QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

ANNUAL REPORT 2018-19

15TH ANNIVERSARY EDITION

Acknowledgement of Country

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

We acknowledge the families and friends of those grieving the death of a loved one.
We recognise the distress that can come about from a death entering the coronial system.
We are ever mindful of your loss.

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 2019.

As required by section 77(2) of the Act, the report contains a summary of each death in custody investigation finalised during the reporting period.

The report also contains a summary of other investigations of public interest and the names of persons given access to coronial investigation documents as genuine researchers.

Several updates were made to the guidelines issued under section 14 of the Act during the reporting period. The guidelines are publicly available and can be accessed at: https://www.courts.qld.gov.au/courts/coroners-court.

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

Terry Ryan
State Coroner
17 December 2019

Purpose

This annual report provides information about the financial and performance measures of the court for the period 1 July 2018 to 30 June 2019. It has been prepared under the requirements of the *Coroners Act 2003.*

The report is accessible online at: https://www.courts.qld.gov.au/courts/coroners-court.

Please note: the Coroners Case Management System (CCMS) is a "live" operational database in which records are updated as the status of coronial investigations change and/or input errors are detected and rectified. This constant updating and data verification may result in a slight variance of figures over time.

The content and data contained in this report was correct at the time of publication.

Enquiries and further information

Telephone: (07) 3738 7050

Email: state.coroner@justice.qld.gov.au

Visit: https://www.courts.qld.gov.au/courts/coroners-court.

Feedback

We value your feedback on this report. Any feedback can be provided through the *Get Involved* website: www.qld.gov.au/annualreportfeedback.

WARNING

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

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

A list of support organisations can be found at: https://www.courts.qld.gov.au/courts/coroners-court.

CONTENTS

The year in review

Investigations

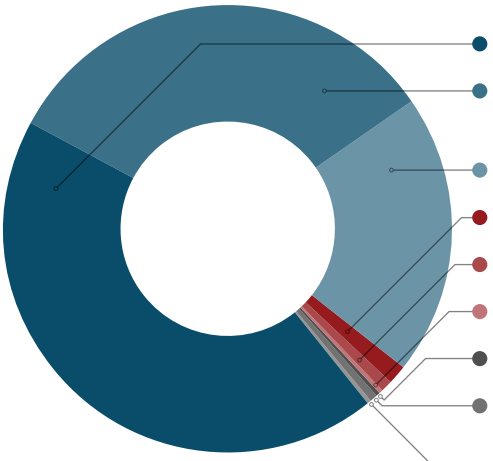
5797
Cases reported

5860
Cases finalised

101.09%
Clearance rate

17.58%
Backlog indicator

Reportable deaths[1]



- **2549** Violent or unnatural deaths
- **1892** Death certificate not issued and not likely to be issued
- **1176** Health care related deaths
- **93** Deaths in care
- **46** Suspicious circumstances
- **17** Deaths in custody
- **11** Unknown persons
- **27** Suspected deaths (missing person)
- **10** Deaths as a result of police operations

Timeframes

175
Average days to finalise

81.41
% finalised in less than 12 months

Inquests and recommendations

29
Inquests held
Represents 0.05% of all cases reported

61
Recommendations made

40
Under consideration[2]

11
Agree/implemented

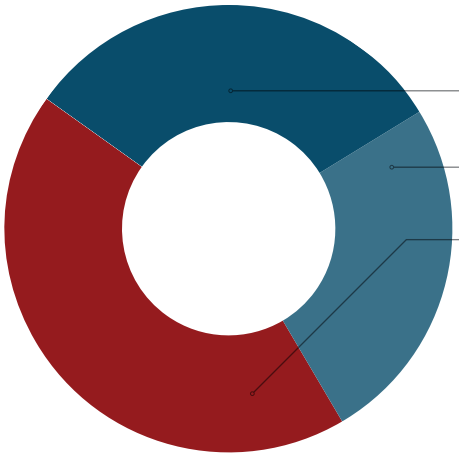
9
Agree/in progress

1
Agree in part/in progress

1 Primary Reportable Type report — may include instances where more than one reportable type selected.
2 Under consideration and/or no response published to date.

Autopsies

2476
Ordered (includes multiple orders)



31.51% Full internal
25.29% Partial internal
43.20% External

$330,585
spent on fee-for-service autopsies

Conveyances by government contracted undertaker

Funeral assistance applications approved

Information requests (finalised matters)

1752
Requests for documents

2
General research enquiries

3
Genuine researchers approved

237
Media queries

STATE CORONER'S OVERVIEW

The 2018-19 Annual Report of the Coroners Court of Queensland marks the fifteenth anniversary of the commencement of the *Coroners Act 2003*. The number of matters finalised by Queensland coroners has increased from 2,423 in 2004-05 to 5,860 in 2018-19.

Since 2011, when Queensland moved to a system where all reportable deaths are investigated by the seven full time coroners, and the coronial registrar, the number of deaths reported each year for investigation has increased by 27 per cent. In the same time there has been no increase in the permanent allocation of judicial officers attached to the court.

A focus for the Court during the 2018-19 financial year has been engagement in the development and implementation of responses to the seven recommendations contained in the Queensland Audit Office's October 2018 Report, *Delivering coronial services Report 6: 2018–19.*

This work was overseen by the Coronial Services Governance Board, which is comprised of senior officers from the Department of Justice and Attorney-General, the Queensland Police Service and Queensland Health, together with the Chief Forensic pathologist, the Deputy State Coroner and the State Coroner. The Board has been established for a period of three years, and I have appreciated the high level of collaboration between the agencies represented on the Board and the Court in responding to the challenges identified in the QAO Report.

The support provided by the Queensland Government in allocating additional resources to the coronial system in 2018-19 produced tangible benefits in terms of better support for bereaved families during coronial investigations and an improvement in the CCQ's clearance rate.

While the number of deaths reported to the CCQ remained relatively stable, with 5,797 deaths reported, during 2018-19 the court cleared 5,860 matters, the largest number of matters cleared in the court's history. The court's clearance rate was 101.09%.

A large number of the deaths that are reported to coroners each year do not need to be the subject of a detailed judicial investigation by a coroner. This is reflected in the fact that autopsy examinations were ordered for only 2,427 (42%) of the deaths reported.

In responding the QAO Report, priority is being given to the early identification of cases that can be diverted from the coronial system, particularly apparent natural cause deaths reported by police, and deaths reported by health care practitioners. Together, those categories of death constituted 53% of the deaths that were reported in 2018-19.

Health care related deaths made up 20% of the total number of deaths reported in 2018-19. Most of those deaths are reported using the Form 1A process. Many are subsequently determined not to be reportable following a review by the coronial registrar, often with the assistance of the Clinical Forensic Medicine Unit in Queensland Health. By contrast, in Victoria in 2018-19 only 5.2% of reported deaths were identified as being due to medical or surgical complications.

There is obviously scope to examine why apparent natural cause and health care related deaths are entering the system in disproportionate numbers. This would result in a decrease in the extent of unnecessary reporting, alleviate pressure on the limited resources available to the coronial system as a whole, and prevent distress caused to bereaved families as a consequence of unnecessary engagement with the system.

In conclusion, I take this opportunity to thank the front line staff from the Queensland Police Service, Queensland Ambulance Service, Queensland Health Forensic and Scientific Services and within the court.

They respond professionally each day to sudden and unexpected deaths across the State with compassion and dedication. In particular, I acknowledge the contribution of the long serving court staff, many of whom have served the court since its inception. They are recognised within the body of this report. I also acknowledge my fellow coroners and thank them for their support and ongoing dedication to the work of the court in independently investigating and preventing deaths.

Terry Ryan
State Coroner

ABOUT THE CORONERS COURT OF QUEENSLAND

- OUR CORONERS

BRISBANE CORONERS

Mr Terry Ryan – State Coroner

Mr Terry Ryan was appointed to the position of State Coroner for a second term of five years on 5 July 2018. The State Coroner is responsible for coordinating and overseeing the coronial system to ensure it is administered efficiently, and that investigations into reportable deaths are conducted appropriately.

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 may also issue guidelines under s. 14 of the Coroners Act[1] 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 chairs the Domestic and Family Violence Death Review and Advisory Board (the Board). 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[2].

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

During 2018-19, 58[3] deaths were reported to the State Coroner for investigation; this included two directions (one to investigate and one to re-open an inquest) from the Attorney-General and Minister for Justice. The State Coroner also finalised 13 inquests and finalised 40 investigations without proceeding to inquest. Most notably the State Coroner finalised the inquest into the suspected death of Daniel Morcombe who disappeared in December 2003 and the death in custody of Hamid Khazaei, an asylum seeker detained under the *Migration Act 1958* (Cth).

The State Coroner also has a review function under the 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 2018-19, the State Coroner received 17 applications in this regard and finalised 20 matters of this nature.

[1] The State Coroners Guidelines 2013 can be accessed: - http://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/resources-and-legislation .

[2] 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.

[3] The 'reported' and 'finalised' figure for each coroner in this section does not include the number 'reported' or 'finalised' by other coroners acting throughout the period in their designated region.

Mr John Lock – Deputy State Coroner

Mr Lock was appointed as a coroner in January 2008 and to the position of Deputy State Coroner in July 2013. He was re-appointed for a second term of five years ending 9 March 2023. 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.

During 2018-19, 600 deaths were reported to the Deputy State Coroner for investigation. The Deputy State Coroner finalised seven inquests and finalised 567 investigations without proceeding to inquest.

Of particular note, Deputy State Coroner Lock finalised the inquests into the death of Lucas Tran, a five month old boy who died in the care of Family Day Care Educators and Marcia Maynard, in which comments and recommendations about funding counselling support for families and witnesses involved in a coronial investigation and inquest were made.

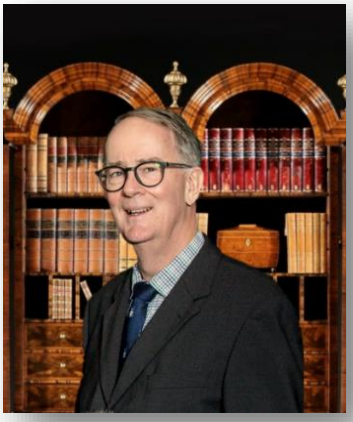
Ms Christine Clements – Brisbane Coroner

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

During 2018-19, 464 deaths were reported to Coroner Clements for investigation. Coroner Clements finalised one inquest and finalised 452 investigations without proceeding to inquest.

During the reporting period Coroner Clements finalised the inquest into the death of Andrew Thwaites, a recreational diving incident that occurred off Moreton Island, which required consideration of technical expert evidence in relation to diving and hyperbaric medicine and breathing air compressors and systems.

Mr Graeme Lee – Brisbane Coroner



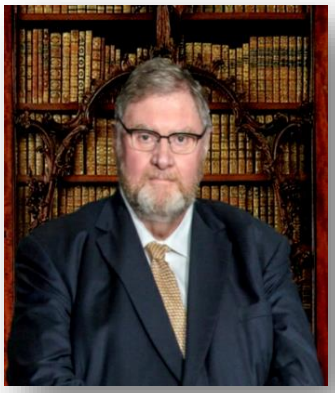
Mr Lee was appointed as a Brisbane Coroner on 6 November 2017. During 2018-19, 603 deaths were reported to Coroner Lee for investigation.

Coroner Lee finalised one inquest and finalised 626 investigations without proceeding to inquest.

Coroner Lee finalised the inquest into the death of Joseph Scaturchio, an experienced jet-ski rider who died competing the Australian Watercross Nationals on the Gold Coast.

At the end of this reporting period the CCQ farewelled Coroner Lee as he returned to the general magistracy on 1 July 2019.

REGIONAL CORONERS



Mr James McDougall – Southeastern Coroner

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

During 2018-19, 479 deaths were reported to Coroner McDougall for investigation. Coroner McDougall also finalised one inquest and finalised 536 investigations without proceeding to inquest.

Coroner McDougall finalised the inquest into the death of Renae Mann who died of a suspected overdose of amitriptyline; the inquest investigated the care and treatment provided to her following admission at the Gold Coast University Hospital. During this reporting period Coroner McDougall presided over a substantial number of hearing days in relation to the Dreamworld inquest in which four people died on a theme park ride.

Mr David O'Connell – Central Coroner

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

During 2018-19, 523 deaths were reported to Coroner O'Connell for investigation. Coroner O'Connell also finalised three inquests and finalised 533 investigations without proceeding to inquest.

Coroner O'Connell finalised a part heard 1988 adjourned inquest into the violent murder of Bryan Hodgkinson, in which comments about the continued application of the *Coroners Act 1958* were made. The inquest into the death of Michael Wills, who was involved in an unwitnessed fatal helicopter crash in Barcaldine was also finalised.

Ms Nerida Wilson – Northern Coroner

Ms Wilson based in Cairns, investigates 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 who is based in Cairns.

During 2018-19, 508 deaths were reported to Coroner Wilson for investigation. Coroner Wilson also finalised two inquests and finalised 307 investigations without proceeding to inquest. Of note, Coroner Wilson finalised the Holly Brown inquest and recommended 'Holly's Law' a protocol for out of hospital emergency medical response be established. An inquest to determine the cause Mrs Stella Hamilton's death, an aged care facility resident in a secure dementia wing was also finalised. All evidence into the triple fatality skydiving deaths at Mission Beach was also completed during the period.

OUR CORONIAL REGISTRAR

Ms Ainslie Kirkegaard

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. The coronial registrar also provides telephone advice to clinicians during business hours about whether or not it is appropriate to issue a cause of death certificate.

During 2018-19, 2,417 deaths were reported to the coronial registrar and the deputy registrar for investigation with 2,390 investigations finalised.

Ms Kirkegaard also acted as a coroner, and finalised one inquest during the reporting period. The inquest involved the health care related death of Joshua (Joshie) Statis, a 12 year old boy who died unexpectedly at the Queensland Children's Hospital (formerly known as the Lady Cilento Children's Hospital) 18 days after cardiac surgery. The inquest identified shortcomings in clinical communication documentation practices within the Queensland Paediatric Cardiac Service.

'DELIVERING CORONIAL SERVICES'

– Queensland Audit Office Report 6: 2018-19

A major focus of the court during the reporting period was responding to the Queensland Audit Office (QAO) report[4] which was tabled in the Queensland Parliament on 18 October 2019. The performance audit of the delivery of Queensland's coronial services was commenced in February 2018 in accordance with section 37A of the *Auditor-General Act 2009*.

The objective of the audit was to assess the performance of the key agencies involved in delivering coronial services; the Department of Justice and Attorney-General (DJAG), the Queensland Police Service (QPS) and Queensland Health (QH), and the support provided by these agencies to coroners and families.

The performance audit assessed information between the period 2011-12 and 2017-18.

PERFORMANCE REVIEW - SUMMARY

The audit report noted that Queensland's coronial system is complex, with each agency playing a key role in the supporting coroners in investigating and helping to prevent future deaths. The report acknowledged the dedication and goodwill of its staff and partner agencies in supporting coroners and families despite resourcing issues and an increasing number of lodgements.

Although the State Coroner is legally accountable for overseeing the efficiency of the system, the report highlighted the role has limited functional control over the resources needed, no one agency is responsible for the coordination of the system or management of a death from start to finish, and QPS and QH have other accountabilities, meaning delivering coronial services isn't their core business.

The report made reference to the work being undertaken to improve triage practises to reduce the number of deaths proceeding to full investigation. However, noted there needed to be a more coordinated and systematic approach to the triage process to realise efficiencies.

The auditors found that communication provided to bereaved families during the initial report of a death was sufficient but was either inconsistent or inadequate as an investigation proceeded. Tied to this, workforce planning and training, particularly for the courts case management staff, was found to be lacking.

Performance monitoring of government undertakers was noted to be variable despite documenting performance expectation in their contracts. A review of the funeral assistance scheme found that assessments of applications lacked rigour and the auditors made reference to the constraints of the Burials Assistance Act in relation to the monetary recovery process that DJAG undertakes.

Queensland's coronial system was described as *"under stress and is not effectively and efficiently supporting coroners or families".*

THE QAO RECOMMENDATIONS

To improve coronial services and the support provided to coroners and families, the QAO report made seven recommendations. The agencies accepted all recommendations made by the QAO, those being:

RECOMMENDATION 1:

The Department of Justice and Attorney-General, in collaboration with the Department of Health, Queensland Police Service, the Department of Premier and Cabinet, and the coroners establish effective governance arrangements across the coronial system by:

- creating a governance board with adequate authority to be accountable for coordinating the agencies responsible for delivering coronial services and monitoring and managing the system's

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

performance. This board could be directly accountable to a minister and could include the State Coroner and Chief Forensic Pathologist;

- more clearly defining agency responsibilities across the coronial process and ensuring each agency is adequately funded and resourced to deliver its services; and
- establishing terms of reference for the interdepartmental working group to drive interagency collaboration and projects, with consideration of its reporting and accountability. This should include its accountability to the State Coroner and/or a governance board if established.

RECOMMENDATION 2: The Department of Justice and Attorney-General, in collaboration with the Department of Health, Queensland Police Service, the Department of Premier and Cabinet, and the coroners evaluates the merits of establishing an independent statutory body with its own funding and resources to deliver effective medical services for Queensland's justice and coronial systems.

