017–18*
Deaths reported	4461	4762	4682	4962	5287	5587	5812
Autopsies	2742	2733	2475	2542	2550	2730	2629
Percentage	61.5	57.4	52.9	51.2	48.2	48.9	45.23

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**	**2017–18**
External	544	629	717	679	769	856	967

Partial internal	639	795	598	597	533	583	630
Full internal	1559	1309	1160	1266	1248	1291	1032
Total	2742	2733	2475	2542	2550	2730	2629

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	2017–18
External	19.8	23.0	29.0	26.7	30.2	31.4	36.7
Partial internal	23.3	29.1	24.2	23.5	20.9	21.4	23.9
Full internal	56.9	47.9	46.9	49.8	48.9	47.3	39.2

During 2017–18, there was a significant reduction 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[7]. These figures demonstrate that triaging processes continue to divert a significant number of cases away from unnecessary autopsy.

The CCQ 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 2017–18, reported deaths have increased by 91 per cent (5,812 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 CCQ 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

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

- 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 2018, these proposals were still under consideration.

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 52 persons were finalised during 2017–18 (outlined in Table 13).

As can be seen in Table 12, there has been an increase in the number of inquests held since 2016–17 but still a decrease 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 deaths where an inquest was finalised

Year	Number
2011-12	81
2012-13	66
2013-14	49
2014-15	78
2015-16	49
2016-17	30
2017-18	52

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 2017–18 assisted in inquests into the deaths of 45 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 2017–18

Name	Coroner	Counsel	Type of death	Recommendations
YOUNG, Anthony; KUMEROA, Shaun; ZIMMER, Laval; LOGAN, Edward; FOSTER, Troy	Ryan	Private/In House	Death in custody, police shooting	19
ROBERTSON, Charlie	Ryan	In House	Death in custody, mixed drug toxicity	0
MARTIN, Christopher	Ryan	In House	Death in custody, DV, restraint	0
COLLINS, Francis	Ryan	In House	Death in custody, natural causes	0
FITTON, Wesley	Ryan	In House	Death in custody, natural causes	0
McLAUGHLIN, Mark	Ryan	In House	Death in custody, natural causes	0
BERNARD, Peter	Ryan	In House	Death in custody, natural causes	0
MURRAY, Eric	Ryan	In House	Death in custody, natural causes	0
DAY, Robert	Ryan	In House	Death in custody, natural causes	0
HOUDINI, Franky	Ryan	In House	Death in custody, hanging	2
HOLSTEIN, Zachary	Lock	In House	Death in custody, hanging	2
HAMILTON, Blair	Lock	In House	Death as a result of police operations	0
CHAN, Shui Ki	Hutton	In House	Traffic accident, hit and run	0
ACKERMAN, James	Lock	In House	Sporting injury, rugby club	0
JACOBS, Roy	Kirkegaard	Private	Rural hospital, clinical deterioration	0
RICHARDS, Karen	Hutton	In House	Mixed drug toxicity, heroin overdose	1
STEPHENSON, Ethan	Hutton	In House	Drink driving, speeding, mechanical defects, skateboarding	15
PARSONS, Ann	Clements	Private	Health care related, brain cancer	7

Name	Coroner	Counsel	Type of death	Recommendations
LEONARDI, Christine & Samuel	Hutton	In House	Motor vehicle collision, pick an carry crane	14
OSBOURNE, Warren	Ryan	In House	Restraint in a hospital setting, amphetamine use, restraint asphyxia	3
BROWN, Stephen	Lock	In House	Heavy vehicle crash	2
ROSS, Matthew	Lock	In House	Electrocution, workplace incident	2
MILWARD, Paul	Lock	In House	Aged care, choking on food	4
SMIT, Bernardus	Lock	In House	Traffic controller, motor vehicle crash	0
FULLER, Jo-Anne	O'Connell	In House	Traffic collision, driver falling asleep	2
GLENNON, Lardeen & Matthew	O'Connell	In House	Motor vehicle accident, speeding	2
SCHOFIELD, Wayne & REDFERN, Haydn	O'Connell	In House	Aviation, helicopter crash	2
BEALE, Tracy	O'Connell	In House	Domestic violence, neck compression	2
FARRELL, Bethany	O'Connell	In House	Drowning, scuba diving	3
SMITH, Jodie Anne; HOUSE, William; WHITE, Vanessa; MILNE, David	McDougall	In House	Prescription opioids	7
WLODARCZYK, Julian	Priestly	In House	Drowning, cable car ferry	0
DAVIS, Bernard & CROWLEY, Byron	Priestly	In House	Stray horses	3
FINLAYSON, Eric	Priestly	In House	Drowning, snorkelling	2
HITCHINS, Steven & GUDGE, Shawn	Priestly	In House	Suicide, mental health unit	2
CHENEY, Danny	Priestly	In House	High voltage transmission towers, construction, electrocution, safe work	0
KENNEDY, Dale	Priestly	In House	Apprentice, non-electrical work, electrocution, adequacy of ESO investigation	1
DARDASS, Rami	Clements	In House	Inadvertent overdose	0
JOHN, Timothy	Hutton	In House	Suicide, smoking cessation	3

Name	Coroner	Counsel	Type of death	Recommendations
SARGENT, Sean	Hutton	In House	Missing person, army officer	0
VANCE, Jason	Lock	In House	Missing person	0
Total				**100**

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 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.

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 adjacent 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 CCQ 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 CCQ 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:

- Emma Buxton – New South Wales, Domestic Violence Death Review Team
- Associate Professor Molly Dragiewicz, Jake Leite and Clare Ferguson – Queensland University of Technology, School of Justice
- Associate Professor John Allan, Dr John Reilly, Dr Kelly Dingli, Ms Linda Leatherbarrow and Dr Rebecca Soole – Mental Health Alcohol and Other Drugs
- Estelle Pretorius – CARRS – Queensland
- Marni Manning – Queensland Sentencing Advisory Council
- Kevin Perry and Dr Sarah Wanner – Central Queensland University
- Denise Cullen and Associate Professor Kataria Fritzon – Bond University

Systemic Death Review Initiatives

There is 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 (DFVDRU) was originally established in 2011 within the CCQ 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 CCQ and provides advice on national and state policy and practice initiatives, as they relate to the coronial jurisdiction.

Domestic and Family Violence Deaths

In 2015, the Special Taskforce on Domestic and Family Violence released their final report, *Not Now, Not Ever: Putting an end to Domestic and Family Violence in Queensland*, which called for enhancements to the domestic and family violence death review process in place at the time.

This included an expansion in the size and scope of the DFVDRU, to ensure that it was better able to perform its functions, including to support the State Coroner in his position as Chair to the new independent, multidisciplinary Domestic and Family Violence Death Review and Advisory Board.

In the three years since the implementation of these recommendations commenced, staff within the unit have provided advice and assistance in over 405 coronial investigations, including for the deaths of 82 children known to child safety services (which includes homicides, suicides, accidents or SIDS related fatalities) and for 323 homicides and suicides that were identified as being potentially domestic and family violence related.

Coroners have referenced the work of the DFVDRU in (inquest or non-inquest) published findings for 13 of these deaths, as well as in many others that have not been published.

The unit has also established comprehensive databases for homicides in a domestic or family relationship that have occurred in Queensland, as well as domestic and family violence related suicides. This includes data pertaining to the relationship dynamics, service system contact, and any risk indicators present before the death.

This data continues to be regularly published and used by government and non-government entities to inform policy, planning and prevention initiatives. Staff within the unit present regularly at conferences and within public forums about data findings and the death review process more broadly, including at the Australian Institute of Criminology Conference in Melbourne in early June 2018.

Most significantly during this financial year, as part of the Australian Domestic and Family Violence Death Review Network, the unit contributed to the development of the

first ever national domestic and family violence context, intimate partner homicide database.

Relevant data from this database was published during this reporting period in the Australian Domestic and Family Violence Death Review Network Data Report (2018)[8].

This work is the culmination of significant planning that has been undertaken across all jurisdictions to establish a national minimum dataset of these types of deaths, and it is the first national data that comprehensively reports on the prior history of domestic and family violence before the fatal event.

Moving forward, the National Network aims to continue collating and reporting on domestic and family violence homicide and suicide data, with the aim of enhancing current understandings of these types of deaths in Australia.

During this reporting period, the Central Coroner, Mr David O'Connell, held an inquest into one of these deaths, which is summarized in brief below.

Tracy Ann BEALE – Neck compression causing death, medical cause of death, possible asphyxia, possible vaso-vagal inhibition, domestic violence, law reform, consideration of amendment to s. 315A of the Criminal Code to encompass vaso-vagal inhibition.

Findings delivered – 28 March 2018

Tracy Ann BEALE died on 21 January 2013 following an altercation with her husband where he restrained her in a chokehold.

Circumstances of the death

The Central Coroner stated that the precise time of the incident that led to Mrs Beale's death is uncertain but likely to be a little after midnight.

Mr Beale advised police on the night he was asleep in the bedroom after earlier having an argument with his wife. Mrs Beale who was affected by alcohol at the time, woke him, by entering the room to yell at him and then go out.

At the time of the fatal incident, Mr Beale advises he was punched or hit in the face by Mrs Beale and, in an attempt to 'calm her down', he squeezed her neck in the 'V' formed by his left arm.

When he released his hold, he noticed she was limp and not breathing and appeared to be unconscious. He rang 000 at 12:20am on 21 January 2013 and spoke to police. He did not attempt CPR.

Police arrived on the scene approximately four minutes later and commenced CPR until the arrival of paramedics which occurred shortly after police attended. Extensive CPR was continued until 1:06am when life extinct was declared.

[8] https://aifs.gov.au/cfca/2018/06/04/report-australian-domestic-and-family-violence-death-review-network-data-report-2018

The investigation
The Queensland Police Service (QPS) commenced an investigation into the death and charged Mr Beale over her death but it did not proceed to trial. The autopsy examination raised significant questions as to the precise mechanism of her death. That is whether Mrs Beale died of neck compression or possibly if there was a triggered 'sympathetic' vasovagal (reflex cardiac arrest) episode which lead to her death.

The inquest
Evidence about disagreements throughout the relationship of Mr and Mrs Beale was given at the inquest, usually in the context of financial issues. The Central Coroner noted that it was apparent that Mr Beale restricted his wife accessing funds, providing her with only limited monies. Although there was no police or court recorded formal history of domestic and family violence, the Coroner accepted there were a number of instances of intimate partner violence within the relationship that went unreported.

The focus of the inquest was the sequence of events that night, how Mrs Beale was restrained, the medical cause of her death and whether the domestic violence laws adequately deal with the circumstances that arose in this case.

Evidence at the inquest by Professor Heather Douglas was that the specific Criminal Code offence relating to choking and strangulation in the domestic violence setting possibly overlooks a situation of reflex cardiac arrest or vasovagal reflex. The Central Coroner agreed with this view.

Findings and comments
The Central Coroner found that Mr Beale, following an assault by Mrs Beale, held his wife in a mild-to-moderate chokehold for a short period of time, likely a few seconds. Mrs Beale went limp whilst standing and they both fell to the floor, whilst Mr Beale still restrained her.

The medical cause of death was asphyxia and a possible vasovagal reflex. The Central Coroner concluded that the force of the restraint was not severe, and the duration not prolonged. As a result, the Central Coroner highlighted there is a real danger in any form of neck compression.

Recommendations & referral
The Central Coroner made the following recommendations to the Attorney-General:

> (a) after allowing submissions from appropriate interested parties, review Criminal Code s.315A to determine if it is adequate to deal with the incidence of so called vasovagal reflex, and whether the types of neck compression specified in the provision should be defined in the legislation; and
> (b) determine if an appropriate public awareness campaign should be conducted to educate of the dangers of neck compression (of whatsoever type) in the domestic violence setting.

Noting the stated position of the Director of Public Prosecutions in relation to charges, the Central Coroner made a referral as per mandatory provision pursuant to s. 48 of the *Coroners Act 2003*.

Deaths in care of people with a disability

The *Coroners Act 2003*, s. 8(3)(f) in conjunction with s. 9(1)(a) and (e), makes reportable the death of persons with a disability who live 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.

The deaths of persons living in accommodation for persons with a disability who are recipients of services under the National Disability Insurance Scheme (NDIS) are also reportable deaths.

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.

During 2017-18, 98 deaths in care were reported. Of these, 67 related to deaths in care of people with a disability.

More broadly during this reporting period the CCQ has been participating in a range of planning activities across government to assist in the transition to NDIS in Queensland.

This follows on from work undertaken by CCQ discussed in previous Annual Reports, in follow up to the Public Advocate report on the deaths of care of people with a disability in 2016[9]. This report, *Upholding the right to life and health* (2016) identified the need for coroners to have access to specialist advice and assistance to inform their investigation into these types of deaths.

Two coronial findings of note that have referenced the Public Advocate's report were the published investigation findings into the death of David Orton and the inquest findings into the death of Paul Joseph Milward.

[9] https://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

David Orton – Death in Care, intellectual and physical disability, standard of care, Public Advocate review, Expert Panel Review

Findings – 11 May 2018

David Orton was aged 41. There was a long history of cerebral palsy, intellectual disability, anxiety, persisting gastrointestinal problems presenting as constipation and evidence of a dilated tonic colon. He also suffered from severe kyphoscoliosis which had a significant effect on movement and lifestyle. There had been progressive neurological and functional decline over 18 months with weight loss, increasing agitation, decreasing mobility, chronic abdominal pain and constipation.

Mr Orton received 24-hour care by Residential Facility at Currimundi funded by Disability Services Queensland. He had been there since 2005. Up until 2000 he had been cared for by family and then at other supported accommodation until 2005.

Mr Orton died on 26 January 2016. Because of his disability and residential arrangements his death was reportable as a Death in Care.

Mr Orton's family also had expressed concerns regarding his deterioration over a period of 18 months with very little clarity on his diagnosis. They were concerned that he had been inappropriately discharged from hospital at times and there were difficulties regarding the support provided to him. They were concerned that the obvious pain David had was disregarded as ‘behavioural’.

Mr Orton’s medical care was reviewed by the Clinical Forensic Medicine Unit (CFMU). The CFMU review identified possible issues with Mr Orton’s death that needed to be addressed. This included a possible public health issue with respect to Salmonella infection and a possible failure to diagnose an underlying disease such as malignancy.

An in-depth review of his overall care was also undertaken by an Expert Review Panel, who convened to review 11 apparent natural causes deaths in care of people who were residents in supported residential accommodation and in which potential concerns were identified about the adequacy of the health care management prior to death.

Consensus was unable to be reached by the Panel as to the quality of the treatment provided to Mr Orton prior to the death. Some members of the Panel found there were aspects of the care provided to him that were substandard. One reviewing clinician clarified Mr Orton’s decline may well have been a progression – natural or otherwise of his cerebral palsy.

The Deputy State Coroner concluded that overall the issues identified by the Panel were also largely identified as issues by the Public Advocate report “Upholding the right to life and health: a review of the deaths in care of people with disability in Queensland (2016)”. The finding sets out many of the recommendations made in those reviews and were supported by the Deputy State Coroner.

Paul Joseph Milward – Residential aged care, Huntington's disease, cognitive and swallowing impairments, choking on food, preventative recommendations, Public Advocate review of disability deaths in care

Findings delivered – 5 June 2018

Paul Joseph Milward was aged 53 and resided at an aged care nursing home residential facility at North Ipswich at the time of his death. Mr Milward was diagnosed with Huntington's disease in 2009 and went into care in 2013 after he could no longer live independently.

Mr Milward was noted to be a difficult resident to manage given his cognitive impairment, challenging behaviours and physical difficulties. These matters were recognised and care plans, including those for food/fluid intake given his swallowing/choking risk, were put in place by his nursing home.

Staff did not strictly apply the care plan strategies and the incident that led to his death saw him left alone in a closed room for two hours with a bread sandwich. Unfortunately, Mr Milward choked on his sandwich and died.

The Deputy State Coroner commissioned an expert report to provide an opinion on the care provided to Mr Milward, which identified two factors; lack of compliance with the care plan and an unacceptable period of non-supervision. That report recommended mandatory training for staff on how to care for persons requiring texture modified diets and ensure care staff are fully aware of the importance of providing supervision if it is listed as an intervention.

The Public Advocate report "Upholding the right to life and health: a review of the deaths in care of people with disability in Queensland (2016)" also identified the same issues as the independent expert report.

An inquest was held on the basis of similar issues identified as contributory to the death and to consider if any further recommendations could be considered.

The Deputy State Coroner noted the actions recommended by the expert and since undertaken by the facility since this death were consistent with the preventative recommendations suggested by the Public Advocate. The recommendations included strict compliance with and regular review of mealtime management plans, training for staff in relation to the importance of ensuring plans are complied with and review of resourcing and rostering considerations when developing such plans.

In those circumstances, the Deputy State Coroner did not consider there were any further recommendations that could be directed to the facility. However, noted some of the Public Advocate recommendations should be considered by those engaged in the aged care industry and other carers providing residential services to vulnerable people.

Specifically, one of the recommendations was that the State Coroner consider establishing a Residential Aged Care Death Review Process (or alternatively, an Elder Abuse Death Review process that could include the review of deaths in residential

aged care where definitions of program and institutional elder abuse are included) and a Disability Care Death Review Process.

The Deputy State Coroner noted the Public Advocate's recommendation for a specialist death review process was based on:

- the wide-ranging care and systemic issues that have been identified in Mr Milward's and other coronial matters;
- the specialist knowledge and skills that can be developed from the adoption of specialist death review processes that could help reduce unexpected and potentially avoidable deaths;
- the risk that without specialist review processes, the limitations of the definitions in the *Coroners Act 2003* for reportable deaths/deaths warranting investigation could result in missed opportunities to identify systemic issues in the residential aged care and disability care systems that are causing or contributing to potentially avoidable deaths.

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

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Charlie Mark John ROBERTSON – death in custody, mixed drug toxicity

Findings delivered – 14 December 2017

Charlie Mark John Robertson was just 19 years of age when he died on 13 June 2015 at a Gold Coast apartment he shared with two friends.

Mr Robertson was completing a degree in Property at Bond University and had received a Dean's award from the University on the night before his death.

Circumstances of the death
On the evening of 12 June 2015, Mr Robertson and his friends engaged in drug use at the apartment, and he eventually went to sleep.

The following morning seven Queensland Police Service (QPS) officers from the Rapid Action Patrol, executed a search warrant at the address. As police entered the unit some occupants jumped from the unit's balcony and two others were located hiding in a wardrobe.

The police officers who thought Mr Robertson was asleep made several unsuccessful attempts to wake him over a 90 minute period as the search of the apartment was progressed. It was noted he was snoring loudly but otherwise completely unresponsive, even during the application of pain stimulus and during a search under and around the mattress he lay on.

The Queensland Ambulance Service (QAS) had been called to attend to another male at the premises, however were not asked to check on Mr Robertson's wellbeing.

At the conclusion of their search the police officers left Mr Robertson in the presence of three female minors who had been at the premises overnight. After asking an adult neighbour to check on Mr Robertson, the young women left the apartment at 8:37am. One of Mr Robertson's flatmates returned home at 12:35pm to find him deceased.

The investigation
The QPS Ethical Standards Command (ESC) conducted the investigation into the death. The investigation was informed by recorded interviews with all persons at the unit on the night before the death, close friends and associates of Mr Robertson as well as other relevant persons from the unit complex. Disciplinary interviews with all of

the involved police officers were conducted. All officers were directed to answer, abrogating privilege against self-incrimination.

A full internal autopsy examination, with associated toxicology and CT scans was conducted. The pathologist concluded the formal cause of death was toxic effects of multiple drugs – cocaine, MDMA and GHB.

The State Coroner was further assisted by two experts who provided reports and gave concurrent evidence at the inquest regarding which drug was the significant contributor to the death and whether the concentrations of the drugs detected in Mr Robertson's system were survivable.

The inquest
All of the ESC investigation material was tendered at the inquest and evidence heard from eighteen witnesses. The State Coroner was satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed and analysed.