RECOMMENDATION 3: The Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners improve the systems and legislation supporting coronial service delivery by:

- identifying opportunities to interface their systems to more efficiently share coronial information, including police reports (form 1s), coroners orders and autopsy reports;
- reviewing the *Coroners Act 2003* to identify opportunities for improvement and to avoid unnecessary coronial investigations. This should include considering the legislative changes to provide pathologists and coronial nurses with the ability to undertake more detailed preliminary investigations (such as taking blood samples) as part of the triage process; and
- reviewing the *Burials Assistance Act 1965* and the burials assistance scheme to identify opportunities for improvement and provide greater ability to recover funds. This should include a cost benefit analysis to determine the cost of administering the scheme against improved debt recovery avenues.

RECOMMENDATION 4: The Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners improve processes and practices across the coronial system by:

- ensuring the Coroners Court of Queensland appoints appropriately experienced, trained and supported case managers to proactively manage entire investigations and be the central point of information for families. This should include formal agreement from all agencies of the central role and authority of these investigators;
- ensuring there is a coordinated, statewide approach to triaging all deaths reported to coroners to help advise the coroner on the need for autopsy;
- establishing processes to ensure families receive adequate and timely information throughout the coronial process. This should include notifying families at key stages of the process and periodically for investigations that are delayed at a stage in the process; and
- ensuring sufficient counselling services are available and coordinated across agencies to support families and inquest witnesses.

RECOMMENDATION 5: The Department of Justice and Attorney-General, Department of Health, and the Queensland Police Service, in collaboration with coroners assess more thoroughly the implications of centralising pathology services and determine which forensic pathology model would have the best outcomes for the system, coroners, and regions, and the families of the deceased.

RECOMMENDATION 6: The Department of Justice and Attorney-General implements a strategy and timeframe to address the growing backlog of outstanding coronial cases. In developing and implementing this strategy it should collaborate with the Department of Health, Queensland Police Service, and coroners.

RECOMMENDATION 7: The Department of Justice and Attorney-General improve the performance monitoring and management of government undertakers. This should include taking proactive action to address underperformance where necessary in accordance with the existing standing offer arrangements.

THE CORONIAL SERVICES GOVERNANCE BOARD

The Coronial Services Governance Board (the Board), established in December 2018 is leading implementation of the recommendations. Board members include the State Coroner, the Deputy State Coroner, Queensland Health's Chief Forensic Pathologist, and other senior representatives from the Queensland Police Service, Queensland Treasury and the Department of the Premier and Cabinet.

The purpose of the Board is to provide greater leadership, governance and accountability over the delivery of coronial services and drive system-wide planning to progress implementation of the recommendations. The Board is supported by a Project Director who with members of the QPS and QH provides secretariat, policy and research assistance.

During 2018-19 the Board determined due to the scope of the reforms and collaborative system-wide planning required to effectively implement the recommendations; a staged approach over three financial years be progressed, in summary:

- Phase 1 (2018-19): Planning our approach
- Phase 2 (2019-20): Designing a responsive system
- Phase 3 (2020-21): Sustainability for the future

During the first phase the Board developed the *Coronial Services Reform Framework*. The framework structures how the respective agencies will work together to implement the recommendations across four identified priority areas which align to the recommendations. The priority areas being:

1. enhancing triaging practices to divert not-reportable deaths from the system and ensure coronial resources are allocated to more complex investigations;
2. strengthening the case management, legal and counselling support provided to coroners and families;
3. enhancing structural supports through improving the management of government undertaker contracts and administration of the Burials Assistance Scheme; and
4. driving system innovation, through developing a sustainable state-wide model for forensic pathology services, and a service delivery framework to guide how agencies deliver services to coroners and families.

Significant achievements in the first phase included the establishment of a Triage Working Group (relevant to recommendation 4(b) of the QAO report). The group focused on refining reporting pathways for natural causes deaths and developing a coordinated, state-wide approach to triaging all deaths reported to a coroner.

An Information and Technology Group was also established (relevant to recommendation 3(a) of the QAO report) which concentrated on identifying opportunities to interface partner agencies systems to share coronial information such as police reports, coroners orders and autopsy reports, more efficiently.

Just following the reporting period, the 2019-20 Palaszczuk Government invested in coronial services, providing an additional $3.9 million over the next four years (including $474,000 per annum ongoing). The funding has been allocated to DJAG, the QPS and QH to address immediate demand pressures and to support the implementation of recommendations made by the QAO.

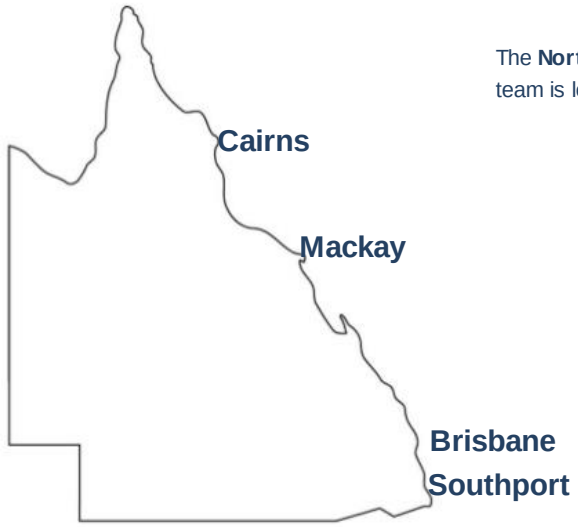
Most significant to the Board's first phase was funding for the establishment of a second coronial registrar (referred to as a deputy registrar) and supplementary support staff (two coronial services officers, a coronial nurse and forensic physician in QH and senior constable in QPS) up until 31 December 2020. This team will triage all apparent natural cause deaths reported by the QPS, one of the largest categories of death reported to the Coroners Court of Queensland (CCQ). The key objective of this trial is to better support families through minimising unnecessary contact with the coronial system and to ensure coroners have a greater capacity to focus on more complex investigations.

The progression of the QAO report recommendations over the next few years will result in further significant change for the court and its staff, its partner agencies, and other interested stakeholders. It is envisaged that the work of the Board will develop long term solutions to current system pressures and enable the system to deliver coronial services effectively and efficiently into the future.

- OUR LEADERSHIP, STRUCTURE AND STAFF

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

At 30 June 2019, the CCQ under the leadership of Director, Dan Matthias, comprised 55 staff members providing legal and administrative support (not inclusive of coroners and the coronial registrar) across the state.



The **Northern Coroner** and her inquest and investigation team is located in the Cairns Magistrates Court

The **Central Coroner** and his inquest and investigation team is located in the Mackay Magistrates Court

The **Brisbane Coroners** and their inquest and investigation teams, Business Services and the Domestic and Family Violence Death Review Unit team are located in the Brisbane Magistrates Court

The **Southeastern Coroner** and his inquest and investigation team are located in the Brisbane and Southport Magistrates Court

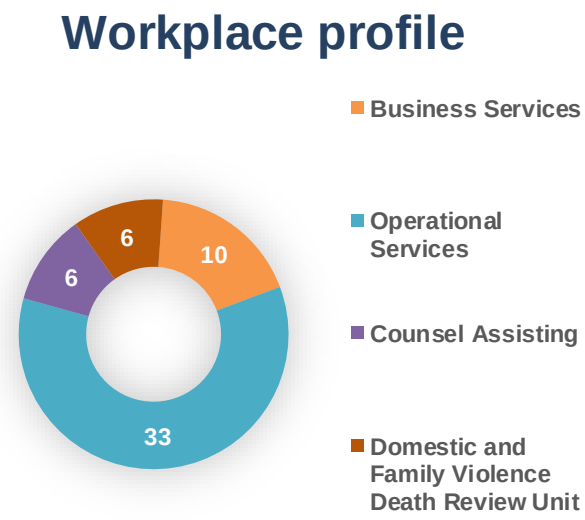
During the 2018-19 reporting period the staff were aligned to four streams each led by a senior manager:

Business Services: supports the corporate governance and operation of the court through finance, information technology, data collation, communications, human resource and contract management functions.

Operational Services: comprises of the coronial services and investigations officers who work closely with coroners and liaise with families and other stakeholders to case manage files.

Counsel Assisting: assists coroners in their investigations by reviewing case files, preparing findings and matters for inquest, as well as appearing as counsel assisting at inquests.

Domestic and Family Violence Death Review Unit: provides expert advice and assistance to coroners in their investigation of domestic and family violence related homicides and suicides.

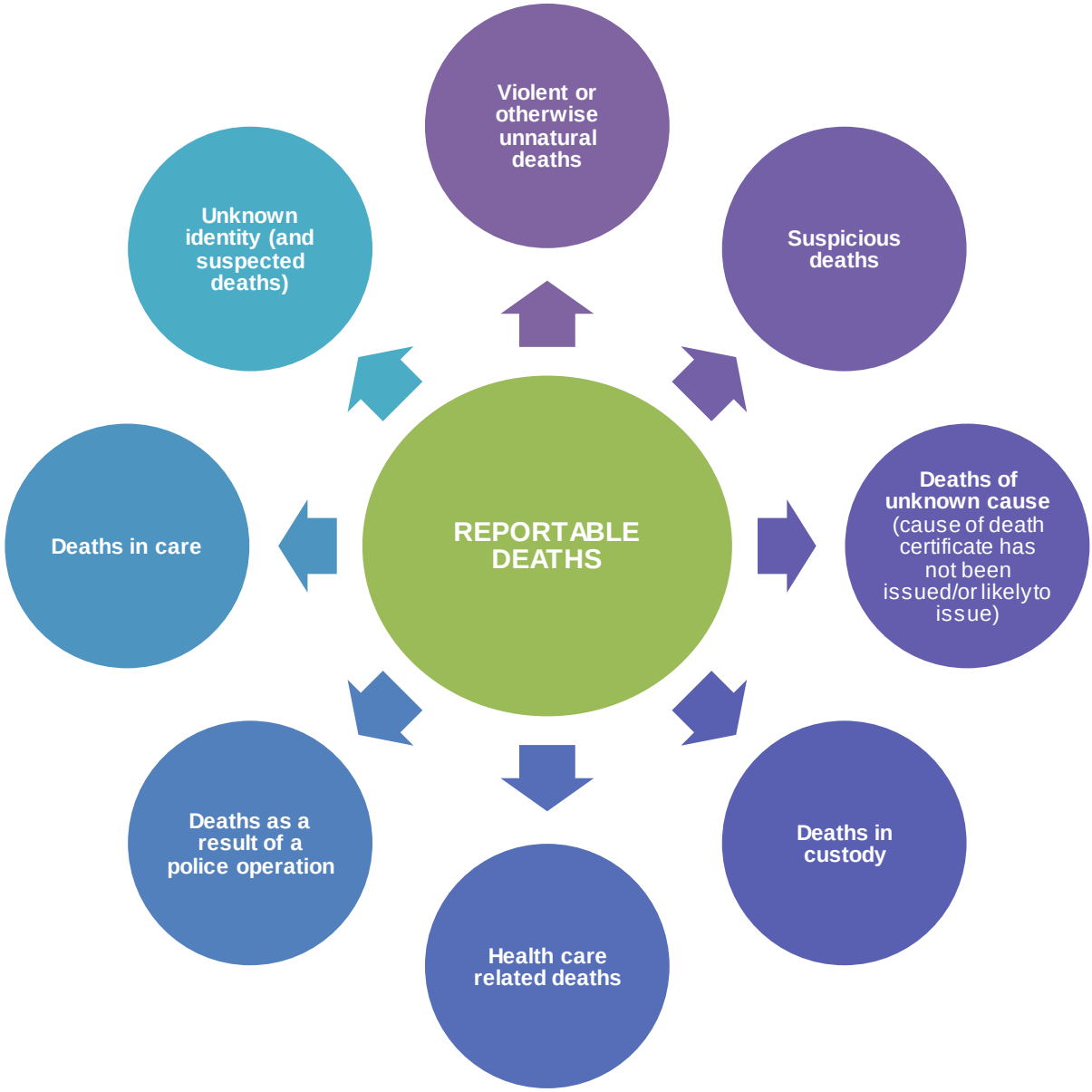


THE QUEENSLAND CORONIAL SYSTEM

- THE SCOPE OF THE CORONER'S ROLE

Queensland's coronial jurisdiction is established and governed by the *Coroners Act 2003*. It is focused on the investigation of ***'reportable deaths'***. Reportable deaths 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.

The Coroners Act provides that reportable deaths, as defined in section 8 of the Act, must be reported to a coroner for investigation. Section 7 of the Act also requires anyone who becomes aware of an apparent reportable death, to report it to either the police or to a coroner. In general terms, reportable deaths can be classified into eight categories.[5]



[5] Refer to Chapter 3 'Reporting Deaths' for further information on categories of reportable deaths - https://www.courts.qld.gov.au/__data/assets/pdf_file/0013/206122/osc-state-coroners-guidelines-chapter-3.pdf

Unknown identity

Even if nothing about the death is suspicious, the death of a person with unknown identity must be reported to a coroner. Various means such as fingerprints, photographs, dental examinations or DNA can be used to identify the person.

A coroner also has jurisdiction to investigate a suspected death e.g. missing person. Suspected deaths are reported when there is reason to suspect the person is dead.

Suspicious circumstances

Suspicious deaths are reported to coroners to enable their circumstances to be investigated. If police consider there is sufficient evidence to prefer criminal charges in connection with the death they may do so. In these cases, the coronial investigation is postponed until those charges are resolved.

Violent or unnatural

A death is violent or unnatural if caused by accident, suicide or homicide rather than a disease's natural progression. Car accidents, falls, drowning, electrocutions, drug overdoses, and industrial and domestic accidents are all reported to coroners.

These deaths are reportable even if a delay occurs between the incident causing injury and the death, as long as the injury caused or contributed to the death and the person wouldn't have died without the injury.

Death in custody

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

Death as a result of a police operation

A death occurring in the course of, or as a result of police operations may include the death of an innocent bystander while police are attempting to detain a suspect.

Cause of death certificate is unlikely to be issued

Medical practitioners must issue a cause of death certificate if they can form an opinion as to the probable cause of death, taking into account what they know about the person's medical history and circumstances of their death. There is no requirement for them to have treated the person or have seen them in a certain timeframe. If they can't, they must report the death to the coroner to determine the medical cause of death.

Death in care

Deaths of certain vulnerable people in the community (namely children in care, involuntary mental health patients, and people with disabilities with high support needs who lived in funded supported accommodation arrangements) are reportable deaths, whatever the cause of death may be or where it occurred[6].

Health care related death

Broadly, this category refers to a health procedure, or any care, treatment, advice, provided for the benefit of human health. A health procedure includes dental, medical, surgical, diagnostic or other health-related procedure, including anesthetic or other drug.

Deaths relating to health care include deaths due to a failure to treat or diagnose, and clinical or medication incidents and errors.

A death is health care-related if both:

- health care, or failure to provide health care, caused or contributed to the death; and/or
- before the health care was provided, an independent person (qualified in health care) wouldn't have expected the health care to cause or contribute to the death, or for the death to occur at that time.

[6] On 1 July 2019 the definition of 'death in care' was amended in section 9 of the *Coroners Act 2003*.

State-wide demand for coronial services has increased significantly with reported deaths increasing from:

3,514 in 2007-08 to 5,797 in 2018-19

Representing 64.97% increase in deaths reported

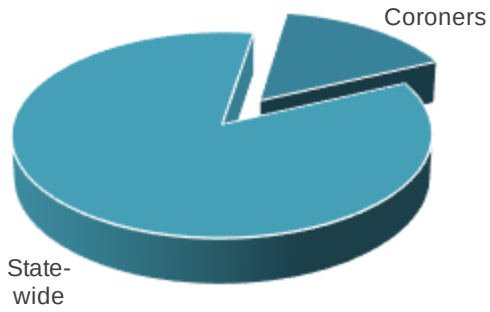
The increase in lodgements to the court is a result of a number of factors including, a growing and ageing population, improved awareness of practitioner coronial reporting obligations, increased family expectations and legislative changes to the types of deaths that are required to be reported to a coroner. Deaths investigated by coroners make up only a small percentage of all deaths in the community.

The 5,797 deaths reported to Queensland coroners represent only 18.47% of the 31,386 deaths registered in Queensland in 2018–19.

A coroner who is investigating a death (or suspected death) must, if possible, 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 so, 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.

Total deaths registered in Queensland



The coroner's statutory role

- who the deceased person is;
- how the person died;
- when the person died;
- where the person died; and
- what caused the person to die

A coronial investigation is an independent, impartial, open and transparent inquisitorial process. The 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. 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.

- FUNERAL ASSISTANCE

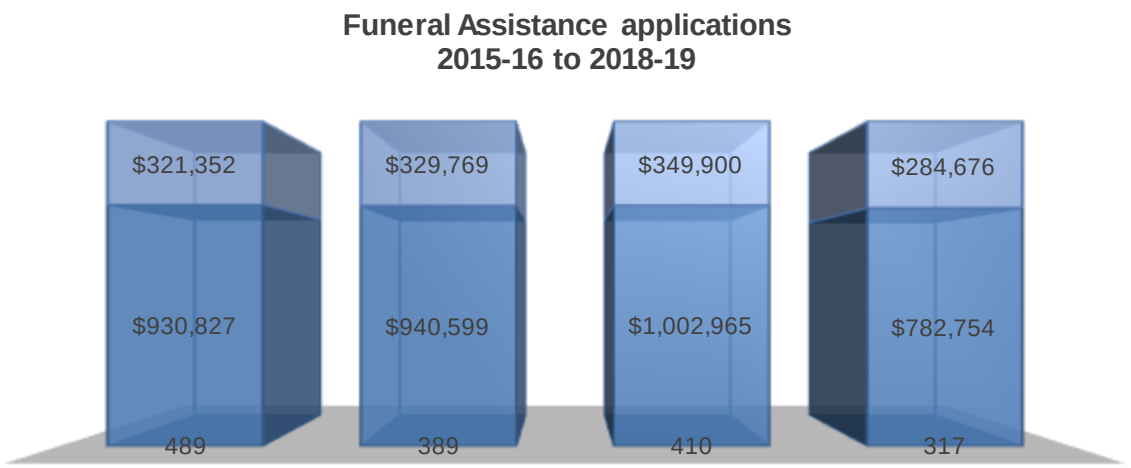
In the interests of public health the *Burials Assistance Act 1965*[7] requires the Department of Justice and Attorney-General (DJAG) to organise a simple burial or cremation of any deceased person whose estate cannot cover the funeral costs and whose relatives and friends cannot arrange or pay for their funeral. This service is called Funeral Assistance.