The focus of the inquest was the appropriateness of the manner in which the QPS officers dealt with Mr Robertson while executing the search warrant and the adequacy of the training provided to QPS officers with regard to recognising symptoms of a drug overdose.

Findings and comments
The State Coroner commented the QPS officers placed an over reliance on Mr Robertson snoring, and therefore breathing. The State Coroner further noted the manner in which officers lifted the mattress while he lay on it unconscious was highly inappropriate.

The State Coroner considered the attending police officers who witnessed Mr Robertson's condition acted inappropriately and incompetently with respect to his presentation.

The State Coroner concluded that Mr Robertson's death was preventable and based on the evidence that had he been provided with supportive oxygen therapy and other critical care measures, it is most likely that he would have survived.

Recommendations and referral
The State Coroner noted the evidence made clear training provided to QPS officers regarding recognising symptoms of drugs overdose was inadequate.

During the inquest the State Coroner was assisted by evidence from the Officer in Charge of the QPS Operational Skills Training Unit who outlined changes being put in place to the current model of first aid training, including recognising and dealing with management of unconscious persons – the default position to seek medical help. Reference to QPS officers also being trained in the use of a patient assessment tool was also noted, and would include annual refresher training.

The State Coroner further heard evidence about the ongoing review of first aid training and advice that all QPS officers are to complete new tactical first aid training program that captures a number of issues that are of a life-threatening nature.

Having regard to work being done by the QPS in these areas, the State Coroner did not make any recommendations. However, pursuant to s48(2) of the Act, the State Coroner made a referral to the Director of Public Prosecutions.

Christopher Leslie MARTIN – death in custody, restraint, domestic violence

Findings delivered - 15 December 2017

Christopher Leslie Martin was 65 years of age when he died on 6 September 2015. He died after trying to avoid being detained by police which resulted in a struggle with an officer. As Mr Martin's death was deemed a death in custody, an inquest was required by the *Coroners Act 2003*.

Mr Martin lived with his elderly parents and had assumed the role of primary carer for them. Police had previously attended to the residence on several occasions in response to allegations of violence committed by him against his parents.

Circumstances of death

On the afternoon of his death, one of Mr Martin's neighbours was en-route to the police station to report a spitting incident he saw him commit. As the neighbour neared the police station, he witnessed Mr Martin hit his father, causing him to fall.

The neighbour returned to assist Mr Martin's father as there was no one in attendance at the police station and Mr Martin had left the scene. A number of calls were made to police to report the incident and the neighbour took Mr Martin's father back to his home, awaiting police arrival, which took some hours.

Two police officers attended and while escorting Mr Martin's father to their vehicle to return him home, he was seen walking up the other side of the street. The officer commenced a recorded conversation with Mr Martin and advised he was to submit to a roadside blood alcohol test.

Mr Martin recorded a reading of 0.07% and was detained for the purpose of a breath analysis. Mr Martin then walked off towards his home and was seen to turn and raise his fists, towards the officer who has followed him.

Mr Martin entered the residence via the garage door, shortly followed by the officer before it was closed. This resulted in the officers being separated from one another.

The officer walked into the living room where Mr Martin was seen to pace around, telling his mother, who was seated in there, that the officer wanted to take him to the station.

The officer reminded Mr Martin he was detained and to sit down. Mr Martin was then witnessed to raise his fists towards the officer who pushed him in the chest causing him to fall backwards into the lounge chair. Following an unsuccessful attempt to handcuff him, the officer transitioned him to the ground and a lateral vascular neck restraint was briefly applied.

During this time the second officer gained entry to the house and handcuffs were then applied. Shortly after, Mr Martin then failed to respond and an ambulance was requested. The officer commenced CPR until their arrival but Mr Martin was unable to be revived.

The investigation
The Queensland Police Service (QPS) Ethical Standards Command (ESC) conducted the investigation into the death. ESC officers attended the scene and conducted a 'walk- through' re-enactment at the scene. Forensic examination and photographs of the scene were taken. The investigation was further informed by statements from the relevant attending officers, Mr Martin's medical records and relevant sections of the police operational procedures manual (OPM).

A full internal autopsy examination was conducted and his brain retained for analysis. The pathologist was unable to attribute a precise cause of death but in her opinion, the immediate cause was ventricular fibrillation, likely caused by his pre-existing ischemic heart condition which was probably precipitated by the application of the neck restraint.

The State Coroner also sought an expert medical opinion on the cause of death from Dr Dodd, of the Victorian Institute of Forensic Medicine. Dr Dodd concluded the cause of death as 'a heart attack occurring during a period of restraint', noting the struggle with police likely tipped his heart into an abnormal rhythm.

It was noted during the investigation that one of the officers did not have a current first aid certificate at the time of the death.

The inquest
All of the statements and medical records were tendered at the inquest and evidence heard from six witnesses. The State Coroner was satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed.

Findings and comments
The State Coroner considered the adequacy of the response from the QPS regarding the various calls for assistance to police, and having regard to the competing priorities being managed on the day and the officers planned approach to the job, was satisfied the response was adequate. The State Coroner also considered the adequacy of the decision to, and manner by which, Mr Martin was restrained. The State Coroner found the decision to restrain was appropriate and the level and type of force used was reasonably necessary.

The State Coroner referred to the police shootings inquest in which he made a recommendation that QPS revise its first aid training for operational police so it is consistent with the current guideline issued by the Australian Resuscitation Council.

Although not considered in any detail at the inquest, the State Coroner commented that the QPS and other agency interactions with Mr Martin and his parents over the year preceding his death highlighted the vulnerability of frail and aged persons who are dependent on their children for their care.

The State Coroner further noted the response of the wider service system to the presentations of Mr Martin's parents. Despite their efforts, his actions were often minimised as his mother wished to continue have him care for them.

In those circumstances, the State Coroner did not consider there were any useful recommendations he could make with respect to Mr Martin's death.

RECOMMENDATIONS FROM INQUEST: Police Shootings – deaths in custody, police shootings, s46 comments from inquest, use of force model, police training, mental illness, police officer welfare, investigation methodologies, body worn cameras, replica firearms, nuisance callers, information sharing

Recommendations delivered – 20 October 2017

Between August 2013 and November 2014, officers from the Queensland Police Service (QPS), acting in the course of their duties, shot and killed five men in unrelated incidents. Findings into s45 factual matters for each of the below deceased men had already been made:

- Anthony William YOUNG;
- Edward Wayne LOGAN;
- Shaun Basil KUMEROA;
- Laval Donovan ZIMMER;
- Troy Martin FOSTER.

As each of the deaths occurred in police custody a joint inquest 'recommendations phase' pursuant to s. 46 of the Act was held in October 2016. The State Coroner noted the intent of this phase was to 'consider opportunities for changes in police and health responses that may lead to the prevention of similar deaths, and the tragic impacts they have on the families of the deceased, officers involved, and the wider community'.

The State Coroner noted that when the use of firearms by police results in a death, it has the capacity to fundamentally 'shift the trust and confidence that the community has in the police'. Notwithstanding this the State Coroner noted the recommendations connected to the deaths were considered in the context that in each case he found the relevant QPS officers acted appropriately in discharging their weapons and that the Ethical Standards Command investigation into each death was adequate.

Issues examined at inquest

The State Coroner examined the following issues common to all deaths;
(1) The appropriateness of the current QPS use of force model and the options of force available to police officers;

(2) The adequacy and appropriateness of Queensland Police Service:
(i) policies in relation to the use of firearms; and
(ii) training provided to operational police officers in the use of firearms.

(3) The adequacy of the approach taken by the Ethical Standards Command Internal Investigations Group in conducting the investigation into the deaths, particularly, whether an improved methodology might be adopted which places appropriate weight on and protects the welfare of first response police officers, post-incident, and also preserves the integrity of the evidence of those officers and other evidence at the scene including whether the timing of and means of conducting interviews of first response officers by ESC officers should be varied or subject to greater flexibility;

(4) The adequacy and appropriateness of the current training of police officers with respect to the imposition of handcuffs after the use of lethal force;

(5) The adequacy of the current processes for dissemination of information, and updates of information, for attending crews to an incident including possible implementation of the Q-Lite program;

(6) The adequacy and appropriateness of QPS policies, procedures and training in relation to police dealing with mental health incidents, including the adequacy of the availability to QPS members, responding to an incident, of information/records from Queensland Health, and other medical practitioners, regarding the mental health history of persons;

(7) The current position regarding ownership of body worn cameras used by QPS officers and the storage of data including the progress of the roll out pursuant to the Commissioner's direction; and

(8) Lessons learned from these five inquests as to the benefits of body worn cameras being used by the police officers in terms of:

(i) preserving evidence;
(ii) providing a reliable record of what occurred;
(iii) avoiding unnecessary controversy about what happened;
(iv) vindicating police officers who have acted in accord with their training and policy.

The recommendations phase also examined the following issues specific to a particular death:

(9) The need for and, if necessary, the appropriate form of regulation of replica firearms in QLD. *(Kumeroa)*

(10) The effectiveness of the negotiation processes as observed in the incident involving Mr Kumeroa, including the options available for use when trying to negotiate a surrender plan and ways in which the process might be assisted in future. *(Kumeroa)*

(11) The positioning of the inner cordon police officers in the incident involving Mr Kumeroa leading to the necessity to use lethal force soon after Mr Kumeroa departed his car and whether any practical alternatives were available or might be available in a future incident. *(Kumeroa)*

(12) The adequacy and appropriateness of QPS policies, procedures and training for Police Communications personnel, especially, in dealing with nuisance callers who are not an appropriate use of 000 service time but may be people facing emotional or other difficulties and may require QPS assistance. *(Zimmer)*

(13) Methods available to first response police officers who are deployed to deal with nuisance callers including means of establishing and maintaining communications without necessarily requiring officers to enter dwelling houses to prevent calls from continuing. *(Zimmer)*

(14) The appropriateness of the mental health assessment of Troy Foster conducted at the Gold Coast University Hospital on 24 November 2014. *(Foster)*

(15) The adequacy of the current processes by which police escort a person detained under ss. 33 – 36 of the *Mental Health Act 2000* to a place of safety; by which police are required to provide information to hospital staff about the person for the purposes of the assessment; and by which hospital staff and police continue to communicate, if necessary, with regard to the person. *(Foster)*

Recommendations

The State Coroner noted that the QPS had already made significant progress in the wake of the shootings in a range of areas which are referred to in the Violent Confrontations Review and the Taskforce Bletchely reports.