The CCQ is responsible for the administration of the funeral assistance scheme throughout the state. The scheme provides for a basic funeral (cremation or burial) - it is not a monetary grant. Eligibility is based on a set list of criteria which must be met before an application is approved.

During 2018–19, 317 applications (decrease from 410 in 2017-18) for funeral assistance were approved state-wide at a cost of $782,754.

DJAG pursuant to section 4A of the Burials Assistance Act is entitled to recover monies from the estate of the deceased, similar to any other debt. If a relative or friend becomes aware of any monies belonging to the deceased's estate they must advise the department. The recovery of outstanding monies however is constrained by conditions in the Burials Assistance Act for e.g. definitions of 'relative' exclude certain family members.

During 2018-19, CCQ recovered $284,676 or 36.37% of this expenditure from the estates of the deceased.



	2015-16	2016-17	2017-18	2018-19
Expenditure recovered	34.52%	35.06%	34.89%	36.37%
Amount recovered	$321,352	$329,769	$349,900	$284,676
State-wide cost	$930,827	$940,599	$1,002,965	$782,754
Appoved	489	389	410	317

In response to the QAO report which recommended DJAG *"tighten the approval process for funeral assistance applications"* an in-house project to review the funeral assistance scheme was initiated during the reporting period by the CCQ. The project is ongoing and to date has involved consultation with Magistrates Courts Service registry staff across the state, and an initial review of the associated guidelines, forms and templates.

The CCQ also commissioned an independent cost-benefit analysis of the scheme. It is expected that proposed enhancements to better support families and others accessing the scheme will be rolled out during 2019-20.

[7] *Burials Assistance Act 1965* - https://www.legislation.qld.gov.au

- GOVERNMENT CONTRACTED FUNERAL DIRECTORS

When a death is reported to a coroner under the Coroners Act the body must be transferred from the place of death to the place where the autopsy will be conducted, then returned to the place of death (unless specified). As noted, under the Burials Assistance Act the Director-General is required to take steps to bury or cremate a deceased person where it appears that no suitable arrangements are being made. For this purpose, the state is divided into 77 local government area boundaries (see Appendix 1).

In early 2018, DJAG finalised a competitive two stage tender process for the renewal of these contracts known as standing offer arrangements (SOA) in relation to the conveyance of human remains (known as Service A) and the burial or cremation of deceased persons (known as Service B). DJAG has SOA with 33 with funeral directors across Queensland. The majority of new contracts commenced on 1 February 2018 and are in effect until 31 January 2021 (with an option to extend for a further two years).

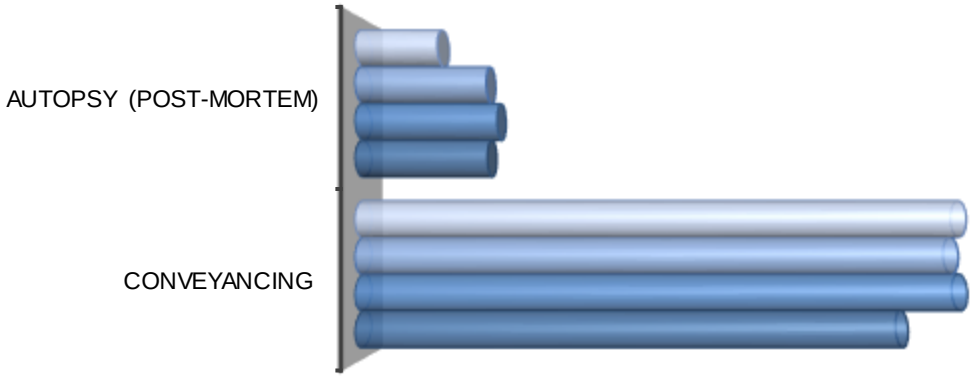
The management of the government contracted funeral directors rests with the CCQ. As a result of recommendations from the QAO to improve the performance monitoring and management of government undertakers, the CCQ established a temporary position dedicated to this function during the reporting period.

- CONVEYANCING AND AUTOPSIES

The conveyance of bodies for coronial autopsy is a necessary requirement and coroners are mindful of the concern and distress some families may experience in having their loved one transported across the state. However, it also represents a significant cost to Queensland's coronial system. The cost is primarily related to annual increases in reportable deaths, the state's dispersed geography and fewer regional pathologists and local mortuaries, which in turn requires multiple conveyances or long haul transport for some bodies to get to a site of autopsy.

During 2018-19, CCQ expended $330,585 on fee-for-service autopsies and $2,446,973 on the conveyance of bodies for coronial autopsy.

Conveyancing and Autopsy costs



	Conveyancing	Autopsy (post-mortem)
2018-19	$2,446,973	$330,585
2017-18	$2,415,436	$526,546
2016-17	$2,451,908	$570,247
2015-16	$2,214,760	$531,538

MEASURING CORONIAL PERFORMANCE & OUTCOMES

- SUMMARY OF ACHIEVEMENTS

CLEARANCE RATES

In 2018–19, 5,797 deaths were reported to the CCQ. Compared to the total numbers of deaths reported in 2017–18, this represents a slight decrease of 15 deaths or 0.26% of lodgements.

Despite only a slight decline in lodgements and increasing complexity of cases, **the court finalised 5,860 matters achieving a clearance rate of 101.09% which exceeded the SDS target.**

Following a review of medical records and circumstances of death, many matters reported to coroners are found to be not reportable or reportable but not requiring autopsy and further investigation. **During 2018–19, of the deaths finalised 2,188 (37.34%) 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 or coronial registrar 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, obtaining advice from doctors at the Clinical Forensic Medicine Unit (CFMU), discussing treatment with family members and liaising with funeral directors. Significant work is often involved in determining whether these matters are reportable.

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 (SDS target) for coroners' courts is that no lodgements pending completion are to be more than 24 months old

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 an increase in the overall number of pending cases (2,548) during the reporting period (up from 2,113 as at 30 June 2018) **but a decrease in the backlog indicator from 18.4% to 17.58%.**

As at 30 June 2019, 448 or 17.58% of pending matters were more than 24 months old.[8] This figure exceeds the national benchmarking target of 0 percent; largely due to the volume of lodgements and the more rigorous investigation required under the Coroners Act.

The finalisation of a coronial investigation can also depend on the completion of autopsy, toxicology and police reports. Dependent on the circumstances of the death, coroners may also be required to await the outcome of other expert investigations and criminal proceedings.

[8] The national average in 2017-18 was 15.8%

Table 1: Overall performance for 2018–19

	Brisbane	Northern	Central	South Eastern	Total
Number of deaths reported to coroner	3,842	716	745	854	**5,797**
Number of Coronial Cases finalised	3,511	646	732	971	**5,860**
Inquest held **this figure represents inquests finalised*	23	2	3	1	**29**
Number of Coronial Cases pending	1,182	708	244	414	**2,548**
Less than or equal to 12 months old	751	377	184	216	**1,528**
Greater than 12 and less than or equal to 24 months old	240	216	29	87	**572**
Greater than 24 months old	191	115	31	111	**448**

Table 2: Number of deaths reported by type[9]

	Brisbane	Northern	Central	South Eastern	Total
Suspected death (missing person)	8	8	7	4	**27**
Death in custody	17	0	0	0	**17**
Death as a result of police operations	15	0	0	0	**11**
Death in care	78	9	10	6	**93**
Health care related death	733	114	213	117	**1,176**
Suspicious circumstances	23	10	13	6	**46**
Violent or unnatural	1,637	337	299	280	**2,549**
Death certificate not issued and not likely to issue	1,046	258	226	380	**1,892**
Unknown persons	3	2	4	2	**11**
TOTAL	**3,560**	**738**	**772**	**873**	**5,821**

[9] The Coroners Case Management System (CCMS) is a "live" operational database in which records are updated as the status of coronial investigations change and/or input errors are detected and rectified. This constant updating and data verification may result in a slight variance of figures over time. These figures were correct at the time of reporting. The total *Reportable Type* maybe different from *the total number of cases lodged*, as multiple Reportable Types maybe selected on a case in the CCMS.

Table 3: Performance statistics 2012–2018

Year	Cases reported	Percent change	Cases finalised	Clearance rate	Backlog	Inquests held
2011–12	4,461	1%	4,771	106.9%	14%	81
2012–13	4,762	6.74%	4,999	105.0%	10.2%	66
2013–14	4,682	-1.67%	4,909	104.8%	12%	49
2014–15	4,962	5.98%	4,638	93.5%	11.9%	78
2015–16	5,287	6.54%	5,313	100.5%	13.6%	49
2016–17	5,587	5.67%	5,014	89.7%	16.6%	30
2017–18	5,812	4.02%	5,618	96.66%	18.43%	52
2018-19	**5,797**	**-0.26%**	**5,860**	**101.09%**	**17.58%**	**29**

KEY COMPONENTS OF THE 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 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 Coronial Services Governance Board.

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.

Temporary senior project and research officer positions are currently embedded within the Domestic and Family Violence Death Review Unit (DFVDRU) and the Secretariat to the Coronial Services Governance Board addressing recommendations derived from a 2018-19 QAO report into Coronial Services in Queensland.

Key initiatives undertaken by QPS CSU during 2018–19 include:

- continuation and support of a temporary Detective Senior Sergeant position attached to the DFVDRU located in the CCQ;
- 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 (*Police Report of a death to a Coroner*) on a mobile device at the scene providing more detailed and timely reporting;
- 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 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. Deputy Chair of the Australia and New Zealand Disaster Victim Identification Committee;
- 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 QAO addressing ways to improve the triaging process of non-suspicious, natural causes deaths; and
- 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 and the coronial registrar.

Coronial autopsies are performed in coronial mortuaries located at 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 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 2018–19 reporting period, the Communication Services Branch received 237 media enquiries, up from 220 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[10].

[10] Refer to State Coroners Guidelines 2013 - Chapter 11 'Memoranda of Understanding' for further information - https://www.courts.qld.gov.au/courts/coroners-court.

Innovation in coronial practice

The first fifteen years 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 2018 - 19, 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 Coronial Registrar

The Coronial 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 2,417 deaths were reported to the registrar[11], representing 41.69% of the total deaths reported state-wide.

Between them, the registrar and deputy registrar finalised 2,390 matters within the reporting period. This represents 40.78% of the total 5,860 matters finalised State-wide.

[11] A number of deaths not included in this figure were initially reported to the coronial registrar and deputy registrar but on review transferred to a coroner as they were outside their delegation. These deaths are recorded against the relevant coroner they were transferred to.

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 2018-19

	Total deaths reported state wide	Total deaths reported into Brisbane	Total deaths finalised by Registrar
2012–13	4,762	2,708	1,265
2013–14	4,682	2,795	1,537
2014–15	4,962	2,991	1,466
2015–16	5,287	3,247	1,931
2016–17	5,587	3,364	2,070 (state wide)
2017–18	5,812	3,445	2,189
2018-19	**5,797**	**3,842**	**2,390**

Apparent natural causes deaths

During 2018-19, 1,550 police reports of apparent natural causes deaths were received state-wide, representing 47.14% 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 932 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 previous 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 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	878 (decrease from 893)
Northern	112 (decrease from 134)
Central	107 (same as 107)
South Eastern	170 (decrease from 197)
TOTAL	1,267 (decrease from 1,331)

The number of deaths reported by the Form 1A process represent approximately 21.86% of the total deaths reported during the reporting period (decrease from 23% in 2017-18).

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 (till the 2017-18 reporting period) the state-wide usage of this process over the past decade. During the 2018-19 period there was a slight decrease in the number of deaths reported by the Form 1A process which is likely a result of improved practitioner awareness and clinical education initiatives by the coronial registrar, including the provision of telephone advice to clinicians (see Table 7).

Deaths reported directly by funeral directors are managed by the registrar using the same process. In 2018–19, 51 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
2018-19	**1,267**	**878**

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 2018-19, 1,246 deaths were reported in this way and determined to be not reportable. This represents 21.49% 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	875 (up from 734)
Northern	107 (up from 103)
Central	146 (up from 77)
South Eastern	118 (up from 55)
TOTAL	**1,246 (up from 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.

A list of the presentations conducted by the Coronial Registrar, Ms Ainslie Kirkegaard is detailed in Appendix 2.

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.

Following the QAO report the Palaszczuk Government allocated an additional $3.9 million over the next four years, including $474,000 per annum ongoing. This funding has been allocated to DJAG, QH and the QPS to address immediate demand pressures and support implementation of the recommendations made in the report. Most significantly this includes funding for the temporary establishment of a second coronial registrar (known as a deputy registrar) from 2 September 2019 to 31 December 2020.

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 2018-19, 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[12] 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 2018–19, the CCQ expended $330,585 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 are only undertaken to the extent necessary to enable the coroner to make findings about the death. Data from 2011-12 to 2018-19 about autopsies is provided in Tables 8, 9 and 10.

Table 8: Percentage of orders for autopsy issued to number of reportable deaths[13]

	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17	2017–18	2018-19
Deaths reported	4,461	4,762	4,682	4,962	5,287	5,587	5,812	**5,797**
Autopsies	2,742	2,733	2,475	2,542	2,550	2,730	2,629	**2,476**
Percentage	61.5	57.4	52.9	51.2	48.2	48.9	45.23	**42.71**

Table 9: 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	2018-19
External	544	629	717	679	769	856	967	**1,049**
Partial internal	639	795	598	597	533	583	630	**614**
Full internal	1,559	1,309	1,160	1,266	1,248	1,291	1,032	**765**
TOTAL	2,742	2,733	2,475	2,542	2,550	2,730	2,629	**2,476**

[12] Refer to Coroners Regulation 2015 - https://www.legislation.qld.gov.au/
[13] Please note the number of autopsies ordered may include (where required) multiple orders made by a coroner

Table 10: 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	2018-19
External	19.8	23.0	29.0	26.7	30.2	31.4	36.7	**42.37**
Partial internal	23.3	29.1	24.2	23.5	20.9	21.4	23.9	**24.80**
Full internal	56.9	47.9	46.9	49.8	48.9	47.3	39.2	**30.90**

During 2018–19, there was a further 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[14]. 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 2018–19, reported deaths have increased by 90.50% (5,797 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
- 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 2019, these proposals were still under active consideration.

[14] Refer to State Coroner's Guidelines – Chapter 5 'Preliminary investigations, autopsies and retained tissue' https://www.courts.qld.gov.au/courts/coroners-court

The role of the coroner in preventing future deaths

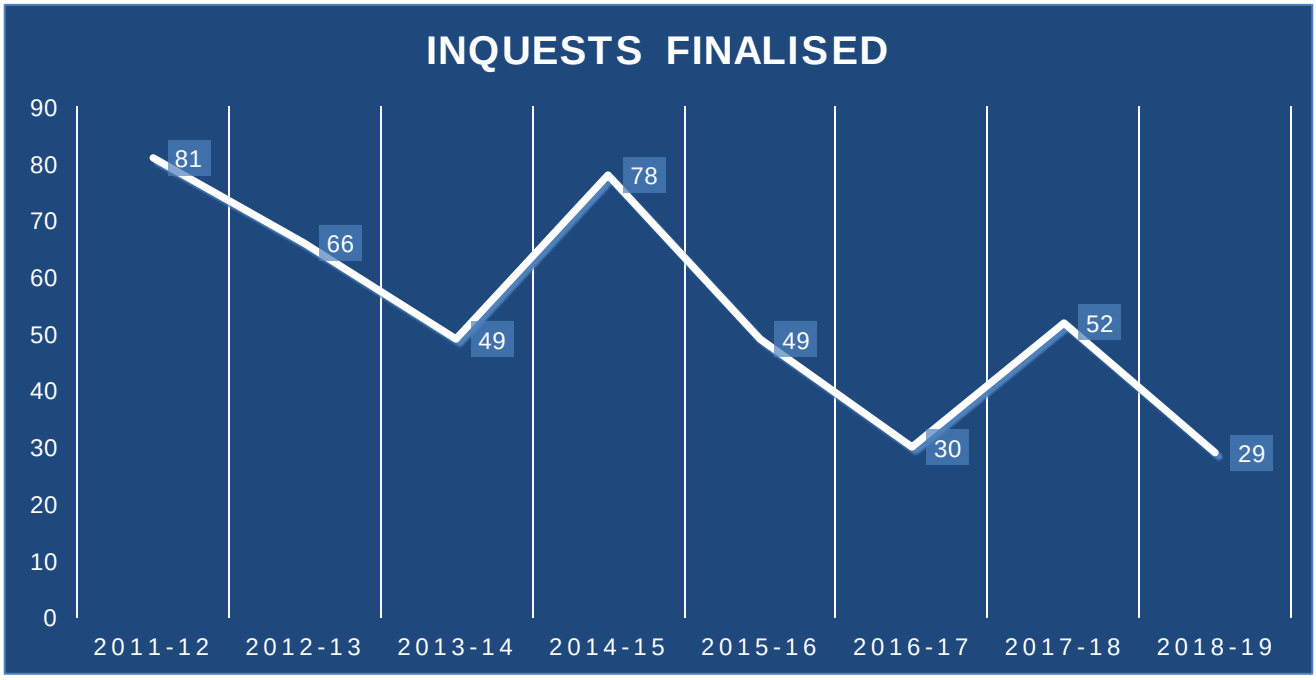
With the legislative authority to make recommendations at inquests that aim to prevent or reduce deaths in similar circumstances from occurring in the future, coroners are in a unique position to be able to influence policy, service and practice change, and to drive systemic reform. Information gathered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

An inquest is the 'public face' of the coronial process; a publicly open 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 small percentage (< 1%) of the total deaths reported each year. The number of inquests finalised during each reporting period since 2011-12 is depicted in the chart below.

Inquests into the deaths of 29 persons were finalised during 2018 - 19.



In 2018-19 the number of finalised inquests declined from the previous reporting period. Factors contributing to this decline include the ongoing increase in workload for coroners and the complexity of inquests and unique circumstances of each death (which cannot be adequately represented in figures). In addition, during the previous reporting period, a number of the finalised inquests were joint matters (clusters of similar deaths) and/or were multiple fatality related matters.

It is also important to note the figures do not account for the number of inquests that were opened by coroners during the reporting period. Table 12 below details the inquests finalised during the reporting period.

Each of the full-time coroners is assisted by a legal officer, known as 'counsel assisting'. These legal officers are increasingly performing the role of counsel assisting and during 2018-19 assisted in inquests into the deaths of 27 persons (as either counsel assisting or instructing counsel assisting). 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.

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

Table 11: Coronial Inquests finalised during 2018-19

Name	Coroner	Counsel	Type of death (catchwords)	Recommendations made
THWAITES, Andrew John	Coroner Clements	Holly Ahern (In-house)	Dive death, recreational diving	13
KHAZAEI, Hamid	State Coroner Ryan	Emily Cooper (In-house)	Death in custody, asylum seeker detained	8
WRIGHT, Kenneth Douglas	State Coroner Ryan	Daniel Bartlett (In-house)	Death in custody, prisoner with impaired capacity	1
HARMER, Jay Maree	State Coroner Ryan	Holly Ahern (In-house)	Death in custody, palliative care	4
MAYNARD, Marcia Anne Kathleen	Deputy State Coroner Lock	Ken Fleming QC (Private)	Suicide, insulin overdose	1
GIORGIO, Pasquale	Deputy State Coroner Lock	Megan Jarvis (In-house)	Death in custody, positional asphyxia	2
COOPER, David	Deputy State Coroner Lock	Megan Jarvis (In-house)	Death in custody, health care related	2
MANN, Renae Jean	Coroner McDougall	Rhiannon Helsen (In-house)	Suspected overdose of amitriptyline	NIL
PARKES, Michael George	State Coroner Ryan	Emily Cooper (In-house)	Death in the course of a police operation, motorcycle accident	2
WINKS, Russell	State Coroner Ryan	Sarah Lane (In-house)	Death in custody, police shooting	1
HAMILTON, Stella	Coroner Wilson	Melia Benn (In-house)	Aged Care, palliative care, euthanasia	NIL

SIMON, Darrell Gene	Deputy State Coroner Lock	Megan Jarvis (In-house)	Missing person	3
SIMONS, Kathleen	Deputy State Coroner Lock	Joanna Cull (In-house)	Death from sepsis to due skin ulcer, aged care nursing	NIL
WILLS, Michael Vincent	Coroner O'Connell	John Aberdeen (In-house)	Aviation fatality, light helicopter in experimental class	1
STATIS, Joshua Ryan	A/Coroner Kirkegaard	Melinda Zerner (Private)	Health care related death, pediatric cardiac surgery	2
Baby M	Coroner O'Connell	John Aberdeen (In-house)	Death of infant within 6 hours of birth, Group B Streptococcal disease	3
HODGKINSON, Bryan	Coroner O'Connell	John Aberdeen (In-house)	Finalisation of adjourned 1998 inquest	1
MORCOMBE, Daniel	State Coroner Ryan	Craig Chowdhury (Private) / Peter Johns (In-house)	Missing child, suspected death	2
DAVIS, John	Deputy State Coroner Lock	Avelina Tarrago (In-house)	Death in care, intellectual and physical disability	1
TRAN, Lucas	Deputy State Coroner Lock	Megan Jarvis (In-house)	Sudden infant death syndrome	3
APPLETON, Garry Ronald	State Coroner Ryan	Emily Cooper / Daniel Bartlett (In-house)	Death in custody, razor blade	6[15]
MALONE, Terrence Michael	State Coroner Ryan	Emily Cooper / Daniel Bartlett (In-house)	Death in custody, disposable razors	6
COOLWELL, Shaun Charles	State Coroner Ryan	Daniel Bartlett (In-house)	Police restraint, amphetamine use, restraint asphyxia	2
BROWN, Holly Winta	Coroner Wilson	Joanna Cull / Melia Benn (In-house)	Past myocarditis, undiagnosed rheumatic fever	2
LAWLESS-PYNE, Timothy Paul	State Coroner Ryan	Sarah Lane (In-house)	Death in custody, natural causes	NIL
MALLIE, William Michael	State Coroner Ryan	Sarah Lane (In-house)	Death in custody, natural causes	NIL

[15] The State Coroner restated the recommendations arising from the Terence Malone inquest as relevant to the circumstances of Mr Appleton's death – therefore those recommendations are not incorporated into the total figure.

BURRELL, Michael Leslie	State Coroner Ryan	Sarah Lane (In-house)	Death in custody, natural causes	NIL
WISE, Paul Robert	State Coroner Ryan	Sarah Lane (In-house)	Death in custody, natural causes	NIL
SCATURCHIO, Joseph Mark	Coroner Lee	Dr Kerri Mellifont QC (Private) / Martina Parry (In-house)	Jet ski collision, reopening of coronial investigation	1
TOTAL				**61**

Monitoring responses to coronial recommendations

When a matter proceeds to inquest, a coroner pursuant to section 46 of the Coroners Act 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 published on the Queensland Courts website adjacent to the relevant inquest findings. The response indicates if a recommendation is under consideration, if and how it will be implemented or the reason a recommendation is not supported. These can be found at http://www.courts.qld.gov.au/courts/coroners-court.

The Queensland Government aims to respond to coronial recommendations (involving government agencies) within six months of the recommendation(s) being made and provides implementation updates every six months until the recommendation(s) is implemented or a decision made not to support the recommendation(s).

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, families of the deceased and others impacted by a death of the steps government is taking to prevent similar deaths.

Of relevance during this reporting period, particularly with respect to the findings and recommendations made by the QAO was the finalised inquest into the death of Marcia Maynard. The Deputy State Coroner made a recommendation about support services available to families and in particular witnesses who come into contact with the coronial system. A summary of the findings with respect to that aspect of the investigation and inquest follows.

Marcia Maynard

Suicide, insulin overdose, personal stressors, nurse witness to be called in an inquest, counter-therapeutic consequences for those involved

Findings delivered 5 September 2018
Deputy State Coroner, John Lock

Marcia Maynard was a registered nurse employed by Offender Health Services at Woodford Correctional Centre. She provided nursing services to a prisoner, Mr Garnett Mickelo, who died in November 2012. Mrs Maynard was to give evidence at the inquest into his death.

Sometime between checking into a hotel on 29 September 2015 and the next day, Mrs Maynard self-administered a lethal dose of insulin. She was found unconscious by hotel staff and taken to the Redcliffe Hospital. She died on 3 October 2015. The death was reportable under section 8(3) of the *Coroners Act 2003* as it was deemed a 'suspected suicide'.

THE INVESTIGATION

Police obtained a number of letters written by Mrs Maynard that were sent or left for her daughter, husband and lawyers. The content of the notes Mrs Maynard left behind indicated she took her life due to a number of matters; including stress as a result of an upcoming inquest she was required to give evidence at, lack of support felt from her employer, and other steps taken by her employer which caused her stress.

As a result the Deputy State Coroner referred the possible stressors existing at her workplace to Workplace Health and Safety Queensland (WHSQ) for investigation.

THE INQUEST

The Deputy State Coroner heard from 15 witnesses including the QPS and WHSQ investigating officers, her work colleagues, psychologist and solicitors involved in drafting her will and assisting in the inquest she was to attend at.

The Deputy State Coroner heard evidence in regard to factors or stressors contributing to her death including, weight loss, her workplace not being a 'healthy work site', her research on euthanasia, and her relationship with her husband and family. In particular evidence around a meeting Mrs Maynard had with her barrister and solicitors about the upcoming inquest and the requirement to give evidence at that inquest was explored.

FINDINGS AND COMMENTS

While the Deputy State Coroner considered Mrs Maynard had supports in place, he noted she still experienced distress at the prospect of giving evidence at the inquest. The Deputy State Coroner commented there is a challenge to fulfil a coroner's statutory role in an investigative process but at the same time minimise the potential for the process to be distressing.

"The death of a witness due to give evidence in a pending inquest is a shocking reminder of the potential counter-therapeutic impacts that not only family members may experience but also others who become involved in the coronial process, such as witnesses".

The Deputy State Coroner recommended:

- the Queensland Government facilitate and fund a program that provides counselling for families as well as witnesses or others who may be involved in and impacted by a coronial investigation and/or inquest, similar to the program currently being facilitated by the Office of Industrial Relations.

As at 3 September 2019 the government provided an implementation update noting consultation sessions will be held in 2019 to bring together those who play a role in supporting people bereaved or otherwise affected by a death reported to the coroner. This will identify opportunities for improvement and discuss new/emerging practices in supporting families and witnesses.

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). The NCIS is the national database or mortality data on deaths reported to a coroner in Australia and New Zealand. 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:

Dr Richard Gun
– University of Adelaide

Dr Gun is undertaking research into deaths attributed to occupational exposure to heat stress. Extensive work has been undertaken worldwide into factors predisposing to heat strain – for example climate factors, clothing, fitness, fatness, illness, medication etc. It is less clear why only a minority of people working in heat are severely affected and Dr Gun will be attempting to identify particular risk factors leading to the deaths.

The aim of the research is to confirm whether death was caused by exposure to occupational heat stress and to determine why the worker died while fellow workers were unaffected. An anticipated outcome of the study may be the ability to identify remediable risk factors to be considered for workers exposed to hot conditions.

Dr Angela Berkhout, Dr Clare Nourse, Dr Vishal Kapoor and Dr Claire Heney
– Queensland Children's Hospital

Dr Berkhout, Dr Nourse, Dr Kapoor and Dr Heney are investigating Herpes Simplex Virus Infection in Infancy and Herpes Simplex Meningoencephalitis in children in Queensland.

Neonatal herpes simplex virus (HSV) infection and HSV encephalitis in children, although uncommon can be devastating with significant associated morbidity and mortality. This concern about adverse outcome has driven increasing empiric prescription of aciclovir in neonates and young children. The few studies of incidence, clinical features and outcome of HSV disease in children in Australia are not comprehensive and have depended on voluntary reporting of cases. Early diagnosis and treatment with high dose aciclovir is crucial for preventing death and long term neurological sequelae following neonatal HSV or HSV encephalitis.

However, the spectrum of clinical manifestations and short and long-term outcomes need to be better defined to decrease the considerable morbidity and mortality still associated with this devastating infection. There is also a need to define the high-risk age group/s and significance of microbiological detection in the absence of clinical features to help rationalise aciclovir use, limit unnecessary treatment and provide guidelines for empiric use.

The aim of the research is to provide a comprehensive and complete report of the incidence and prevalence of neonatal HSV infection (0-3 months) and herpes meningoencephalitis (0-16 years) in Queensland, with case ascertainment based on laboratory confirmation as opposed to voluntary reporting. Clinical features, laboratory results, details of treatment and outcomes of neonatal HSV infection and herpes meningoencephalitis in Queensland will be reported.

Professor Jude McCulloch
– Monash University

Professor McCulloch leads the Monash Gender and Family Violence Prevention Centre project. The aim of the research project is to create new knowledge about family violence. Its research addresses the prevention of gendered family and intimate partner violence the way in which local, national and international patterns influence social and criminal justice responses to violence, and how those who have experienced family violence can be better supported and perpetrators be better held to account.

At the conclusion of the study, the project will develop a national framework for a new integrated systems preventive approach to intimate partner homicide. Findings will be disseminated across a wide range of outlets in cluing scholarly book(s), peer reviewed journal articles and national and international conference representation. An online database and web resources will be also created. There will be no reference to individual cases in the way the results will be presented.

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 or opportunities to prevent future deaths.

Domestic and Family Violence Death Review Unit

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.

Since then, the DFVDRU has grown and expanded as a result of the recommendations of the *Queensland Child Protection Commission of Inquiry and the Special Taskforce on Domestic and Family Violence in Queensland*. In its current form the DFVDRU now assists coroners in their investigations of deaths of children who were known to child safety services prior to the death, and provides advice on national and state policy and practice initiatives as they relate to domestic and family violence and the coronial system. The DFVDRU also provides secretariat support to the independent Domestic and Family Violence Death Review and Advisory Board (the Board).

The Board is established under the *Coroners Act 2003* to undertake systemic reviews of domestic and family violence-related deaths, and to make recommendations to the Queensland Government to improve legislation, policy and practice to prevent or reduce the likelihood of domestic and family violence deaths. More information regarding the membership, function and findings of the Board is available in its 2018-19 annual report that is available on the Queensland Courts website[16].

In the 2018-19 financial year, the DFVDRU completed 41 comprehensive case reviews to assist coroners in their investigations of domestic and family violence-related deaths, and deaths of children known to child safety services. These case reviews, and the supporting research summaries provided by the DFVDRU, have been referenced in multiple published findings.

The DFVDRU also maintains two comprehensive databases of domestic and family violence-related homicides and suicides. This database contains data points related to demographic characteristics and static and dynamic risk indicators that enable the DFVDRU to draw out comprehensive trends and patterns of domestic and family violence homicides and suicides.

The data held by the DFVDRU continues to be shared widely, and is regularly published and shared with the government and non-government sector to inform policy and practice reforms. The DFVDRU has shared the findings of the domestic and family violence death review process in seven presentations to the domestic and family violence sector, two presentations to police and one presentation to Queensland Health (see Appendix 3 for the list of presentations).

[16] Domestic and Family Violence Death Review and Advisory Board Annual Report 2018-19 - https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/630159/domestic-and-family-violence-death-review-and-advisory-board-annual-report-2018-19.pdf

The DFVDRU continues to participate in national initiatives as a member of the Australian Domestic and Family Violence Death Review Network (the Network) and continues to work closely with the various interstate death review mechanisms in Australia. The Network aims to continue to promote data from domestic and family violence related deaths and is focussed on establishing a national register of recommendations from domestic and family violence death reviews.

The DFVDRU completed extensive reviews of the following due to the nature and circumstances of the deaths.

Rinabel Tigalo Blackmore

Domestic violence, intimate partner, manslaughter, criminal proceedings, exit from moving vehicle, police response, heightened post separation risks, non-lethal strangulation, domestic violence protection orders, cultural and linguistic diversity, English as second language (ESL), assessment of risk, supervision and rehabilitation of perpetrators, Queensland Domestic Family Violence Death Review and Advisory Board, Special Taskforce Domestic and Family Violence, Not Now Not Ever Report, sentencing principles.

Findings published 4 April 2019

Northern Coroner, Nerida Wilson

Rinabel Blackmore died as a result of a fatal head injury she sustained when exiting from a moving vehicle driven by her partner, Mr Dickson, around midnight on 31 December 2014.

Ms Blackmore died within 40 hours of her first and only report of domestic violence to police. At the time of the incident, Ms Blackmore and Mr Dickson were in the process of separating when he verbally abused and threatened her in the vehicle, in the context of a protracted episode of domestic violence. Mr Dickson was convicted of manslaughter for his role in causing Ms Blackmore's death.

The Northern Coroner considered it was in the public interest that investigation findings be published to inform the current public discourse regarding domestic and family violence.

In 2014, Ms Blackmore separated from her husband; she had three sons and despite telling family and friends she was living and working in Perth, she had moved to Middlemount in Central Queensland. It appears she commenced a relationship with Mr Dickson, with whom she was living with, prior to the separation but did not inform her family or friends of the relationship.

The investigation revealed during the Christmas period in 2014, when the two spent some time apart (Ms Blackmore in Brisbane and Mr Dickson in Bundaberg visiting friends) he exhibited some controlling and jealous behaviours. Towards the end of December, Ms Blackmore met Mr Dickson at a Bundaberg motel. An argument and 'tug of war' ensued. It was captured on CCTV and observed by the manager of the motel, who at Ms Blackmore's request called for police to attend. The motel manager advised Ms Blackmore told her *"I'm frightened that if you don't get the police, he will kill me".*

On 30 December 2014, Ms Blackmore's friend returned to Middlemount to collect property from Mr Dickson's unit. Her friend discouraged her and they decided she would inform her about her safety, if during a call she said everything was ok, her friend could leave Middlemount, however if she said *"you should come and have a look at the unit"* it meant she was in trouble.