The State Coroner also noted each of the men had a history or suspected mental illness, highlighting the need for QPS to treat mental health as 'core business'. This was reinforced by expert evidence at the inquest and in the Sentinel Events Review Committee report, which identified opportunities for improvements in information sharing and collaboration between health services and the QPS as well as an increase in the level of specialist forensic mental health support to the QPS.

In the context of those reports and the developments made since the deaths the State Coroner made the following 19 recommendations:

In response to issues 1 and 2

1. The QPS implement a model of incident command training for all operational police below the rank of Sergeant.
2. The QPS review Operational Skills and Tactics (OST) Training to incorporate training on appropriate radio communication and active listening techniques to ensure the effective transfer of information, and to assist frontline officers to recognise critical information.
3. The QPS revise its policy regarding first aid training for operational police so that it is consistent with the current guideline issued by the Australian Resuscitation Council.
4. The QPS continue to review its method for reporting the use of force applied by operational police with a view to implementing a system that would provide the QPS with accurate data that can be used to better inform use of force policy, reporting and training.
5. The QPS conduct a review with respect to how often, and in what manner, firearms skills should be refreshed in order to maintain effective performance under stress, and that as part of that review the QPS consider whether OST firearms training should occur more often than once every calendar year.
6. The QPS continue to explore ways in which use of force training in low light conditions can be effectively delivered, including through the use of purpose built and dedicated facilities to assist in the delivery and frequency of this training.
7. That OST training continue to incorporate "lessons learned" from previous shootings into scenario based training, including anticipating the presence of weapons on arrival at the scene, tactical withdrawal, and managing bystanders during an incident.

In response to issue 3

8. The QPS conduct a review of the standing orders governing the conduct of ESC investigations of critical incidents involving a fatality. The State Coroner noted matters the review should consider.
9. The QPS consider adopting service-wide an approach analogous to the system employed by the Special Emergency Response Team (SERT) for post incident support of officers, subject to appropriate adaptations having regard to local circumstances and officers being trained as to the limits of their role.

10. That officers involved in a critical incident involving a fatality be mandated to attend at least one session with a psychologist or psychiatrist independent of the QPS and that this issue be the subject of a separate review by the QPS. The State Coroner noted matters the review should consider.
11. The Queensland Government develop appropriate referral pathways, through an agency such as Victim Assist Queensland, to enable the families of those shot by police and witnesses to such events to be provided with counselling and support.

In response to issue 6

12. The Queensland Government conduct a comprehensive review of the Mental Health Intervention Program (MHIP) to ensure the revitalisation of the MHIP as recommended by Violent Confrontations Review recommendation 2, and its sustainability. The State Coroner noted matters the review should consider.
13. The QPS amend Chapter 6 of the OPM so that that there is no need for a police officer to subjectively assess whether the situation is a 'mental health incident' as defined currently within the OPM. The OPM should be drafted in such a way that frontline police are encouraged to call for mental health assistance in respect of incidents.
14. The QPS retain mental health training as a core component of the Recruit and First year Constable Training Programs.

In response to issues 7 and 8

15. The Queensland Government continue to allocate funds to the body worn camera roll out to enable all front line officers to be equipped with this technology.

In response to issue 9

16. The Queensland Government consider whether a scheme for the regulation of replica firearms with linkages to relevant QPS intelligence holdings should be established in Queensland, having regard to interstate legislation and the work of the national Firearms and Weapons Policy Working Group.

In response to issues 10 and 11

17. The QPS continue to provide SERT officers with training in negotiation and de-escalation skills to ensure that they are equipped to deal with parties in siege situations and other high risk environments.

In response to issues 12 and 13

18. The QPS continue to examine the way in which it deals with threats to the public interest arising from nuisance calls, with a view to continuous improvement in the communication training made available to all call takers with respect to dealing with callers who may have a mental illness and/or cognitive impairment. Such examination should address both training and technology solutions.

19. The QPS incorporate options for dealing with nuisance callers in relevant standing instructions and mandatory training for call takers. The State Coroner noted matters that should be considered.

Francis Ronald Llewelyn COLLINS – death in custody, natural causes

Findings delivered 23 January 2018

Francis Ronald Llewelyn Collins was 85 years of age when he died from respiratory failure at the Princess Alexandra Hospital (PAH) secure unit. As Mr Collins was in custody at the time of his death, an inquest was required by the *Coroners Act 2003.*

In May 2007, Mr Collins was convicted of historical offences relating to the indecent treatment of children. At this time he was aged 77 years and had no prior criminal history. He was sentenced to a term of 11 years imprisonment and was initially accommodated at the Maryborough Correctional Centre before being transferred in August that year to the Wolston Correctional Centre (WCC).

Mr Collin's transfer to the WCC was to facilitate frequent trips to the PAH to manage his multiple co-morbidities, which included diabetes, hypertension, high cholesterol and vascular disease. He also presented with a persistent, non-productive cough that he had experienced for some 20 years.

Circumstances of the death
On 16 August 2015, Mr Collins was transferred to the PAH for treatment of a blister that was not healing. He was also investigated for an acute exacerbation of his chronic cough.

By 19 August 2015, Mr Collins's shortness of breath, cough and foot ulcer appeared to have improved. During his clinical work-up that day, Mr Collins was found to have low iron levels, a possible contributor to his dyspnoea. Soon after midday on 19 August 2015, he was commenced on an intravenous iron infusion.

Mr Collins became short of breath that afternoon. The iron infusion was ceased and he was treated for a suspected anaphylactoid reaction, likely related to components of the iron infusion.

On 20 August 2015, Mr Collins condition deteriorated and he stated he wished only for comfort measures. His breathing became more laboured, and an oxygen mask was applied, which Mr Collins resisted.

Mr Collins was also offered pain relief, which he declined. A short time later, nursing staff checked Mr Collins for vital signs, but none were detected. Mr Collins was declared deceased at 7:45pm on 20 August 2015.

The investigation
The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) conducted an investigation into the circumstances leading to the death of Mr Collins. The CSIU attended both the WCC and PAH and obtained Mr Collins' correctional files and medical records. Statements were taken from relevant custodial correctional officers, clinical staff and treating doctors at the PAH. Mr Collins had been allocated a prison carer and an interview with his carer and other prisoners further informed the investigation.

A full internal autopsy examination was ordered by the State Coroner. The pathologist's report, together with the statements and medical records were provided to the Queensland Health Clinical Forensic Medicine Unit (CFMU) to report on the medical care provided to Mr Collins at both the PAH and WCC.

Dr Home of the CFMU provided the State Coroner with a detailed report which confirmed Mr Collins died due to respiratory failure as a consequence of chronic obstructive pulmonary disease (COPD). Changes following emphysema were seen at autopsy. Dr Home explained that most patients with emphysema also have a degree of chronic bronchitis, which produces a chronic cough, something which Mr Collins had experienced for years. Dr Home explained that sufferers of COPD often experience rapid onset exacerbations of their symptoms in response to chest infections and other factors.

Dr Home raised the apparent anaphylactoid reaction during the iron infusion involving iron polymaltose. He explained that such reactions are considered rare and typically occur within the first few minutes of commencing an infusion.

Having regard to Dr Home's concern regarding the iron infusion, and with consideration for the pathologist listing the iron infusion as a significant condition relating to the cause of death, the State Coroner requested a response from the PAH.

The Director of Clinical Pharmacology, Dr Peter Pillans noted that haematologists seldom give iron infusions to inpatients, and that the most are administered on an outpatient basis using a different iron preparation.

Dr Pillans further indicated that iron polymaltose was almost exclusively used for inpatients at the PAH, and no adverse reactions had been no recorded. He noted that while anaphylactoid reactions to iron infusions are well known, they are rare.

The inquest
The inquest proceeded immediately to submissions in lieu of oral testimony. The State Coroner was satisfied that the investigation was thoroughly and professionally conducted and all relevant material accessed.

Findings and comments
It is a recognised principle that the health care provided to prisoners should be of no lesser standard than that provided to other members of the community. The State Coroner was satisfied the adequacy of the medical care provided to Mr Collins at both the WCC and PAH when measured against this benchmark was appropriate. The State Coroner accepted that the concerns raised by Dr Home were adequately addressed by the PAH.

The State Coroner accepted that the death was from natural causes with no suspicious circumstances associated with it. As the State Coroner was satisfied Mr Collins death could not have reasonably been prevented, there were no comments or recommendations he could make that would assist in prevent similar deaths in future.

Wesley Ronald John FITTON – death in custody, natural causes

Findings delivered - 23 January 2018

Wesley Ronald John Fitton was aged 50 years when he died in custody in November 2015. Accordingly, an inquest was required by the *Coroners Act 2003* to establish the cause and circumstances of his death.

Mr Fitton was convicted on 21 October 2013 of offences relating to making child exploitation material and indecent treatment. This was Mr Fitton's second sentence for offences of this nature and he was incarcerated at the Wolston Correctional Centre (WCC) for a period of four years.

In June 2014, Mr Fitton, then aged 48 years, was diagnosed with a metastatic undifferentiated epithelioid tumour. He was reviewed by an ear, nose and throat specialist and a cancer specialist, who considered that the extent of the disease was such that it was not amenable to curative surgical treatment.

He commenced high dose palliative radiotherapy with chemotherapy. The cancer continued to grow despite ongoing palliative chemotherapy.

Circumstances of death
From 1 November 2015 to the date of his death on 10 November 2015, Mr Fitton's health declined and he was transferred to the Princess Alexandra Hospital (PAH) for pain relief on several occasions.

On 9 November 2015, he was granted exceptional circumstances parole to commence on 11 November 2015, pending the availability of a bed at a palliative care facility. An earlier application for exceptional circumstances parole was declined in September 2015.