According to Mr Dickson, Ms Blackmore stayed the night and later that evening they began arguing again which became physical, where he grabbed her about the collar bone or shoulder, shaking and squeezing her. After it ended, they went to bed but he was unable to sleep.

Evidence during the investigation revealed following that argument a number of text messages were sent between Ms Blackmore's phone and that of her co-worker (due to the content it appeared they were sent by Mr Dickson). Shortly after that message Ms Blackmore's friend received a call and heard her say *"you should really see the unit, you should really, really see the unit. Maybe next time".*

In his interview with police Mr Dickson advised as they could not sleep a decision was made that night to drive to Brisbane. Forensic examination of the vehicle found that the child lock in the back seat where Ms Blackmore was seated was engaged and the rear door on the other side was blocked with luggage. It was noted her phone was located in the driver's door well.

During the drive Ms Blackmore climbed over the front passenger's seat and complained of motion sickness. Another argument ensued. Mr Dickson denied using any physical violence at this time but was screaming at her. He told police: ""*I was screaming – I screamed at her and the next minute she's going to the door and she's gone, mate*".

Mr Dickson advised he stopped the vehicle, did a U-turn, carried her from the shoulder of the road and placed her in the front passenger seat. Triple 0 was called and he drove her back to the Middlemount Ambulance Station under the direction of the operator where he was met by a paramedic. Ms Blackmore was taken to hospital but never regained consciousness.

The coroner noted that there were missed opportunities by the attending police officers to assess Ms Blackmore's risk and gather evidence at this time for e.g. taking a statement from the hotel manager that could have formed the basis for a charge against Mr Dickson. It was noted the only action taken by police after the events was to prepare an application for a protection order during which it was apparent that Mr Dickson had a prior history of domestic and family violence.

"The terror experienced by Ms Blackmore in the last days, hours and minutes of her life precipitated her fatal decision to exit a vehicle travelling at 100 kilometres per hour so as to escape her abuser.
Based on Ms Blackmore's expressed intention to separate from Mr Dickson and return to Brisbane, the fact she had secured a rental unit in Brisbane, her request for assistance to both the motel manager and police, the use of a coded message to seek help from her friend, and the absence of any previous expression of suicidal ideation to friends, family or others, I have concluded that Ms Blackmore did not intend to kill herself and that her actions were a desperate act of self-preservation".

The coroner noted the comprehensive response provided by the Queensland Police Service about changes and improvements to finding new and better ways to deal with domestic violence on the front line, including improved training and support to less experienced officers attending incidents such as Ms Blackmore's.

The coroner also noted legislative amendments since Ms Blackmore's death that created a specific offence for non-lethal choking, suffocation or strangulation of a person in a domestic setting. The investigation into Ms Blackmore's death also noted the need to consider challenges around domestic and family violence experienced by culturally and linguistically diverse people. Ms Blackmore was a Filipino woman and English was not her first language.

The coroner also referenced the lethality risk assessment coding system based on the Ontario Domestic Violence Death Review Committee, which lists 40 risk factors that indicate the potential for lethality in a relationship. Using that coding system, eleven lethality risk indicators were identified.

The Northern Coroner found that it was more probable than not that Ms Blackmore exited the vehicle to escape the terror of the events unfolding whilst in fear for her life.

Death of SW

Domestic and family violence death; Aboriginal intimate partner homicide; remote indigenous community; perpetrator's extensive domestic and family violence history; current domestic family violence order; perpetrator on parole; Queensland Domestic and Family Violence Death Review and Advisory Board; Queensland Government Framework for Action: Reshaping our approach to Aboriginal and Torres Strait Islander domestic and family violence (May 2019).

Findings published 16 May 2019
A/Coroner, Ainslie Kirkegaard

SW was a 26 year old Aboriginal woman who died from serious injuries sustained in a violent assault upon her by her partner IN, after a prolonged drinking session in April 2016. On the morning of her death, her partner attended the local police station and told them he had assaulted his girlfriend and he thought she was dead. On arrival at the house, police found SW lying face down on the bedroom floor with traumatic injuries to her head and left bicep. A small axe and large serrated pruning saw were located in the room.

The investigation revealed that SW and her partner began drinking at around midday and other people including her daughter attended the house during the day. After they left SW and her partner continued to drink. In his interview with police SW's partner advised police they started to argue, he then hit her in the face a number of times before arming himself with a pruning saw. He advised he slashed SW a number of times to keep her away from him. He was charged with murder, rape and interfering with a corpse and ultimately convicted of murder.

At the time of the assault, he was named as the respondent in a current Domestic Violence Protection Order with SW as the aggrieved. The order was made in July 2015 relation to an incident where SW's partner had assaulted her with a knife, threatened to take her out bush and chop off her head. A few days later they reconciled. He again assaulted her with a knife. He was subsequently sentenced to nine years imprisonment with directions to abstain from alcohol. He was released from custody in October 2015 and they once again reconciled. In January 2016 police responded to

a disturbance between the couple in which SW alleged her partner had threatened her, police determined the allegation to be unfounded. This was the last service contact before SW's death three months later.

The investigation revealed that their relationship was characterised by a sustained pattern of physical, verbal and psychological abuse with SW the victim of significant acts of violence often involving the use of weapons. He was known in the community for his violence against women and reportedly nicknamed *'killer'* due to his prior history of domestic violence perpetration. A review of his records showed extensive service system contact as a result of violence towards SW and others. He was named as the respondent in violence orders relating to seven women including SW. Her death led to his tenth custodial episode for violence related offending.

The coroner noted that the circumstances leading to SW's death highlighted the critical importance of robust interventions for serious family violence offenders given it was recognised in the community he presented a sustained risk of harm. It also highlighted the importance of reducing alcohol related harm. Despite the community having an Alcohol Management Plan in place, he was able to acquire and consume excessive quantities prior to the assault on SW.

"At the time of SW's death, the community was one of several indigenous communities in which an Alcohol Management Plan was in place to limit the sale and consumption of alcohol outside controlled settings. Despite this, IN was able to acquire and consume excessive quantities of 'sly grog' immediately prior to his fatal assault on SW. His intoxication was a significant factor in the escalation of events preceding the assault that night."

The coroner referred to the 2016-17 DFVDRAB Annual Report recommendation that the Queensland Government in partnership with Elders and other experts develop a specific Aboriginal and Torres Strait Islander family violence strategy as a priority.

In May 2019 the government released *Queensland's Framework for Action: Reshaping our approach to Aboriginal and Torres Strait Islander domestic and family violence*[17] . The framework documents the Government's commitment to taking a new approach to working with Aboriginal and Torres Strait Islander families and communities to address the causes, prevalence and impacts of domestic and family violence.

[17] https://www.csyw.qld.gov.au/resources/campaign/end-violence/qld-framework-for-action-reshaping-approach-atsidfv.pdf

Deaths in care of people with a disability

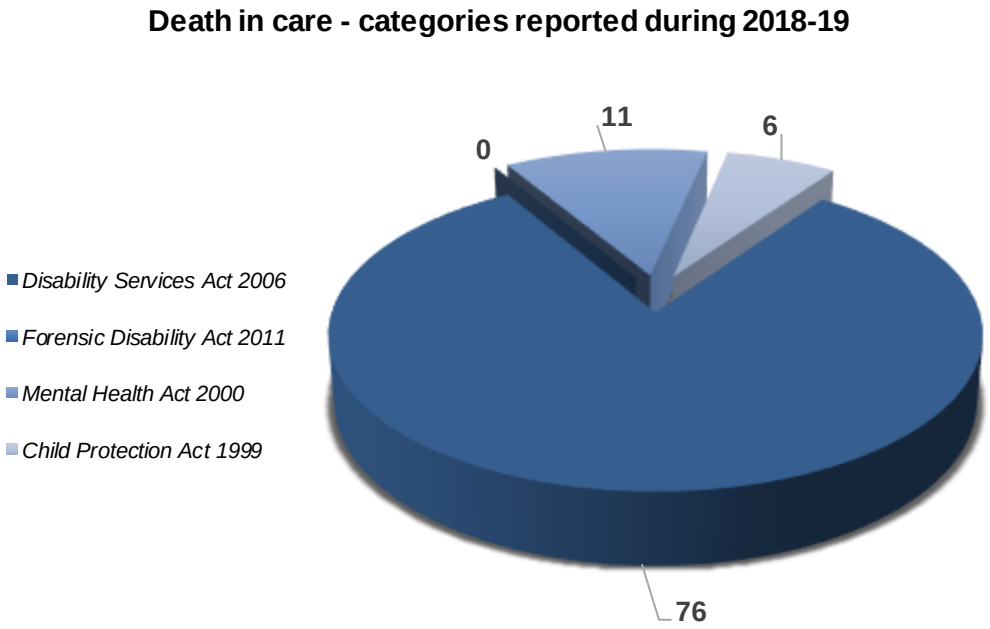
The *Coroners Act 2003*, s. 8(3)(f) in conjunction with s. 9(1)(a) and (e), makes reportable the death of persons with a disability who live in supported residential accommodation that is either a level 3 residential service under the *Residential Services (Accreditation) Act 2002* or a government operated 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 2018-19, 93 deaths in care were reported. Of these, 76[18] related to deaths in care of people with a disability. Further details on the categories of death in care reported to the court for investigation are noted below.



With the commencement of the NDIS in Queensland on 1 July 2019, the CCQ continued to participate in a range of planning activities across government to assist in the transition and to ensure these deaths are reported and are properly scrutinised.

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[19]. This report, *Upholding the right to*

[18] Of the 93 deaths reported, one death was recorded as a death in care – disability and involuntary mental health. For the purpose of reporting, this death was included in the total 'disability' figures.
[19] 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

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.

In response to the Public Advocate's report, the State Coroner requested an Expert Review Panel (the Panel) process be trialled to examine the health care management of persons whose deaths had been reported to the coroner as a death in care (disability). The panel consisted of six members who had expertise and experience in the health care management of people with a disability with complex needs in care.

Given the commencement of the NDIS in Queensland, the State Coroner considered it timely to release a de-identified/redacted version of the Panel report to key agencies involved in the care of NDIS participants. A copy of the report was also published on the CCQ website.[20]

During the reporting period the Deputy State Coroner finalised his inquest into the death of Mr John Davis which was reportable as a death in care disability. Given the Deputy State Coroner had issues with the circumstances of the care provided to Mr Davis, an inquest was required.

John Davis

Death in care, intellectual and physical disability, choking on food, adequacy of resuscitation provided by carer and ambulance services, Public Advocate Report

Findings delivered 17 April 2019
Deputy State Coroner, John Lock

John Davis was 50 years old at the time of his death and had resided for a number of years at a supported residential service. He had an intellectual disability and a long history of disabling comorbidities, including compilations of an acquired brain injury he sustained at birth.

CIRCUMSTANCES OF DEATH

On 8 April 2018, Mr Davis had just eaten his lunch when he was heard by his carer to collapse to the ground. Emergency services were called by his carer. At the time of the call it is apparent Mr Davis was breathing but during the emergency call his breathing deteriorated to the extent that it was likely to be agonal and ineffective. At no point in the emergency call was there any indication by the carer of any airway obstruction or information which would have led a listener to believe that a food obstruction of the airway was an issue.

The Deputy State Coroner found there had been previous investigations performed regarding recurrent aspiration pneumonia in the context of possible swallowing issues but at the time of his death there was no documented concerns regarding his capacity to swallow and eat a relatively normal diet.

Some minutes later Mr Davis appears to have stopped breathing and at this point the carer was instructed to commence CPR. On review, the Deputy State Coroner considered that CPR could have commenced sooner. Ambulance officers arrived shortly after and took over CPR. It became evident to the ambulance officers that Mr Davis' airway was obstructed due to the failure to be able to successfully ventilate him. An officer checked the airways and used a laryngoscope but unfortunately due to a combination of inexperience in the use of the device and a faulty laryngoscope, a food bolus that was lodged in the airway was not observed.

It was not until an advanced Clinical Care Paramedic (CCP) attended that the problem was quickly observed and the food bolus removed. Unfortunately, by that time and probably well before the arrival of paramedics, Mr Davis had been without oxygen for a period of time such that his brain was deprived of oxygen and he suffered from hypoxic brain damage. The Deputy State Coroner noted that although he was subsequently ventilated this damage was irretrievable and he died a few days later.

THE INQUEST

At inquest, in addition to the findings required by the Act, the Deputy State Coroner examined;

- Whether the health, disability and supported accommodation services provided to the deceased were adequate and appropriate.
- Whether first aid and disability services carer training of the supported accommodation carers were adequate and appropriate.
- Whether the resuscitation performed by the Queensland Ambulance Service was adequate and appropriate.

[20] Deaths in care (Disability) Expert Review Panel Final Report - https://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/resources-and-legislation

- Whether there are any matters about which preventative recommendations might be made

The Public Advocate in recognition of their independent role for helping to ensure the safety and wellbeing of persons in care with a disability, and to assist the Deputy State Coroner to consider what recommendations might be appropriate, were granted leave as a 'public interest intervener'.

The Deputy State Coroner heard expert evidence from Dr Rashford, the QAS Medical Director with respect to the emergency call. Dr Rashford considered that although human factors resulted in the delay in recognising the choking episode, he was of the opinion Mr Davis had suffered severe hypoxia before the initial paramedic crew attended. An independent medical opinion from Dr Ian Home of the Clinical Forensic Medicine Unit was also obtained. Dr Home stated that if the CCP had attended 10 minutes prior and removed the food bolus, the outcome for Mr Davis may have been different.

FINDINGS AND COMMENTS

The Deputy State Coroner accepted that although Mr Davis had isolated occasions of swallowing issues, it could have been more routinely investigated, and there could have been better communication between carers at the facility and clinicians at his hospital attendances about his diet. The Deputy State Coroner found that the transfer of information from the carer to QAS was not optimal but stated that he was not critical as it was 'out of scope of practice' for disability support workers to make clinical judgements.

RECOMMENDATIONS

The residential care facility identified a gap in the annual *Comprehensive Health Assessment Program* (CHAP) report with respect to nutrition and swallowing and has now developed a checklist to assist carers in identifying issues with swallowing.

In consideration of this, the Deputy State Coroner recommended that his findings be provided to the NDIS to pass onto its members with a recommendation a similar checklist be considered for general use by care providers who are providing disability care services to those who would be considered in a risk category of swallowing issues.

Retrospective

– Looking back over the last 15 years of coronial services in Queensland

The 2018-19 reporting period marks the 15th anniversary of the *Coroners Act 2003* and operation of the Coroners Court of Queensland (formerly the Office of the State Coroner). The court has undergone significant change over the last 15 years.

The new Act included the creation of the position of State Coroner, to which Mr Michael Barnes (right) was the inaugural appointee. The reforms under the 2003 Act provide for a modern model for the delivery of coronial services. It places greater emphasis on the prevention of future deaths rather than attributing blame (removing the power of a coroner to commit someone for trial in connection with a death).

The Act gives family members the right to have their views considered in matters such as extent of autopsy and if an inquest should be held. It also put coroners in control of their investigations rather than being recipients of investigator's reports. The Act also introduced a regime for 'genuine researchers' to access coronial information in order to enable diverse research activities and analysis into improving public health and safety and death prevention initiatives.

Coroner Clements (below) has been a coroner since 2000. From 2003 for two, five year terms, Coroner Clements was appointed the Deputy State Coroner. Over the last 15 years, Coroner Clements has investigated thousands of deaths and held over 80 inquests, developing considerable expertise over this period. Coroner Clements' contribution to the court and to bereaved families is immeasurable.

- **April 2003** – The *Coroners Act 2003* passed into law
- **July 2003** – Michael Barnes appointed as inaugural State Coroner
- **December 2003** – Christine Clements appointed as Deputy State Coroner
- **December 2003** – State Coroner's Guidelines developed
- **November 2003** – Office of the State Coroner (OSC) staff moved into the first purpose built coroners facility in the Magistrates Court Building in Brisbane.
- **June 2005** – OSC consists of 16 positions offering legal and administrative support and two full-time coroners
- **June 2005** – 2,423 deaths finalised, 32 inquests held

Former State Coroner, Michael Barnes and Coroner Clements were Queensland's only full-time coroners at the commencement of the 2003 Act. All magistrates were by virtue of their position, coroners and were responsible for ordering autopsies and issuing findings. Former State Coroner Barnes noted this in his 2005 Annual Report as a

challenge for the future and a "*tension of the current system that may need to be resolved by legislative amendment in the future*".

During 2005-06 four significant judicial review decisions in relation to the coronial jurisdiction were handed down. The statutory review applications in Doomadgee & Anor and Hurley v Deputy State Coroner Clements & Ors[21] were heard together and looked at the admission of "propensity evidence". The decision confirmed that the scope of the inquiry under s 45 is extensive and is not confined to evidence directly relevant to the matters listed in s 45(2), and that the coroner has a broad role under s 46 that is ancillary to the role under s 45. The court also published its first substantive annual report.

- July 2005: Commissioner of Police v Clements & Ors [2005] QSC 203
- September 2005: Atkinson v Morrow & Anor [2005] QCA 363
- December 2005: Doomadgee & Anor v Deputy State Coroner Clements & Ors [2005] QCS 357
- June 2006: First substantive Annual Report produced (December 2003 - June 2005)
- June 2006: OSC consists of 17 positions offering legal and administrative support and two-full time coroners
- June 2006: 3,144 deaths reported, 78 inquests held
- June 2007: DJAG allocated funding for the development of a new coronial case management system

During 2006-07 the court received funding of $1.153 million in response to the significant increase in workload in the preceding years. Following the Queensland Public Hospitals Commission of Inquiry Report[22] published on 30 November 2005 the court experienced increased contact from doctors seeking either advice as to whether to report a health care related death, or authority to issue a cause of death certificate under s 12(2)(b) of the Act. Reporting of this category of death during this period increased 43% from the previous year. The court also progressed the development of a specific case management tool in order to maintain a register of reportable deaths, to meet the technical and operational need of the coronial system. The court continued to work with the Coronial Support Unit (CSU) which was established to manage on a state-wide basis coronial processes within the QPS.

- June 2007: OSC consists of 19 positions offering legal and administrative support and two-full time coroners
- June 2007: 3,219 deaths reported, 109 inquests held
- January 2008: John Lock appointed as Brisbane Coroner
- March 2008: Kevin Priestly appointed as Northern Coroner
- June 2008: Michael Barnes reappointed for further five year term as State Coroner
- June 2008: OSC consists of 29 officers offering legal and administrative support and four full-time coroners

The CSU consisted of three police officers located within the court and four police officers at Queensland Health Forensic and Scientific Services (formerly the John Tonge Centre) to assist in the identification of deceased persons and preparation of documents for autopsy.

[21] Doomadgee & Anor v Deputy State Coroner Clements & Ors ; Hurley v Deputy State Coroner Clements & Ors - http://archive.sclqld.org.au/qjudgment/2005/QSC05-357.pdf
[22] Queensland Public Hospitals Commission of Inquiry – Final Report 2005 - http://www.qphci.qld.gov.au/.

Four further staff positions within the court were established and a registrar was permanently appointed. A number of public interest inquests were held during 2006-07 including the Palace Backer packers Hostel Fire in Childers. The fire which resulted in the deaths of 15 people received worldwide media attention.

During 2007-08 the court expanded further with new coronial teams to support the appointment of an additional full time coroner in Brisbane, Magistrate John Lock, and a new Northern Coroner, Magistrate Kevin Priestly who was appointed and based in Cairns. The full time appointment of these coroners resulted in efficiencies for the court by improving clearance rates, relieving pressure on local magistrates and resulting in families receiving timely outcomes and enhanced coronial services in regional areas. It marked the first time the coronial system achieved a clearance rate of 104%. This period also saw the trial of the appointment of an in-house counsel assisting the state coroner. The position was created for one year to assess its effectiveness in reducing legal costs by alleviating the need to brief private counsel. The position was extended to February 2009 and remains to this day.

The State Coroner approved a new version of the 'Form 1A – Medical practitioner report of a death to a coroner' in February 2008 which resulted in coroners receiving a significant improvement in the quality and extent of information from medical practitioners about a death to allow them to determine whether the death was reportable and if so, what further information was required. The use of this form increased 12% in the reporting period in comparison to 2006-07.

Of note, the mandatory inquest into the deaths of Thomas Waite, Mieng Huynh, James Jacobs and James Gear, all of whom died after being shot by police was finalised. The State Coroner noted each of the men were long term sufferers of mental illness and experiencing symptoms at the time of their death. A total of 17 recommendations were made with respect to the adequacy of the mental health treatment each received, the mental health legislative regime and the appropriateness of the police response. State Coroner Barnes also finalised the inquest into the Lockhart River aircraft crash which saw 15 occupants perish when their aircraft crashed into a hillside. The coroner was of the view that the aircraft would not have crashed if the pilots had followed aviation procedures.

- **June 2008** – 3,514 deaths reported, 76 inquests held
- **July 2008** – State Coroner approved new findings forms (Form 20A, 20B, 28A & 28B)
- **August 2008** – John Hutton appointed as Southern Coroner
- **June 2009** – 3,745 deaths reported, 69 inquests held
- **July 2009** – Coroners Case Management System commenced operation
- **November 2009** – *Coroners Act and Other Acts Amendment Act 2009* commenced
- **February 2010** – Procurement process for government undertaker contracts closes.

During 2008-09 a full-time Southern Coroner was appointed in August 2008. Mr John Hutton was appointed to the position and remained a coroner until his retirement in November 2017. Following consultations it was decided that deaths in the Caboolture and Redcliffe areas be reported to the Deputy State Coroner and Brisbane Coroner, relieving those registries of around 150 matters each year. This appointment and change in reporting meant only 30 per cent of all deaths in Queensland were reported to local magistrate coroners.

In April 2008, the *Coroners and Other Acts Amendment Bill 2008* was introduced into Parliament. The amendments included for example, the establishment of a new category of death that 'happened in the course of, or as a result of police operations', revision to the 'death in custody' definition to include deaths in detention under all state and Commonwealth legislation (with limited exceptions), a duty to report deaths of those who provided residential services to those with a disability and changes to facilitate access to documents by genuine researchers. Of note, the inquest into the disappearance of the Malu Sara vessel which resulted in the deaths of five people was finalised. The State Coroner noted the deaths occurred because several people dismally failed to do their duty and made a referral for disciplinary action.

During 2009-10 was the first time five-full time coroners were operating in Queensland. The court successfully implemented the purpose built case management system (CCMS). In addition, a major tender and evaluation process for new undertaker contracts for the transportation (under the Coroners Act) and the burial and cremation of deceased persons (under the Burials Assistance Act) was commenced. Following inquests, a total of 157 recommendations were made during this reporting period. Despite there being no obligation on any government or private body to respond to a coroner's recommendation, the Government had a preventative focus and required all public sector bodies advise the Attorney-General of their response for inclusion in a report tabled in Parliament. The first of these reports was published in August 2009.

- June 2010 — OSC consists of 30 positions offering legal and administrative suport to five full-time coroners
- June 2010 — 4,256 deaths reported, 78 inquests held
- October 2010 — The Registrarposition title changed to Director
- December 2010 — New government undertaker contracts in effect
- January 2011 — Establishment of the Domestic and Family Violence Death Review Unit
- March 2011 — Workshop on 'vicarious trauma' delivered to OSC staff
- June 2011 — 4,416 deaths reported, 46 inquests held

The re-opened inquest into the death in custody of Mulrunji Doomadgee who was found deceased in a cell of the Palm Island police station in November 2004 was finalised in May 2010. The case received significant media, attention and resulted in civil proceedings for a number of years. The inquest initially conducted by former Acting State Coroner Clements, found Senior Sergeant Chris Hurley caused fatal injuries by inflicting a number of punches to his abdominal region. The findings were set aside in June 2009 and former Coroner Brian Hine was appointed to re-open the inquest. Coroner Hine concluded that while an accidental cause for the injuries could not be excluded, he found sufficient evidence to allow for the possibility that Senior Sergeant Hurley's actions had been intentional.

During 2010-11 the court was involved in numerous bodies of work, including the finalisation of the tender process for the government undertaker contracts which resulted in 70 contracts entered into with 34 service providers. A major review of the State Coroner's guidelines in relation to autopsies was undertaken. This was done in recognition that these procedures are invasive and costly and should only be conducted to the extent necessary to enable coroners to make findings. The period saw the establishment of a 12 month trial of a specialist Domestic and Family Violence Death Review Unit (DFVDRU) to provide specialist advice and assistance to coroners in their investigations of domestic and family violence-related deaths. The DFVDRU was established following an October 2010 report of the Domestic and Family Violence Death Review Panel that recommended additional resourcing be provided to assist the coroner in their investigations of

domestic and family violence deaths. The unit was initially staffed by a Principal Researcher and Coordinator and a police officer. In recognition of the impacts experienced by coronial staff, workshops for staff well-being were delivered in March 2011 by a psychologist who specialised in vicarious trauma.

During 2011-12 the former Chief Magistrate, Judge Rinaudo AM was appointed as the Regional Coroner to support local magistrate coroners by dealing with more complex investigations and inquests. Some months later the then government implemented an election promise to appoint a full-time coroner in Mackay. The appointment of Magistrate David O'Connell saw all coronial cases managed by a specialist, full-time coroner. Coroner O'Connell remains with the court having developed significant expertise in investigations and presiding over a number of significant public interest inquests across central Queensland.

Another innovation during the period was a six month trial of the appointment of a coronial registrar, Ms Ainslie Kirkegaard, who handled all natural causes deaths reported to Brisbane coroners. The success of the trial saw the registrar assist in finalising 2,000 matters. As a result of what State Coroner Barnes described as 'herculean efforts' the position was extended for a further twelve months.

- **January 2012** – Ainslie Kirkegaard appointed Registrar for a trial to reduce the workload of Brisbane based coroners
- **January 2012** – Former Chief Magistrate Ray Rinaudo appointed 'Regional Coroner'
- **June 2012** – 4,461 deaths reported, 81 inquests held
- **June 2012** – OSC has six full-time coroners
- **August 2012** – David O'Connell appointed as Central Coroner
- **April 2013** – Full-time coroner model extended state-wide with only four reporting centres
- **April 2013** – 10th anniversary of the *Coroners Act 2003*

In January 2011, Queensland was impacted by an adverse weather event, the worst of which occurred in the Toowoomba and upper Lockyer Valley. The inquest into the suspected deaths of three persons and the deaths of 22 people who died as a result of that flooding event was finalised. Also of note was the inquest into the death of Ryan Saunders, a two year old boy who died at the Rockhampton Base Hospital. Following the inquest, the development of 'Ryan's Rule' began. Launched in 2013, the rule provides a process for families of patients of any age to seek a clinical review if they are concerned about a patient or, are not satisfied with a response provided by a nurse or doctor.

During 2012-13, the tenth anniversary of the assent of the *Coroners Act 2003* took place. Michael Barnes concluded his ten-year tenure as the inaugural State Coroner with Magistrate Terry Ryan subsequently appointed to the position. In July 2013, Magistrate James McDougall was appointed as the Southeastern Coroner and remains in the position. The significant growth in the southern region and subsequent increase in reportable deaths has been capably managed by Coroner McDougall over many years. Ms Kirkegaard's achievements in the coronial registrar trial saw the role established on a permanent basis with her tenure extended. In October 2012, the reporting catchment was expanded and covered in addition to Brisbane, the Sunshine Coast region north to Gympie and South West Queensland. One of the successes during this period was the development of a triage process for apparent natural causes deaths which enter the coronial system simply because a cause of death certificate has not issued. The approach engaged forensic pathologists, clinical nurses, forensic medical officers and coronial counsellors to identify where a cause of death certificate could be issued.

- June 2013 • Michael Barnes concludes ten-year tenure as inagural State Coroner
- June 2013 • 4,762 deaths reported, 66 inquests held
- July 2013 • Terry Ryan appointed as State Coroner
- July 2013 • James McDougall appointed as Southern Coroner
- July 2013 • Ainslie Kirkegaard appointed permanently as Coronial Registrar
- July 2013 • All police positions coordinated by Detective Inspector, Coronial Support Unit
- August 2013 • Leahy v Barnes [2013] QSC 263

Deputy State Coroner Clements finalised the inquest into the death of Antonio Galeano. Mr Galeano was restrained by police, who during the 25 minute interaction resulted in the deployment of capsicum spray and multiple applications of electrical charge from a Taser by police. The inquest into his death lasted six weeks and found that the Taser activated 28 times during the struggle. The coroner found however, there was no evidence that this directly caused his death. The coroner made 18 recommendations as a result of the inquest in which the cause of death was considered to be excited delirium.

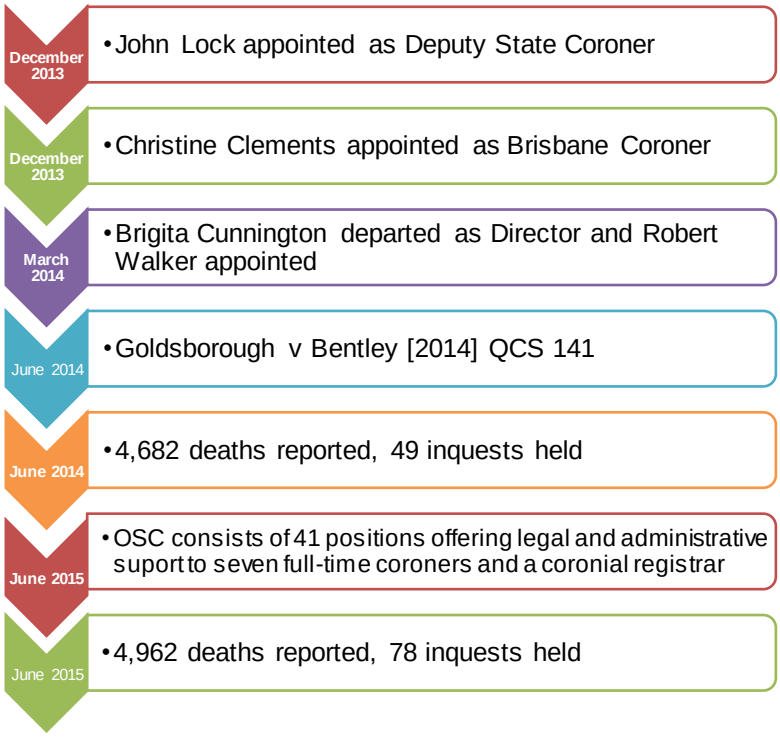
State Coroner Barnes conducted and finalised inquests into four 'cold cases' arising from two separate incidents. The inquests were conducted pursuant to a direction from the Attorney-General as the deaths occurred before the 2003 Act. The inquest into the deaths of Vicki Arnold and Julie-Anne Leahy was the third coronial inquest and came about from 'public disquiet about the findings' that being Ms Arnold killed her friend Ms Leahy before killing herself. The former State Coroner found numerous failings with the initial police investigation and that there was sufficient evidence to commit Mr Alan Leahy to stand trial for murder. The deaths of Lorraine Wilson and Wendy Evans in 1974 continued to receive media attention almost 40 years after their deaths. Following a lengthy inquest, it was found the two young nurses were murdered but the identities of those responsible could not be established.

During 2013-14, Magistrate John Lock was appointed to the position of Deputy State Coroner in December. Deputy State Coroner Lock's expertise and diligent commitment to the court and families is admirable. Ms Susan Beattie commenced as the Principal Researcher and Coordinator in the DFVDRU. Ms Brigita Cunnington, the current Executive Director/Principal Registrar of the Magistrates Courts Service Queensland, departed the court as Director after eight years of leadership. State Coroner Ryan noted many of the Office's achievements over that period were not have been accomplished without her enthusiasm, vision and support.

The period also saw the court undergo its first administrative review to examine the staffing structure and the effectiveness of the regional service delivery model. A number of recommendations were made, the primary recommendation from the Report presented in March 2014 was that the administrative work associated with supporting regional coroners to manage daily reported deaths be centralised to Brisbane. The commencement of this trial began in May with a review proposed in the 2014-15 period.

Following the 2012 appointment of a permanent Detective Senior Sergeant position in Cairns to support the Northern Coroner, a submission to have a dedicated officer in the Mackay Courthouse to support the Central Coroner was successful, with an officer commencing in November 2013. The coronial support officers across the state continue to bring a wealth of knowledge and experience to support the work of the court.

Amendments to the Coroners Act were passed in Parliament and from August 2013 enabled coroners to release investigation documents in the public interest and publish non-inquest findings. Two significant higher court decisions handed down in the period related to the former State Coroner, Michael Barnes' finding that Mr Alan Leahy be committed to stand trial for the murder of his wife and Vicki Arnold. Mr Leahy applied for a statutory order of review seeking that decision be set aside. Justice Henry made an order to that effect.



Magistrate Jane Bentley convened an inquest into the death of a woman at Granite Gorge in North Queensland. A decision not to prosecute under the Work Health and Safety Act 2011 was made by the Office of Fair and Safe Work Queensland. During the inquest the coroner directed an employee of that Office to answer a question relating to the decision not to prosecute, which was challenged by their legal representatives. The principle established by this case was that a coroner's powers under s 46(1) of the Coroners Act 2003 are not qualified by some general prohibition upon an investigation of or comment on a decision whether to prosecute someone in connection with the death being investigated.

During 2014-15, Jane Bentley concluded a two year term as the Northern Coroner in December 2014. Of note, Magistrate Bentley's coronial recommendations in the Jay Brogden inquest resulted in changes in the way the Queensland Police Service managed missing person files. In this period the court commenced implementation of the recommendations made in the 2013 administrative review by transitioning the process of daily reported deaths in the Northern Coroner's region to the Brisbane-based staff. The trial was fully implemented for the northern region with consultation to follow to implement the revised structure in the central and southern regions.

In July 2014, in response to the Child Protection Commission of Inquiry, the DFVDRU expanded its scope and function with a dedicated Senior Advisor position to assist coroners in their investigations of child deaths where there had been contact with the child protection system prior to the death. In 2015 the final report of the Special Taskforce on Domestic and Family Violence in Queensland, *Not Now, Not Ever: Putting an End to Domestic and Family Violence in Queensland* report acknowledged the important work of the DFVDRU and recommended the systemic domestic and family violence death review process be enhanced by increasing the capacity of the unit and by establishing an independent multi-disciplinary Domestic and Family Violence Death Review and Advisory Board (the Board) to undertake systemic reviews and domestic and family violence deaths in Queensland.