That same day, Mr Fitton was brought to the WCC health centre by his carer as he was unable to swallow and was very lethargic. In the early hours of 10 November 2015, he was transferred to the PAH secure unit, where he told medical staff that he did not want any medical intervention.

Over the course of the day he was provided with pain relief. Mr Fitton became increasingly unsettled and continued to have difficulty swallowing and was struggling to breathe. Later that night, it was noticed that there were no signs of breathing and his pulse had decreased. After a brief period of monitoring no pulse could be detected. Mr Fitton was pronounced deceased by medical staff at 10:00pm.

The investigation
The death was investigated by an officer from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). The officer attended both the PAH and WCC and obtained correctional files and medical records. The investigation included statements from the relevant custodial correctional officers, the nurse unit manager at WCC, Mr Fitton's treating doctor at the PAH, and a statement from his wife.

The State Coroner ordered an external autopsy examination with associated CT scans and toxicology testing be conducted. The cause of death was found to be from a tracheal obstruction due to poorly differentiated metastatic malignant epithelioid sarcoma of unknown primary origin.

The court was further assisted by a report from the Queensland Health Clinical Forensic Medicine Unit (CFMU) who examined the statements as well as the medical records from the PAH and WCC and reported on them. The CFMU report explained that sarcomas are a rare soft tissue tumour deriving from embryonic mesenchymal cells responsible for development of muscle, fat, fibrous tissue, cartilage and bone. They are aggressive tumours with extremely poor prognosis for the patient once they spread through the body.

The inquest

The inquest proceeded immediately to submissions in lieu of oral testimony. The State Coroner was satisfied that the investigation was thoroughly and professionally conducted and all relevant material accessed.

Findings and comments

The statement of Mrs Fitton set out a number of concerns relating to decisions by the Parole Board to deny her husband parole on compassionate grounds, and limits placed on contact with him on his final day at the PAH. The State Coroner, while appreciating that these are matters of great concern to others whose family members are diagnosed with terminal illness while in custody, did not consider that they were ultimately connected to Mr Fitton's death, or whether they could have prevented other deaths in similar circumstances. Accordingly, the State Coroner did not examine this matter in any detail.

The State Coroner concluded that the death was from natural causes and could not have reasonably been prevented. With respect to good medical care, appropriate investigation and treatment of medical conditions, the CFMU confirmed, in accordance with the recognised principle that the medical management and health care provided to prisoners should mirror that in the community.

In this regard, the CFMU did report on a concern regarding a regarding a six week delay for a CT scan in 2015, however, clarified that in terms of the overall outcome, this delay did not have any impact, as it was unlikely that earlier recognition would have changed the outcome.

The State Coroner accepted that Mr Fitton was given appropriate medical care by staff at the WCC and PAH and when he chose not to undertake treatment, his wishes were respected. The State Coroner did not make any recommendations.

Mark Ian McLAUGHLIN – death in custody, natural causes

Findings delivered – 24 January 2018

Mark Ian McLaughlin was a 55 year old man who died at the Townsville Hospital (TTH), shortly after he was diagnosed with an extremely aggressive brain tumour. While Mr McLaughlin's death was clearly from natural causes and he was awaiting transfer to a

correctional centre when he was noticed to not able to mobilise properly, an inquest was mandated by the *Coroners Act 2003* as he was in custody at the time of his death.

Mr McLaughlin had no criminal history prior to being convicted of Commonwealth and State offences relating to possessing and distributing child exploitation material in April 2016. Following his release for imprisonment for State offences, he was scheduled to serve time for his Commonwealth offences.

Circumstances of death
On 24 April 2016, Mr McLaughlin was transferred from the watch house to the Cairns Hospital (CH) suffering vertigo, an inability to walk and blood in his urine.

He was seen by the emergency department registrar and investigations revealed an elevated white cell count and brain metastases which resulted in him being admitted and a review by the Neurosurgical Registrar at the TTH sought. Mr McLaughlin was transferred to the care of the neurosurgeon at the TTH and he was transported there via Retrieval Services for surgery.

Upon further review at the TTH it was concluded that his tumour was aggressive and incurable. He was assisted by a social worker, end of life measures put in place and his family contacted about the diagnosis, prognosis and treatment options, which included a referral to palliative care services for ongoing management.

Mr McLaughlin's condition continued to deteriorate over the course of May and June and on 18 June he was unable to be roused. He died on 20 June 2016.

The investigation
The death was investigated by the Queensland Police Service, Corrective Services Investigation Unit (CSIU). The investigator attended the TTH and his medical files and correctional records were obtained. Statements from relevant custodial officers, clinical and treating staff as well as his son, also informed the investigation.

The State Coroner ordered an external and partial internal examination with associated CT scans and toxicology testing. An independent medical opinion was also sought from the Queensland Health Clinical Forensic Medicine Unit (CFMU) who examined the statements as well as the medical records from the CH and TTH and reported on them.

The CFMU review did not identify omissions in Mr McLaughlin's clinical management at any stage which may have altered the outcome. There was no earlier opportunity at which to diagnose his brain tumour. It was noted his care in hospital was very thorough, and the diagnosis was sensitively managed. The State Coroner agreed, the level of health care was equivalent to what would be expected within the general community.

The inquest
The inquest proceeded immediately to submissions in lieu of oral testimony. The State Coroner was satisfied that the investigation was thoroughly and professionally conducted and all relevant material accessed.

Findings and comments
The State Coroner accepted that the death was from natural causes with no suspicious circumstances.

Though the State Coroner accepted that there were no comments or recommendations that would assist in preventing similar deaths in future; it was noted in the statement tendered by Mr McLaughlin's palliative care specialist, that contact was made on several occasions with Queensland Corrective Services to prevent his death from becoming a death in custody, and seeking his release on exceptional circumstances parole, due to his rapidly deteriorating condition and expected death.

While not examined in any detail at the inquest, the State Coroner noted it appeared that Mr McLaughlin may not have been considered eligible for exceptional circumstances parole because he was also serving a period of imprisonment for Commonwealth offences.

The State Coroner stated provisions in this regard require parallel applications to the Attorney-General (under s 19AP of the *Crimes Act 1914*) and the Queensland Parole Board, however there is no legal impediment for such applications to be made.

The State Coroner considered in appropriate cases such early release would clearly be of significant benefit to the family of the dying person, who are otherwise left to endure the decline of their next of kin, who is likely to be restrained, in the presence of custodial officers in circumstances where the person poses no risk to community safety.

Peter Matthew BERNARD – death in custody, natural causes

Findings delivered – 24 January 2018

Peter Matthew Bernard was a 42 year old Indigenous man who died on or about 27 February 2016 from coronary artery atheroma. Though Mr Bernard died from natural causes, an inquest was mandated by the *Coroners Act 2003* as he was in custody at the time of his death.

Mr Bernard was from Kowanyama and English was his second language. He had a lengthy custodial history, dating back to his childhood. Mr Bernard had a diagnosed acquired brain injury, resulting in a very significant level of impairment. As a result, from April 2014, he was the subject of a Guardianship Order appointing the Public Guardian to make decisions regarding accommodation, health care, provision of services and legal matters. The Public Trustee was appointed to manage his financial matters.

On 25 January 2016, Mr Bernard was arrested and remanded in custody at the Lotus Glen Correctional Centre (LGCC) for offences including trespass, disorderly conduct and numerous assaults. His medical history while in custody related mostly to his mental health, episodes of seizures associated with epilepsy, and the clinical care provided to him as a result of regular altercations with other prisoners.

Circumstances of the death

On 26 February 2016, Mr Bernard, was seen exercising for an extended period of time - he had been doing chin ups, push ups and exercises on the stairs. During the course of the investigation, information provided by various inmates confirmed he would exercise for up to an hour on most days.

Late in the afternoon, inmates reported he was pale, sweating and had complained of feeling unwell. Mr Bernard did not seek or receive any medical review and was assisted back to his cell around 5:40pm by another inmate who shut his cell door for him. Nothing further was heard from Mr Bernard over the course of the evening.

During the morning muster the following day, Mr Bernard failed to exit his cell. A Custodial Correctional Officer (CCO) confirmed she looked through his cell window and could see him lying face down on his bed, covered by a doona. The CCO entered the cell, called out to Mr Bernard and touched his foot with her finger. He was noted to be cold to touch and did not respond. The officer requested the assistance of another CCO who after pulling the doona off Mr Bernard and attempting to get a response called a Code Blue.

A Registered Nurse attended to the cell and it was agreed resuscitations efforts would be futile as he was in a stage of rigor mortis. Paramedics attended and pronounced Mr Bernard deceased.

The investigation

Upon being notified of Mr Bernard's death an investigation was conducted by the Queensland Police Service, Corrective Services Investigation Unit (CSIU). The CSIU was assisted by a local detective from the Mareeba Criminal Investigation Branch. Mr Bernard's correctional files and medical records from the LGCC were obtained. The investigation was further informed by statements from the relevant CCO's, inmates and the nursing staff from the LGCC. The CCTV footage of Mr Bernard's unit at the time of cell lockdown including the discovery of his body was also obtained and tendered at the inquest.

The State Coroner ordered a full internal autopsy examination with associated CT scans and toxicology testing. The post-mortem examination results showed severe (90%) narrowing of one of the arteries of the heart with some narrowing of other arteries, an excess of fluid in the lungs, some scarring over the lung services, enlargement of the prostate and bladder.

There were no features to suggest any recent assault or evidence of recent restraint. The pathologist indicated the cause of death was most likely arrhythmia which is a recognised cause of sudden cardiac death and, in many cases, the first and only manifestation of cardiovascular disease.

An independent medical opinion was obtained from the Clinical Forensic Medicine Unit (CFMU). On review of the autopsy report and medical records, the CFMU report specifically noted that *"there was no way of predicting the presence of severe coronary artery disease in this man and no opportunity to intervene prior to his death."* The report further confirmed there was no recorded history of any cardiovascular disease and no mention of any episodes of chest pain in his medical records.