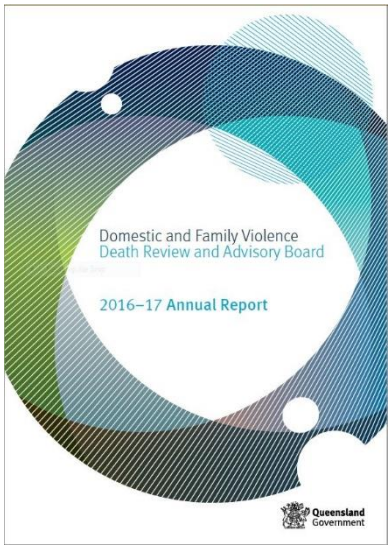
The Queensland Government amended the *Coroners Act 2003* to establish the Board for the purpose of identifying common systemic failures, gaps, or issues in its reviews of domestic and family violence deaths and to make recommendations to the Queensland Government to improve systems, practices and procedures to prevent future domestic and family violence deaths. The DFVDRU received additional resourcing to support the Board. The DFVDRU received one additional Principal Researcher and Coordinator with the other staff focused on management, administrative support and case management. Ms Susan Beattie was successful in a recruitment process for the Manager of the unit and has been integral in establishing and advancing the DFVDRU and in particular coordinating delivery of the Board's 2016-17 and 2017-18 annual reports.

- **September 2015** – Coroners (Domestic and Family Violence Death Review Advisory Board) Amendment Bill 2015 introduced in Parliament
- **June 2016** – CCQ consists of 48 positions offering legal and administrative suport to seven full-time coroners and a coronial registrar
- **June 2016** – 5,287 deaths reported, 43 inquests held
- **July 2016** – The Office of the State Coroner changed its name to the Coroners Court of Queensland
- **July 2016** – Domestic and Family Violence Death Review and Advisory Board appointed with State Coroner as Chair
- **January 2017** – Coronial Registrar workload adjusted due to unsustainable workload

The State Coroner acknowledged the continued support provided by our key partner agencies the Queensland Police Service and Queensland Health Forensic and Scientific Services during the period, in particular the leadership of Detective Inspector Roger Lowe whose tenure as the officer in charge of the Coronial Support Unit concluded in June 2015. Toward the end of the reporting period the Deputy State Coroner and office representatives contributed to a public forum to discuss feedback from affected families about the impact of the often inconsistent response by government agencies in investigating serious of fatal workplace injuries.

During 2015-16 period the Public Advocate released its report on a review of the deaths in care of people with a disability in care. On consideration of the recommendations in that report, the State Coroner agreed to report annually on deaths in care and to convene an expert panel to review the health care management of persons whose death had been reported to the coroner as a death in care (disability).

On 1 July 2016, the Office of the State Coroner changed its name to the Coroners Court of Queensland (CCQ) to better identify where the organisation sits within the Queensland Courts structure and to reflect its core business, being the administration of the coronial jurisdiction across the State of Queensland. Funding of $2.1 million was allocated to the CCQ for four years to enhance staffing in the DFVDRU and to support the establishment of the DFVDRAB (the Board). In October 2015, the legislative framework for the Board was established setting out its role and function as being separate and independent to the coronial investigation.



During 2016-17 the Government appointed 12 members of the Board, chaired by the State Coroner, Terry Ryan. The Board published its first annual report making 21 recommendations that aimed to enhance service accessibility and availability for victims and

perpetrators of domestic and family violence with the aim to prevent or reduce the likelihood of domestic and family violence deaths in Queensland.

The court again underwent a further organisational review in response to increased workloads and concerns about inefficient administrative processes. Due to an unsustainable workload, the coronial registrar's role was readjusted from January 2017 and the State Coroner noted that the efficiencies this role brings, and the workload pressures could be alleviated by a second coronial registrar. In May 2017 funds were allocated by the government to the Caxton Legal Service and the Townsville Community Legal Service to deliver state-wide Coronial Assistance Legal Service for three years (until June 2020). The initiative intended to offer grieving families free legal advice and representation at inquests. Data on deaths in care were reported on in the court's annual report for the first time. In addition, a summary of the findings of the Expert Panel report commissioned by the State Coroner in response to the Public Advocate's report were summarized with common issues identified across the eleven cases examined. A copy of that report was published on the CCQ website in July 2019.

During 2017-18 the court both responded to the largest number of deaths and cleared the largest number of deaths in its history. Magistrate Nerida Wilson was appointed to the position of Northern Coroner in September 2017 after Magistrate Priestly returned to the general magistracy. Coroner Wilson has adeptly stepped into the role taking carriage of a diverse range of reportable deaths due to the vastness of the Northern region.

As part of the Australian Domestic and Family Violence Death Review Network, the DFVDRU contributed to the development of the first ever national domestic and family violence context, intimate partner homicide database.

- June 2017 — CCQ consists of 50 positions offering legal and administrative suport to seven full-time coroners and a coronial registrar
- June 2017 — 5,587 deaths reported, 30 inquests finalised
- January 2018 — Workplace Edge report provided to DJAG, 36 of 42 recommendations accepted
- February 2018 — Queensland Audit Office review commences
- June 2018 — CCQ consists of 54 positions offering legal and administrative suport to seven full-time coroners and a coronial registrar
- June 2018 — 5,812 deaths reported, 52 inquests finalised

The 2018-19 reporting period was again a significant time of change for the court, its staff and partner agencies with the progression of implementation of recommendations from the independent organisational review. One of the 42 recommendations made was to return staff back to regional offices to better support regional coroners and bereaved families in these locations. This period also marked the commencement of a further review, this time by the Queensland Audit Office to assess the delivery of coronial services, which has been detailed earlier in this report.

The structure of the Coroners Court of Queensland, which started with only two full-time coroners in Brisbane, has evolved over the years with the number of judicial officers and legal and administrative staff increasing considerably across the State in order to respond to significant demand pressures. An increasing population, growing awareness of the importance of the coronial system and amendments to the Act have resulted in the number of reportable deaths increasing considerably over the last 15 years. The Queensland coronial system now has seven full-time specialist coroners and a coronial registrar dedicated to ensuring reportable deaths are independently examined with consideration given to prevent future deaths in similar circumstances.

A number of our staff have remained with the court for some time. Daniel Grice (second from bottom right), Leanne Field (bottom middle), Kristy Harvey (bottom left) and Paula Campbell (second down on the left), all pictured in the court's first annual report (right) have dedicated themselves to the court for many years.

Kristy began with coroners in 2002 and was instrumental in designing and developing the Coroners Case Management System, she remained with the court until early 2017.

Paula began with the office in 2005 and was appointed to the position of Office Manager in 2007, which she held until she retired in mid-2019. Paula was an invaluable support for staff and coroners and is an irreplaceable source of historical knowledge across all coronial processes. The announcement of her retirement was felt with genuine sadness by staff within the court and amongst our stakeholders.

Daniel has shaped the court's investigation and inquest case management practices and Leanne possess expertise in information release and genuine researcher enquiries and applications. Both Daniel and Leanne remain with the court to date.

The CCQ is also very fortunate to have retained a number of its staff for many years. The below staff have given five or more years' service to the court:

- Ainslie Kirkegaard
- Alana Martens
- Allison Crawford
- Angela Jacobsen
- Anna Tame
- Caitlin Honess
- Carla Nuessel
- Chloe Stubbings
- Debra Howarth
- Emily Cooper
- Jodie Simpson
- John Aberdeen
- Karen Porter
- Kaye Flynn
- Lyn Murray
- Lyndon Brewin
- Mark Ozolins
- Mary Hansen
- Megan Jarvis
- Michael Green
- John Aberdeen
- Patrice Bensted
- Peter DeWaard
- Peter Johns
- Purisima Rea
- Rhiannon Helsen
- Robyn Govan
- Sareeta Clarke
- Stephen Galler
- Sue Burns
- Susan Beattie
- Toni Mavrick

The individual contribution of these staff and all members of the court is gratefully acknowledged.

Following the QAO report the court continues to undergo significant reforms in order to adapt and be flexible to the changing needs and demands of the coronial system. The intent is to ensure that coroners are effectively supported to carry out their statutory function, court staff are equipped to deliver quality services and manage the distressing content they encounter, our relationships with our partner agencies are strengthened and enhanced and most importantly the bereaved families, friends and other persons who engage or come into contact with the coronial system are provided with sensitive, timely information and feel confident in the coronial investigation process into the death of their loved one.

Deaths in custody

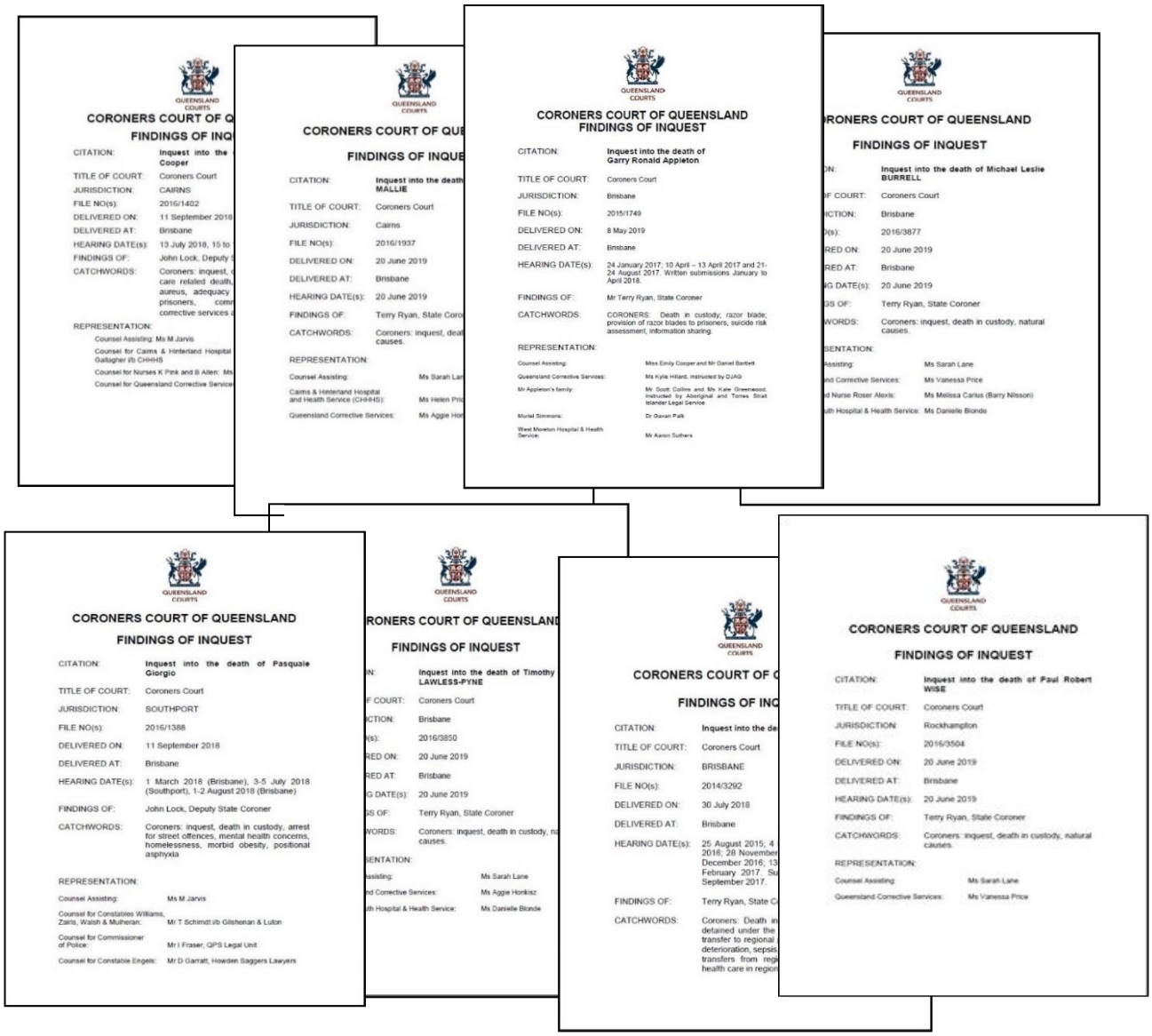
The term ***'death in custody'*** is defined in s10 of the Act to include those who, at the time of their death, are in custody, trying to escape from custody or trying to avoid being placed into custody.

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

It is ***mandatory*** for the State Coroner to conduct an inquest into a death in custody.

The following 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.



Russell Winks

Death in custody, police shooting, s46 comments from inquest, use of force model, police training, deployment of service rifles

Findings delivered 12 December 2018
State Coroner, Terry Ryan

Russell Winks aged 65 years, resided with his wife at a small rural property at Freestone. On 17 November 2016, he left his house and went into a gully at the back of his property. Mr Winks had taken a rifle with him and informed his wife that he was going to shoot himself. When his wife heard shots, she made a 000 call for assistance, advising that she thought her husband had shot himself.

Queensland Police Service (QPS) officers attended the property. On arrival, Mr Winks walked towards them with his rifle, yelling for police to shoot him – he also asked them to get a rifle as he did not want to be shot with a handgun.

Mr Winks ignored police directions to drop his rifle and walked out of their sight, back into the gully. Further police crews arrived, including an officer with a service rifle.

As police were in the process of effecting a withdrawal to avoid provoking Mr Winks, he walked from the gully towards them – he was waving the rifle, walking back and forth erratically and yelling at police to shoot him.

Mr Winks repeatedly ignored calls to drop his rifle. When Mr Winks raised his rifle in both hands to chest height and aimed it directly at the officer with a service rifle, he was shot by that officer and died at the scene.

THE INVESTIGATION

The QPS Ethical Standards Command (ESC) attended the scene and conducted a 'walk-through' re-enactment and obtained statements and recorded interviews with the attending police and Mr Winks' next of kin. The investigation was also informed by the QPS body camera footage, ambulance and medical records, and various forensic examinations, including photographs of the scene.

An expert review on the conduct of the officers and whether the use of lethal force was in accordance with the relevant sections of the police operational procedures manual was obtained.

A full internal autopsy examination was conducted, concluding the cause of death to be a gunshot wound to the right upper chest.

THE INQUEST

Mr Winks' death was deemed a death in custody and death in the course of a police operation. The inquest took place over three days in Toowoomba – with evidence heard from 12 witnesses, including Mrs Winks.

The focus of the inquest was whether the police 'use of force' was appropriate, whether there were any 'less than lethal' options not taken and whether the ESC investigation was sufficient.

During the inquest the issue of the deployment of the service rifle assumed prominence, with competing views heard in respect to the definition of deployment. At the conclusion of evidence, the State Coroner heard a statement from one of Mr Winks' daughters - setting out the impact her father's death had had on their family.

FINDINGS AND COMMENTS

The State Coroner noted the community has high expectations of police officers, particularly in times of crisis where 'use of force' options are employed in the performance on their functions.

The State Coroner found the application of lethal force to Mr Winks was appropriate in the circumstances and carried out in accordance with the policy in place at the time.

"The use of firearms by police, particularly when that use results in a death has the capacity to affect the trust and confidence that the community has in the police. A death in these circumstances raises many issues.."

The State Coroner concluded there was no 'less than lethal' use of force option open to the officers involved and that they were working towards the common goal of resolving the incident peacefully. Evidence heard at the inquest raised whether the presence of the service rifle 'escalated' the situation. While the State Coroner considered the deployment of the service rifle was authorised, he concluded there was insufficient evidence to find it was a major factor that worsened the situation.

The State Coroner was satisfied that the integrity of the evidence was preserved, and the investigation was thoroughly and professionally conducted.

RECOMMENDATIONS

The State Coroner accepted there was ambiguity in relation to the meaning of the word 'deployment' in the relevant provision of the QPS Operational Procedures Manual (OPM).

In that regard, the State Coroner recommended:

The QPS review the Operational Procedures Manual in order to clarify the use of the term 'deployment' with respect to service rifles, including the point at which authorisation is required and the criteria necessary to justify such deployment.

On 16 April 2019, the QPS Commissioner informed the State Coroner the recommendation to amend the OPM with respect to service rifles had been approved.

David John Cooper

Death in custody, health care related death, pneumonia due to S. aureus, adequacy of health services to prisoners, communication between corrective services and health services

Findings delivered 11 September 2018
Deputy State Coroner, John Lock

David John Cooper was a 54 year old inmate at the Lotus Glen Correctional Centre (LGCC) when he died. In the eleven days leading up to his death, Mr Cooper had been complaining of flu-like symptoms. Though not examined by a doctor, he was seen on two occasions by nursing staff of the Lotus Glen Offender Health Service (LGOHS) and prescribed pain relief and antibiotics.

On 5 April 2016 a custodial officer offered Mr Cooper the opportunity to be assessed at the medical clinic, he declined. The following day Mr Cooper was found in his bed, with no signs of life.

THE INVESTIGATION

The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) conducted the investigation. Relevant medical records and statements from custodial officers, nursing and medical staff were obtained.

The Deputy State Coroner sought an independent medical opinion on the clinical care provided to Mr Cooper.

A Root Cause Analysis (RCA) was conducted by the Cairns and Hinterland Hospital and Health Service (CHHHS) and provided to the Deputy State Coroner.

The autopsy determined the cause of death to be pneumonia due to staphylococcus aureus (a common bacteria that lives on the skin and in some peoples' noses which can cause mild to severe infections which can be fatal).

THE INQUEST

The inquest was held in Cairns and the formal findings required pursuant to s45 of the *Coroners Act 2003* formed the basis of the issues to be explored at the inquest.