The inquest

The inquest proceeded immediately to submissions in lieu of oral testimony. The State Coroner was satisfied that the investigation was thoroughly and professionally conducted and all relevant material accessed.

Findings and comments

The State Coroner accepted that the death was from natural causes with no suspicious circumstances. On the basis of the evidence, the State Coroner was satisfied that the medical care provided to Mr Bernard was appropriate and that his death could not have

been reasonably foreseen or prevented. Accordingly, the State Coroner made no recommendations.

Robert Raymond DAY – death in custody, natural causes

Findings delivered - 6 February 2018

Robert Raymond Day was 62 years of when he died in early 2016. At the time of his death he had been in custody for over 27 years, therefore his death was subject to an inquest as required by the *Coroners Act 2003*.

At the age of 12, Mr Day was found to be in need of "care and control" and placed in the care of the State until he was 18 years of age.

In December 1990, he was sentenced to life imprisonment for the December 1988 attempted murder of a tourist he had befriended and taken to remote bushland at Redland Bay, as well as armed robbery associated with that offence. In sentencing Mr Day, the Supreme Court recommended that *"he should not be released from custody at any time in the future".*

Circumstances of the death
Mr Day was transferred from the Wolston Correctional Centre (WCC) to the South Queensland Correctional Centre (SQCC) for end-stage palliative care on 16 December 2015. After deteriorating significantly, Mr Day was transferred to the Princess Alexandra Hospital (PAH) secure unit on 27 January 2016.

Mr Day was well-known to the Palliative Care Team and Oncology Treating Team at the PAH who noted that he had symptoms consistent with the terminal phase of his disease. He was given a prognosis of between hours to days to live, and comfort cares commenced, consistent with his advance health directive. Mr Day died there surrounded by family members at 7:54pm on 28 January 2016.

The investigation
The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) conducted an investigation into the death. CSIU officers examined Mr Day's body at the PAH, reporting no concerning marks or injuries. Correctional files and medical records from the SQCC and PAH were obtained, together with a statement from the relevant custodial correctional officer and Resident Medical Officer at the PAH.

Mr Day's family did not express any concerns about the circumstances of his death.
An external autopsy examination, which included a full body CT scan was conducted. The results of the autopsy revealed extensive osteoblastic skeletal metastatic disease, bilateral adrenal masses and retroperitoneal and lateral pelvic nodal metastatic disease. The cause of death was opined as metastatic prostate cancer.

The State Coroner was further assisted by a report from the Queensland Health Clinical Forensic Medicine Unit (CFMU), who examined the autopsy report as well as Mr Day's voluminous medical records. The CFMU reported on the 12 months leading up to Mr Day's death.

The report noted that the treatment afforded to Mr Day from the time of his diagnosis was of a very high standard, with no concerns about the quality of care provided at the PAH or the correctional centres where he was incarcerated.

The inquest
The inquest proceeded immediately to submissions in lieu of oral testimony. The State Coroner was satisfied that the investigation was thoroughly and professionally conducted and all relevant material accessed.

Findings and comments
The State Coroner concluded that Mr Day died from natural causes and that none of the correctional or medical officers caused or contributed to his death.

The State Coroner was satisfied that Mr Day was given appropriate medical care by staff at both the SQCC and PAH. As the State Coroner concluded his death could not have reasonably been prevented, there were no comments or recommendations that could be made to assist in preventing similar deaths in future.

Eric James MURRAY – death in custody, natural causes

Findings delivered – 6 February 2018

Eric James Murray was a 69 year old Indigenous man who had a long criminal history in Queensland, New South Wales and the Northern Territory. In July 2013 he was sentenced to life imprisonment. At the time of his death, Mr Murray was accommodated at the Wolston Correctional Centre (WCC). Although the death was from natural causes, as he was in custody when he died, an inquest into the death was required by the *Coroners Act 2003*.

Mr Murray was a morbidly obese man, and was domiciled in a single bed cell in a unit for special needs prisoners. Over the years, he was reviewed regularly by nursing, medical and allied health staff while he was in prison. He was wheelchair-bound and had a lengthy medical history.

Mr Murray was under the care of both ophthalmology and endocrinology teams at the Princess Alexandra Hospital (PAH) between July 2011 and May 2016. Among numerous other admissions, he was admitted due to a myocardial infarction in August 2012, and again in April 2014 due to symptoms of angina.

Circumstances of death
On 8 August 2016, at 4:11am, a prisoner called a Code Yellow (officer distress call), to Master Control after he could hear Mr Murray moaning loudly. A Custodial Correctional Officer (CCO) attended to and accessed Mr Murray's cell at 4:23am. Mr Murray was located on his bed, trying to get up, and said ""help me, help me. I cannot breathe."

The CCO tried to ascertain where Mr Murray's pain was, but he stopped communicating. The CCO contacted Master Control to request an ambulance be called. Two other CCO's attended to the cell and CPR was commenced including the use of a defibrillator, which at all times instructed the officers 'no shock' and to continue the administration of CPR.

At 4:30am, paramedics arrived and took control of resuscitation efforts. No signs of life were noted at this time and Mr Murray was in asystole. The paramedics administered adrenaline and oxygen while CCO's continued to help with manual compressions.

Mr Murray's rhythm changed to pulseless electrical activity with a wide QRS complex and a rate of 30 beats per minute. This increased to a rate of 60 beats per minute, with audible heart sounds and cardiac output evidence on capnography. This was maintained for several minutes, until Mr Murray re-arrested. Despite continued efforts, Mr Murray was declared deceased at 5:25am.

The investigation
The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) conducted the investigation into the death of Mr Murray. The CSIU attended to WCC the morning of 8 August 2016 and obtained Mr Murray's correctional files and medical records from both the centre and the PAH.

The investigation was informed by statements from the relevant custodial correctional officers and from the director of the secure unit at the PAH. Mr Murray's sister was also contacted to provide a statement but declined advising that she had no concerns. An external autopsy examination with associated CT scans and toxicology testing was conducted by Senior Forensic Pathologist, Dr Nathan Milne. The CT scans showed obesity, dilated cerebral ventricles, sternal wires, triple vessel coronary artery calcification and aortic calcification. Dr Milne concluded that the cause of death was ischaemic cardiomyopathy.

The State Coroner also sought an independent medical opinion from the Queensland Health Clinical Forensic Medicine Unit (CFMU). The CFMU examined the statements as well as the medical records for Mr Murray from WCC and the PAH and reported on them advising that he was provided with an equivalent (if not better) level of health care in custody in the last 12 months prior to his death, as would be expected in the general community.

The inquest
All of the statements and medical records were tendered at the inquest which proceeded immediately to submissions in lieu of oral testimony. The State Coroner was satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed.

Findings and comments
The State Coroner accepted the death was from natural causes and that none of the correctional officers or other prisoners caused of contributed to the death. The State Coroner was satisfied the medical care provided to Mr Murray by staff at the WCC and PAH was appropriate and his death could not have been prevented. Accordingly, the State Coroner made no recommendations.

Franky HOUDINI – death in custody, hanging, continuing detention under the *Dangerous Prisoners (Sexual Offenders) Act 2003*, information sharing between Queensland Corrective Services and Prison Mental Health Service employees

Findings delivered - 16 May 2018

Franky Houdini was 41 years of age when he was founded hanged behind the door of his cell at the Wolston Correctional Centre (WCC) on 2 June 2015. He worked as a magician/escape artist before his imprisonment in 2010 for offences relating to maintaining a sexual relationship with a child, indecent treatment of a child and possessing and creating child pornography.

Before his full time release date, in September 2014, an interim detention order was made for his continuing detention under the *Dangerous Prisoners (Sexual Offenders) Act 2003 (DPSOA)*.

As Mr Houdini died in custody an inquest was required by the *Coroners Act 2003*.

Circumstances of death
Following an assessment in 2014, Mr Houdini was transferred to The Park Centre for Mental Health (The Park) and placed on an involuntary treatment order (ITO) on 5 December 2014, diagnosed with paranoid schizophrenia.

Mr Houdini was received back to WCC from The Park in March 2015 as he was assessed as not requiring ongoing admission, displaying an improvement in mental state, he however remained on the ITO.

In the months before his death, Mr Houdini was advised preparation for his DPSOA application was to commence and would include an assessment by various external psychiatrists

On 26 May 2015, Mr Houdini was reviewed by his treating Prison Mental Health Service (PMHS) psychiatrist. He was compliant with medication and did not report any stress in regards to the DPSOA process. He was however concerned about being charged with some new offences.

On 28 May 2015, he was interviewed by a QCS psychologist who noted he presented unremarkable and no current suicide ideation, intent or plan was detected. The PMHS requested the QCS psychologist conduct a welfare check on Mr Houdini which was conducted on 1 June 2015, the day before his death.

On this day, Mr Houdini again presented unremarkably, responded to all questions, maintained eye contact and presented with his usual flat affect. He did not report any concerns, only that he found psychiatric assessments “challenging”. The QCS psychologist did not detect any current suicidal ideation, intent or plan.

At 10:40am on 2 June 2015, correctional services officers conducted the morning muster which required prisoners to stand beside their cell door. On approach to Mr Houdini’s cell, it was noted the glass window of the door was covered. The officer attempted to open the door but it was locked. A master key was used to unlock the cell

door and Mr Houdini's body was located hanging, by a nylon cord from the tennis court, behind the door.

A Code Blue was called and Mr Houdini's body was cut down; there were no signs of life. CPR was commenced by the officers until medical staff attended. They used a defibrillator to check for signs of life, of which there were none. Mr Houdini was pronounced deceased soon after.

The investigation
Mr Houdini's death was investigated by the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). Statements were taken from staff and interviews conducted with inmates of the facility. The investigation was further informed by relevant medical and correctional files and scenes of crime photographs.

The Chief Inspector, Queensland Corrective Services (QCS), appointed investigators to examine the incident under the powers conferred by s294 of the *Corrective Services Act 2006*. A report was submitted to the Office of the Chief Inspector (the OCI Report) which examined matters beyond the scope of the inquest. A full internal autopsy examination and associated toxicology testing was conducted by experienced forensic pathologist, who attended the scene of the death on 2 June 2015. The pathologist confirmed the cause of death as being from hanging.

The inquest
The issues for the inquest were informed by the OIC report which made investigation findings about the fact that assessments of Mr Houdini by QCS psychologists were hampered by a lack of information about his mental health status and needs from the PMHS, lack of awareness of the DPSO application and the stress this was placing on Mr Houdini and a failure to carry out checks to the extent of his self-reported family supports.

At the inquest, the State Coroner heard evidence about information sharing relating to a prisoners' mental health treatment between QCS and PMHS, the Queensland Parole System Review recommendation regarding review of prison and community forensic mental health services, and policies and procedures in place to deal with mental health treatment of prisoners subject to orders pursuant to DSPOA.

Findings and comments
The State Coroner was satisfied that no other prisoner or member of staff at WCC was directly involved in Mr Houdini's death. In regards to the nylon cord from the tennis court, the State Coroner did not consider preventing access to the cord could have prevented his death as he had a range of other possible methods at his disposal.

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

The State Coroner discussed the five recommendations made in the OCI report and acknowledged the body of work that is continuing, particularly with respect to enhancing funding for the PMHS, and the resolution of practical difficulties with sharing of confidential information.

The State Coroner accepted that while QCS Psychological Staff were aware in broad terms of the DPSOA application process, they should have been better informed about the key stages to understand his response to it. The State Coroner also accepted that collateral checks should have been undertaken to verify claims Mr Houdini was being supported by his family.

The State Coroner heard it was not the practice of the PMHS to provide QCS, specifically, psychologists, written information about a prisoners' mental health. However, several methods are used to share information with QCS including weekly meetings, telephone conferences, and other informal sharing within the limits of the Memorandum of Understanding (MOU).

The State Coroner considered the policy underpinning the current information sharing agreement is sound, requiring the wishes of a prisoner be respected in relation to the release of information about their mental health. The State Coroner agreed that enhancing working relationships between the respective agencies to operationalise the MOU is likely to lead to improved information sharing.

Recommendations
Noting that an existing working group is examining the MOU and Operating Guidelines, the State Coroner recommends that Queensland Health and Queensland Corrective Services consider:

- whether amendments are required to legislation to supplement the release of information (including documents) under the MOU on Confidential Information Disclosure to optimise the health care provided to persons in custody; and protect health practitioners from liability when sharing prisoner health information appropriately; and
- amendments to the Operating Guidelines under the MOU on Confidential Information Disclosure to provide more relevant contextual information in relation to the sharing of information in correctional settings.

Zachary James David HOLSTEIN – death in custody, hanging, communication between medical staff and corrections staff, Root Cause Analysis, Chief Inspectors Report

Findings delivered 20 June 2018

Zachary James David Holstein was 23 years of age when he was found hanging from a bed sheet behind the door of his Woodford Correctional Centre (WCC) cell on 8 February 2016. An inquest was required by the *Coroners Act 2003*.

Mr Holstein had a history of mental illness, self-harm and substance abuse. His criminal history dated back to October 2009 for drug and fraud related offences. On 27 September 2015, his parole was suspended after he was charged with resisting arrest when police located him attempting to break into a dwelling. He was transferred to WCC on 20 October 2015.

Circumstances of death
During an afternoon muster at about 2:44pm on 8 February 2016, one of the correctional officers noticed a blue towel covering the observation window of the lockable cell occupied by Mr Holstein. The officer unlocked the cell and located Mr Holstein hanging from the end of a white sheet tied that was around the outside of the door handle.

A Code Blue was called and the officers removed the sheet and commenced chest compressions. On arrival, medical staff continued CPR. QAS transported Mr Holstein to the Caboolture Hospital, he was later transferred to Redcliffe Hospital and placed on life support which was turned off on 12 February 2016.

The investigation
The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) conducted an investigation as directed by the Deputy State Coroner. The Office of the Chief Inspector (OIC) also provided an independent report which covered issues wider than the incident on 8 February 2016, including the adequacy of health services provided to Mr Holstein whilst in prison.

A full internal autopsy examination with toxicology testing was ordered by the determined the death to be 'hypoxic-ischaemic encephalopathy, due to, or as a consequence of hanging'.

The inquest
The inquest explored whether there was information held by Offender Health Services, Metro North Hospital Health Services and/or any of its staff that would further add to or amend the findings and recommendations made by the OIC. The response of Queensland Corrective Services (QCS) and Queensland Health (QH) to the recommendations made by the OIC was also examined.

Findings and comments
The Deputy State Coroner heard evidence in response to a number of findings published in the OIC report. Both the WCC, Nurse Unit Manager and Visiting Medical Officer (VMO) disagreed with assumptions made about the request for mirtazapine being a concern for suicide risk. The VMO also disagreed with the assertion made about information sharing between QCS and QH.

Dr Jill Reddan a consultant psychiatrist on behalf of Metro North Hospital and Health Service (MNHHS) was highly critical of clinical aspects of the report. Dr Reddan stated they made 'sweeping accusations' based on little evidence about services provided to prisons.

The Deputy State Coroner was satisfied there was no failure to share information with QCS. The Deputy State Coroner further noted there were difficulties in accepting some of the OIC findings and recommendations made in respect to health services where the Inspectors had little experience, including no clinical experience.

In response, the Deputy State Coroner commented that there should be improvements made to the internal review process and OIC Inspectors should be seeking information from relevant affected agencies.

However, the Deputy State Coroner had concerns that despite Mr Holstein submitting a number of medical request forms from 20 October 2015, he was not seen by the VMO until 5 November 2015.

Recommendations
The Deputy State Coroner made the following recommendations pursuant to s46 of the Act;

- MNHHS urgently consider additional resourcing of Offender Health Services within WCC (both staffing and consultation rooms) to ensure prisoners are able

to see a doctor within at least seven days after they have been triaged and identified as requiring non-urgent medical consultation and /or within a timeframe commensurate experienced by members of the general public; and

- The OIC, QH and all hospital and health services who provide health services to prisoners jointly consider ways for ensuring that, where a prisoner dies and health services provided are relevant to the OIC investigation, there is a mechanism for gathering relevant information to inform that investigation.

Public interest inquests

This section contains a summary of coronial investigations that received a high level of public interest.

James William ACKERMAN – Rugby League football, shoulder charge, carotid artery dissection, steps taken to mitigate risk of injury, rule and penalty charges

Findings delivered – 9 November 2017

James William Ackerman was a 25 year old semi-professional rugby league player with the Sunshine Coast Falcons at the time of his death.

On 20 June 2015, Sunshine Coast were playing against the North Devils at Norths' home ground in Nundah. Mr Ackerman scored a try in the early minutes of the game, and then Norths kicked the ball from half-way to restart the game.

Circumstances of death
Following this re-start, Mr Ackerman was playing in the front row. He received a ball and was at the defensive line. Mr Ackerman and another player collided hard with each other, and he immediately fell to the ground. The referee stopped play.

At the time of the incident, the referee had placed the other player on report for review of the contact which was described as a "shoulder charge". Mr Ackerman was struggling to breathe and was otherwise unresponsive. Emergency medical treatment was provided on the ground by a doctor until arrival of an ambulance.

Mr Ackerman was taken to the Royal Brisbane and Women's Hospital. He was experiencing bleeding to the brain and placed in an induced coma. Over the next two days it became apparent that his condition was incompatible with life and his life support was terminated. Mr Ackerman was declared brain dead on 22 June 2015.

The investigation
The Deputy State Coroner's investigation was informed by actions taken and material provided by Queensland Rugby Football League Ltd, the Queensland Police Service and Workplace Health and Safety Queensland (WHSQ). The game and therefore the incident was captured on video recording.

An external autopsy examination with CT scan was conducted. The pathologist determined the cause of death to be 'traumatic subarachnoid haemorrhage' resulting from a 'right intracranial internal carotid artery dissection'.

The inquest
The family of Mr Ackerman requested an inquest be held to provide answers to actions in response to the death and to make improvements to player safety.

The inquest examined the circumstances surrounding the on field incident, actions taken by the relevant entities both in response to and after the death to manage risk to player safety

associated with shoulder charges and whether there were any matters about which preventative recommendations might be made.

There was some contention at the inquest as to whether the tackle fell within the definition of a "shoulder charge" within the laws of the game of rugby league.

Findings and comments
The Deputy State Coroner commented that the process that resulted in the penalty against the other player was appropriate and legitimatised the finding that it was a shoulder charge. It was noted that the reluctance to use the send-off process as an aspect of deterrence for should be re-examined.

The Deputy State Coroner also noted that there are a number of legal and policy issues that make the law around sporting related deaths somewhat complex. This included the applicability of workplace health and safety principles and legislation to sporting events, which are vague, especially in the instance of an injury or fatality on a sporting field.

The Deputy State Coroner commented that it would be appropriate for WHSQ to spell out in a policy statement, which activities will be investigated by it and what is seen as outside its jurisdiction and why.

The Deputy State Coroner accepted that the game of rugby league has in recent times endeavoured to implement policies and practices designed to ensure greater safety of the players.

William John House, Vanessa Joan White, Jodie Anne and Daniel Keith Milne – Prescription opioids, drugs of dependence, opioid overdose, oxycodone, fentanyl, Schedule 8 medications, controlled drugs, doctor shopping, prescribing practices, real time prescription monitoring, electronic recording and reporting of controlled drugs

Findings delivered – 21 May 2018

The Southeastern Coroner conducted a joint inquest into these deaths in order to consider the universal and widespread issues associated with the growing misuse of opioid prescription (Schedule 8) medication in Queensland. The deaths of these persons were selected as a representative sample as they were typical of the circumstances in which death often occurs as a consequence of prescription opioid abuse.

The Coroner noted that more than 20 coronial inquests across Australia have considered opioid abuse and, the shortfalls of monitoring measures. This inquest considered broad issues associated with opioid medication misuse, the sufficiency of the monitoring in place in relation to the prescribing and dispensing of Schedule 8 medication as well as the implementation of the Commonwealth Government's initiative, the Electronic Recording and Reporting of Controlled Drugs (ERRCD).

Circumstances of death
William John House was 30 years old when located deceased at his residence. In the dwelling police located multiple prescriptions and medications as well as over 50 syringes capped and

uncapped. The cause of death was determined to be as a result of acute fentanyl toxicity in a man with epilepsy.

Jodie Anne Smith was 41 years old at the time of her death. Mrs Smith was located by her husband lying face down in bed; he had noted that earlier in the morning she had been breathing heavily, and at times, snoring. Police attended and located a substantial number of medications and two sets of prescriptions for OxyContin. The cause of death was established as the combined effects of myocarditis (as caused by viral infection) and the ingestion of a large quantity of medications for Complex Regional Pain Syndrome, for which she had been diagnosed for in 2009.

Vanessa Joan White while celebrating her 38th birthday with her boyfriend, had been injecting OxyContin, taking other medications and drinking throughout the day. Ms White was located deceased the next day by her boyfriend. The cause of death was determined to be as a result of multiple drug toxicity.

David Keith Milne had a long history of illicit drug use. Flatmates of Mr Milne located him deceased with a syringe in the back of his hand; he was 40 years of age. The cause of death was confirmed as acute fentanyl toxicity.

Investigation and inquest
The coroner sought expert opinions from a forensic medical officer, pain medicine specialist and pharmacist in relation to the issues associated with the prescribing, dispensing and monitoring of Schedule 8 medicines in Queensland. Non-party submissions were received from the Australian Medical Association (AMA) and the Royal Australian College of General Practitioners (RACGP). The coroner also considered previous Queensland and interstate coronial recommendations and responses.

Referral and Recommendations
The coroner did not make any referrals about the professional conduct of any of the practitioners involved.

The coroner made the following recommendations:
Queensland Department of Health -

- urgently consider and determine how a real-time prescription monitoring system can be implemented in Queensland at the earliest opportunity, but certainly within the next two years. A determination as to whether the ERRCD is a suitable system to be utilised should be made without delay. If so, the plan to implement such a system, and the necessary changes to legislation and other regulatory requirements, needs to be actioned urgently

- urgently consider what additional steps can be taken to educate general practitioners and pharmacists as to the scope and functions of Medicines Regulation and Quality (MRQ), particularly the availability of advice as to appropriate prescribing practices. Incidences of over-prescribing of opioids, once this education campaign has been completed should be dealt with by professional disciplinary bodies, by regulation.

- consider the suitability of resourcing currently provided to MRQ in order to appropriately perform their regulatory functions in a proactive manner, particularly given the timeframe changes as stipulated in the new S8 Monitoring Strategy.

The Commonwealth Department of Health -

- liaise urgently with all state governments to speed up the introduction nationally of the ERRCD and;

- that consideration be given to legislating the banning of the promotion of prescription opioids to health practitioners by drug manufacturers.

The Royal Australian College of General Practitioners –

- urgently consider what further measures and programs can be introduced through their continuing professional development requirements for general practitioners, to improve education and standards of care in relation to the prescribing of Schedule 8 medicines, and chronic pain management.

The Pharmacy Guild of Australia, the Pharmaceutical Society of Australia and the RACGP –

- liaise with a view to promoting the use of staged supply and other means to reduce the risk of the misuse of prescription medication.

Bethany Emily Farrell – Death by drowning while engaged on introductory scuba dive in Whitsunday Islands, separation of novice diver from instructor and group, poor visibility, adequacy of instruction of deceased, and of lookout by servants of diving company, recommendations as to conduct of future introductory diving excursions, re-establishment of Dive and Snorkelling Death review Panel.

Findings delivered – 30 May 2018

Bethany Emily Farrell was a United Kingdom national who had only been in Australia for six days on a backpacking trip with two friends when she undertook an introductory scuba-dive that led to her death.

Circumstances of the death

The three day/three night diving trip commenced at Airlie Beach in the Whitsundays. There were 34 persons on board the vessel; 28 of them paying passengers. The vessel left its berth at about 1:20pm on 17 February 2015 en-route to Blue Pearl Bay.

The first group of three passengers to undertake an introductory dive included Miss Farrell, her friend and another passenger. The dive briefing conducted was described by the Central Coroner as a ‘brief practical presentation’ and did not assess any practical skills.

Once at Blue Pearl Bay the three divers were taken to the beach in their diving gear to conduct certain elementary diving skills but this did not include proper instruction about how to achieve and maintain positive buoyancy on the surface.

At about 4:00 pm, the group of three and the instructor then made their way underwater when Miss Farrell encountered a positive buoyancy issue (i.e. drifting upwards towards the surface). As a result the instructor placed a three pound weight in the pocket of her BCD to create negative buoyancy.

During the dive, the instructor decided to take a different route to avoid confusion and separate from a certified diver group they had crossed paths with.

The Central Coroner notes that at this time the visibility had deteriorated when the two groups intermingled, perhaps up to five meters at the very best. The instructor had also had to roll

over from her backward seated position, where she could see her divers, to negotiate some coral bommies.

Once turned back the instructor could not see Miss Farrell and immediately commenced to retrace her steps. The Central Coroner concluded from the dive computer profiles that at this time Miss Farrell realised she was separated and commenced ascending quite quickly.

The dive computer records three moments when Miss Farrell was at the surface, likely for a little over 40 seconds.

After about an hour of searching, the instructor located Miss Farrell at a depth of about 10.7 meters. All attempts to revive her were unsuccessful.

The investigation
Workplace Health and Safety Queensland was the lead agency investigating the death and provided a report to the Central Coroner about the various entities and individuals involved in the fatality. The Queensland Police Service (QPS) also conducted an investigation into the circumstances of Miss Farrell's death, which included a re-enactment at the location of the incident.

The inquest
The focus of the inquest was why the death occurred, whether the conditions were suitable for a novice diver, whether a resort dive (dive done by inexperienced persons) should have commenced in confined open water, whether the dive complied with the appropriate Code of Practice and methods of preventing future deaths in similar circumstances.

Findings and comments
The Central Coroner found that Miss Farrell drowned after she had become separated, likely due to poor water visibility and a lack of adequate instructor supervision. The Central Coroner considered the environmental conditions were suitable for novice divers provided appropriate training and supervision occurred.

The Central Coroner found that although the underwater response of the instructor was appropriate; the response undertaken by the tour operator was inadequate, as they did not respond within the critical first moments. The response came from the crew of a nearby vessel.

The Central Coroner found that the tour operator, skipper and instructor failed to adhere a number of principles in the relevant Code of Practice and that introductory divers should first demonstrate competency in a controlled environment.

Recommendations and referral
The Central Coroner made a number of recommendations to the Office of Industrial Relations (OIR), specifically, that within six months they review and consider inclusion of a number of relevant code of practice issues. It was further recommended that the Dive and Snorkelling Death Review Panel be re-instigated.

The Central Coroner formed an opinion that the tour operator, its skipper, its employee and the dive instructor may have committed an offence under workplace laws and therefore made a referral to the OIR for determination.

Higher courts decisions relating to the coronial jurisdiction

Hytch v O'Connell [2018] QSC 75

This decision involved a judicial review application to the Supreme Court by Robert Paul Hytch for orders that three inquest findings in relation to the suspected death of Rachel Antonio, made by the Central Coroner, Mr David O'Connell, be set aside. The application for judicial review was dismissed by Justice Applegarth on 18 April 2018.

In 1997 and early 1998, the applicant, Mr Hytch, then aged 24, and Ms Antonio, a 15 year old schoolgirl, had a secret, intimate relationship. By April 1998, the applicant had "moved on" and was in a relationship with another woman.

On the evening of 25 April 1998, Ms Antonio planned to meet with the applicant at Queens Beach, Bowen to confront him about certain matters. She went there on the pretext of going to the movies, and waited to meet the applicant. Ms Antonio disappeared that night and was never seen again.

Ms Antonio's disappearance was investigated by police and suspicion fell on the applicant as he could not satisfactorily explain his absence during a period of about 30 minutes.

The circumstantial case that the applicant killed Ms Antonio went to a jury trial at which the applicant was convicted of manslaughter. However, due to a misdirection to the jury, his conviction was set aside and a retrial granted by the Court of Appeal. At the second trial, which commenced in 2001, the applicant was acquitted.

Investigations into the suspected death of Ms Antonio continued, and included hearings before the Queensland Crime Commission. The applicant did not give evidence at either criminal trial and was not compelled to give evidence at the Queensland Crime Commission hearings.

In April 2013, the State Coroner directed the Central Coroner to investigate the suspected death of Ms Antonio. An inquest was convened and held on various dates in 2014 and 2015. The Central Coroner was informed by a large number of witness statements, transcripts, and other documents and evaluated the credibility and reliability of the evidence of many witnesses, including the applicant, who gave evidence at the inquest.

The Central Coroner delivered his findings on 28 July 2016, and concluded that;

- Ms Antonio died shortly after 7pm on 25 April 1988 as a result of an altercation with the applicant;
- He then secreted her body; and
- He later disposed of her body.

The applicant sought orders that Central Coroner's findings be set aside based on the following:

- The inquest was heard and determined under the *Coroners Act 2003* when it should have been conducted in accordance with the *Coroners Act 1958*. This limb of the application related to the issue of whether the word "death" in s100(4) of the 2003 Act has its ordinary meaning or whether it should be understood as if it read "death or suspected death".

- The applicant further argued the Central Coroner "erred in law" in making his findings, or that those decisions were an improper exercise of power, as they were not supported by probative evidence. That is, there was no evidence to support the findings.

The Supreme Court did not accept either of the applicant's arguments, and concluded that the Central Coroner:

- had jurisdiction to proceed under the 2003 Act to investigate the suspected death of Ms Antonio and diligently evaluated a large body of circumstantial evidence, including evidence which was not available to the juries at the applicant's criminal trials; and;
- applied the appropriate standard of proof and appreciated a high degree of satisfaction was required before adverse findings could be made.

The court also concluded that:

- a reasonable decision-maker in the coroner's position was entitled to reject key aspects of the applicant's evidence and to conclude the applicant gave deliberately false evidence; and
- each finding had an evident and intelligible justification and each could be reached on the evidence which the Central Coroner accepted.