In determining "how" Mr Cooper died, the inquest inquired into the adequacy of the health services received by Mr Cooper in the days prior to his death. In addition, the inquest also considered whether custodial or other staff had information about Mr Cooper's health that if communicated to nursing staff would have resulted in actions that might have had a different outcome for Mr Cooper.

FINDINGS AND COMMENTS

The Deputy State Coroner considered it likely Mr Cooper deteriorated rapidly as he was not critically unwell the day before his death.

Evidence was heard evidence from LGOHS and correctional staff that interacted with Mr Cooper on 5 April 2016. The Deputy State Coroner commented that there were no systemic communication issues that impacted on the care Mr Cooper received on 5 April 2016, when he reported feeling unwell, but declined to attend the medical centre.

The Deputy State Coroner commented that the RCA was critical of a number of documentation issues in Mr Cooper's medical records, making it difficult to conduct a review and primarily to determine what actions the nurses took at particular times and whether they were appropriate.

The Deputy State Coroner found the assessments and actions by the nursing and medical staff were reasonable.

"Only Mr Cooper knew how unwell he felt on 5 April 2016. It cannot now be known why he refused medical treatment that day, when on several occasions previously he had actively sought treatment.."

Evidence was explored with various witnesses whether an improvement to allow LGOHS staff to share confidential health information about a prisoner with QCS staff for the purpose of enabling them to assist in monitoring a prisoners' wellbeing. Reference to the Memorandum of Understanding (MOU) in this regard was discussed.

LGOHS and custodial staff noted in evidence that information sharing about a prisoner's health is shared without unnecessarily disclosing confidential information. The Deputy State Coroner however commented that it was not the role of, or

should custodial officers be expected to monitor a prisoner's wellbeing.

The Deputy State Coroner further commented with respect to the RCA that despite an adverse finding about an apparent failure by custodial staff to pass information to LGOHS staff, it was evident those staff were not interviewed as part of the process.

RECOMMENDATIONS

The Deputy State Coroner heard evidence from a number of LGOHS staff that significant improvements have been made following Mr Cooper's death.

In that context the Deputy State Coroner made two recommendations:

1. the review underway by a working group of Queensland Health and QCS examining the MOU and Operating Guidelines and referred to in two recent inquests also include consideration of the circumstances of Mr Cooper's death and findings.

2. where a Hospital and Health Services conducts a RCA in relation to the death of a prisoner who was receiving a health service, and concerns/opportunities for improvement are identified in relation to Queensland Corrective Services (QCS) policies and practices, the health service liaises with QCS to jointly review and take appropriate action and ensure there is a mechanism for gathering relevant QCS information to inform that investigation, including through interviews with QCS staff.

As at 7 May 2019, with respect to the MOU recommendation the Deputy State Coroner was advised it is under review and a working group will develop guidelines to support the sharing of information between hospital and health service staff with QCS officers.

Implementation of recommendation two is also in progress with the responsible agencies establishing a MOU to draw upon each other's investigation expertise and RCA processes.

Jay Maree Harmer

Death in custody, palliative care in a correctional setting, Hepatitis C, prisoner carers, exceptional circumstances parole applications.

Findings delivered 10 August 2018
State Coroner, Terry Ryan

Jay Maree Harmer had a complex medical history when she died, aged 38 at the Brisbane and Women's Correctional Centre (BWCC). From her teenage years, Ms Harmer had a history of opioid dependency and was on an opiate replacement therapy at the time of her death.

From July 2013 to early 2016, Ms Harmer's health deteriorated. A prison carer was assigned to her in May 2016. In the weeks leading up to her death her health worsened significantly; she chose to return to BWCC from hospital and was referred to palliative care. While waiting for an application for exceptional circumstances to be considered she was found deceased by her prison carer on 2 July 2016.

THE INVESTIGATION

The investigation was conducted by the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). CSIU officers attended the scene and obtained Ms Harmer's correctional records, medical files and statements from her cell mate, custodial officers and nursing and medical officers at the BWCC.

An expert review of Ms Harmer's medical care and information from the Queensland Parole Board with respect to Ms Harmer's parole application were also obtained.

Ms Harmer's mother objected to an internal autopsy - an external autopsy and associated toxicology testing and review of medical records was undertaken. The pathologist commented Ms Harmer had a high risk of potential death and did not identify any suspicious circumstances.

The cause of death was found to be consistent with complications of decompensated liver failure, related to cirrhosis secondary to Hepatitis C infection with non-alcoholic steatohepatitis.

THE INQUEST

Five witnesses were called to give oral evidence with respect to:

- the appropriateness of the facilities available to inmates with chronic or terminal illness at BWCC;
- the adequacy of health and palliative care Ms Harmer received from Queensland Corrective Services (QCS) and their in-house health providers; and
- the process by which her special circumstances parole application was considered.

The State Coroner heard evidence that due to the severity of her illness in June 2016, it was inappropriate for Ms Harmer to be housed in a prison cell, when she clearly required inpatient palliative care.

Further to this, evidence regarding whether or not Ms Harmer should have been forced to return to hospital with respect to s21 of the *Corrective Services Act 2006* (which provides a prisoner must submit to medical examination/treatment if the doctors considers the prisoner requires it) and in light of an adult with capacity having the right to refuse treatment, was also examined.

The State Coroner also heard evidence about the significant challenges associated with the provision of palliative care to prisoners and steps being taken to improve the treatment and care available to prisoners in BWCC in relation to Chronic Hepatitis C.

FINDINGS AND COMMENTS

The State Coroner agreed, despite Ms Harmer's very challenging clinical and social circumstances, she received regular and appropriate health care from the prison health services and had access to specialist and hospital treatment.

The State Coroner accepted that in the absence of Ms Harmer's consent to remain at hospital, a direction under s21 or a grant of exceptional circumstances parole, there were no suitable alternatives available. The State Coroner agreed that such care is best provided outside the prison environment.

The family of Ms Harmer submitted that information provided to the Parole Board was not the best available evidence and resulted in a missed opportunity for her to reconnect with her family and die in accordance with a palliative care plan. While the State Coroner agreed, he made no adverse comment in this regard.

"It was clear from evidence at this inquest that there are significant challenges associated with the provision of quality palliative care to prisoners, including at BWCC, and that the available facilities are generally inadequate for this population."

The Deputy President, Parole Board Queensland noted in evidence that the decision to grant exceptional circumstances parole on medical grounds is an evidence-based approach, with many factors considered.

It was further stated that due to an ageing prison population, there is difficulty finding accommodation in the community due to the nature of their offending (often historical sexual offences). The State Coroner commented where appropriate to do so, prisoners requiring palliative care should be removed to other facilities that are better able to manage their health needs at a lower cost.

RECOMMENDATIONS

The State Coroner made four recommendations:

1. The Queensland Government comprehensively review the model for the provision of palliative care to prisoners, including how and where it is delivered and post-release support accommodation;
2. QCS develop of a policy in relation to the selection of prisoner carers, requiring they be trained in basic first aid;
3. Queensland Government ensure the Parole Board Queensland has access to relevant reports tendered during sentencing proceedings i.e. medical, psychiatric and enhance information sharing between QCS and Queensland Health; and
4. QCS and Parole Board Queensland prepare guidelines to assist doctors when preparing reports in relation to exceptional circumstances parole applications with consideration being given to obtaining advice from the Clinical Forensic Medicine Unit.

As at 2 June 2019, the Department of Health advised the recommendation was agreed to in part and implementation was in progress which has resulted in the established of the Office for Prisoner Health and Wellbeing. The Office will have oversight of health service delivery for prisoners statewide. As at 7 May 2019, recommendations 2-4 were under consideration by QCS with preliminary information gathering undertaken.

Kenneth Douglas Wright

Death in custody, prisoner with impaired capacity, palliative care, deteriorating patient, emergency response.

Findings delivered 3 August 2018
State Coroner, Terry Ryan

Kenneth Douglas Wright died at the aged of 71 in the Advanced Care Unit (ACU) at the Southern Queensland Correctional Centre (SQCC) a privately run facility by Serco.

Mr Wright had a slight cognitive impairment and was bedridden as a consequence of significant head and other injuries sustained at a different correctional facility in 2014.

After serving an initial period of imprisonment, in 2013, Mr Wright was charged with further child

pornography offences and was remanded in custody up until his death – the charges were listed for mention in late March 2015, he died on 20 March.

THE INVESTIGATION

The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) attended the scene and conducted the investigation. CSIU officers acquired relevant medical and correctional records. Statements from SQCC correctional officers and nursing staff as well as a medical officer at the Princess Alexandra Hospital (PAH) were also obtained.

The State Coroner sought an independent medical opinion on the care provided to Mr Wright at the SQCC and the PAH.

Following autopsy, the cause of death was found to be aspiration pneumonia, due to or as a consequence of traumatic brain injury, which was a consequence of a fall from height.

THE INQUEST

Five witnesses were called to give oral evidence with a focus on the events of 20 March 2015, in particular:

- the adequacy and appropriateness of the care provided to him at SQCC;
- the management of the Code Blue and decisions surrounding resuscitation, specifically the decision not to commence CPR; and

In evidence, the independent medical officer expressed concern about Mr Wright's management after he was found unstable on 20 March 2015, particularly a decision to leave him unmonitored and unattended.

The State Coroner heard that no observations or medical treatment were provided to Mr Wright from 1:33pm (when unstable concerning vital signs were observed) to 2:40pm when a nurse came and checked on him. That nurse than exited the room to call a Code Blue.

In further evidence it was stated that following the Code Blue call an assessment of Mr Wright by nursing staff determined CPR would not have assisted and was not commenced.

In his findings the State Coroner noted, having raised the alarm, both the Code Blue guidelines and Death in Custody procedure requires the administration of first aid and lifesaving measures.

The State Coroner also heard evidence from the nursing staff involved that the procedure relating to calling an ambulance was confusing.

FINDINGS AND COMMENTS

The State Coroner noted Mr Wright was a chronically unwell man with complex medical issues and due to his status as a remand prisoner he was ineligible for exceptional circumstances parole.

The State Coroner noted that any contention in relation to the Code Blue response might have been removed had there been more proactive communication between SQCC and the Public Guardian in relation to consent about withholding of ventilation and CPR.

The State Coroner found the care provided to Mr Wright at SQCC was generally of a high standard. However, the response to his deteriorating state on 20 March 2015 should have been to provide supportive oxygen as a matter of urgency, while ambulance assistance was enlisted, and a medical officer consulted.

The State Coroner commented that there was a failure in the emergency response to Mr Wright.

"In this case there was a failure to respond to the clear warning sign of diminishing oxygen saturation levels in timely way. The response should have been to provide supplementary oxygen, increase observations and call for urgent QAS assistance."

The State Coroner accepted that at 2:43pm when the Code Blue was called, nursing staff took suitable actions to review Mr Wright's vital signs and they appropriately formed the view that CPR efforts would be futile.

RECOMMENDATIONS

Serco provided evidence that steps have been taken to ensure elderly prisoners in SQCC who do not wish to be resuscitated complete relevant paperwork. In addition, induction for new staff includes a unit on emergency procedures and contingency codes.

In 2017, Queensland Health produced a Prison Health Services Queensland Adult Deterioration Detection System (Q-ADDS) tool, designed for detecting deterioration in a prison setting. While this tool did not exist at the time of Mr Wright's death it was introduced to SQCC on 19 March 2018.

In that context, the State Coroner made one recommendation:

1. Serco, in conjunction with QCS conduct a review of the process for calling for ambulance attendance at the SQCC, and the priority given to those requests. Consideration should be given to authorising clinical staff to directly request urgent ambulance assistance.

As at 7 May 2019, the State Coroner was advised the recommendation had been implemented.

Timothy Paul Lawless-Pyne

Death in custody, natural causes

Findings delivered 20 June 2019
State Coroner, Terry Ryan

Timothy Lawless-Pyne died at the age of 57 in the palliative care unit at the Princess Alexandra Hospital Secure Unit (PAHSU).

In his early teens Mr Lawless-Pyne was reported to have developed a drug habit which led him into the criminal justice system. His sister advised in his mid-twenties Timothy was diagnosed with marijuana induced bipolar disorder.

Mr Lawless-Pyne's criminal history escalated in seriousness over the course of his life. His fourth adult period incarceration was a sentence of life imprisonment for murder on 30 April 1998, during which time he committed two further offences in prison.

THE INVESTIGATION

The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) attended the PAH upon his death. CSIU offices acquired relevant medical and correctional records, statements from SQCC correctional officers and nursing staff as well as the PAH medical officer.

The State Coroner requested an independent medical opinion on the care provided to Mr Lawless-Pyne in the twelve months leading up to his death.

Following an external autopsy with associated testing and medical record review the cause of death was found to be;

1(a) Bleeding oesophageal varices;
1(b) Cirrhosis and metastatic hepatocellular carcinoma; and
1(c) Hepatitis C infection

THE INQUEST

Due to the circumstances of the death, being on its face, a death from natural causes, the inquest proceeded directly to submissions in lieu of any oral testimony. All material obtained during the course of the investigation was tendered at the inquest.

FINDINGS AND COMMENTS

The State Coroner accepted the death was from natural causes with no suspicious circumstances associated with it. The State Coroner further commented that Mr Lawless-Pyne was provided with appropriate medical care by WCC staff and at the PAH.

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

In those circumstances the State Coroner accepted that there were no comments or recommendations that could be made that would assist in preventing future deaths or otherwise relate to public health and safety.

Paul Robert Wise

Death in custody, natural causes

Findings delivered 20 June 2019
State Coroner, Terry Ryan

Paul Robert Wise died on 17 August 2016 at the age of 48 in his cell at the Capricornia Correctional Centre (CCC). He was secured in his cell around 6:00pm the night before and was located deceased, still in his bed, by correctional officers, the following morning around 7:45am. Mr Wise had only returned to the CCC on 13 July 2016 after failing a drug test while on parole.

THE INVESTIGATION

Upon his death, officer from the Rockhampton CIB attended the correctional centre; they noted he was the only occupant of the cell and did not have any concerning marks or injuries.

A report provided by the investigating Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) was provided to the State

Coroner. The CSU report was informed by statements of correctional officers and one provided by Mr Wise's mother, who further expressed concerns to the Coroners Court about her son's death.

An internal and external autopsy was conducted. The pathologist commented on the presence of severe coronary artery disease and determined the cause of death to be, coronary artery occlusion due to or as a consequence of coronary artery atheroma.

The State Coroner requested an independent medical opinion on the health care provided to Mr Wise in the twelve months leading up to his death. The autopsy report, Mr Wise's medical records, the police report and Mrs Wise's concerns were reviewed by the doctor.

THE INQUEST

Though the death of Mr Wise was from natural causes an inquest was required by the Act as he died in custody. In those circumstances, the inquest proceeded directly to submissions in lieu of any oral testimony.

All material obtained during the course of the investigation was tendered at the inquest. The State Coroner also had the benefit of written submissions from Queensland Corrective Services.

FINDINGS AND COMMENTS

The State Coroner accepted the death was from natural causes with no suspicious circumstances associated with it.

"I am satisfied that Mr Wise was given appropriate medical care by staff at the CCC. Mr Wise's death could not reasonably been prevented".

Accordingly, there were no recommendations that could be made.

William Michael Mallie

Death in custody, natural causes

Findings delivered 20 June 2019
State Coroner, Terry Ryan

William Michael Mallie, a Torres Strait Islander man, was 58 years old at the time of his death. Mr Mallie was serving a lengthy period of imprisonment when he died in the hospital wing of the Lotus Glen Correctional Centre (LGCC) where he had been receiving his regular dialysis treatment.

Shortly after 1:30pm on 14 May 2016, Mr Mallie went into respiratory distress and became unresponsive. CPR was commenced by nursing staff and then taken over the Queensland Ambulance Service staff on their arrival, but he was unable to be resuscitated.

"At 1:56 pm QAS arrived and took over Mr Mallie's resuscitation. Paramedics worked on Mr Mallie in the medical centre for just over an hour, but unfortunately, he did not recover."

THE INVESTIGATION

The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) officer provided a report to the State Coroner, which was informed by Mr Mallie's correctional records, medical files and statements.

The State Coroner requested an independent medical opinion on the care provided to Mr Mallie in the twelve months leading up to his death. The material provided included a complaint to the Office of the Health Ombudsman (OHO) submitted on Mr Mallie's behalf by the Deaths in Custody Watching Group. The complaint centred on the LGCC not having adequate medical services to provide treatment to him and that his cultural needs were not able to be meet at the centre.

The Cairns and Hinterland Hospital and Health Service responded by providing an expert report. The OHO advised it would take no further action and was satisfied the medical and cultural care provided was appropriate.

An autopsy consisting of an internal and external examination determined the cause of death to be atherosclerotic cardiovascular disease with diabetes mellitus listed as another contributing factor.

THE INQUEST

Though an inquest was required by the Act as Mr Mallie died in custody. All of the material obtained during the course of the investigation was tendered and the inquest proceeded directly to submissions in lieu of any oral testimony. The State Coroner also had the benefit of written submissions from Queensland Corrective Services.

FINDINGS AND COMMENTS

The State Coroner accepted Mr Mallie's death was from natural causes with no suspicious circumstances associated with it. The State Coroner further commented that he was provided with appropriate medical care by LGCC staff.

In those circumstances the State Coroner accepted that there were no comments or recommendations that could be made that would assist in preventing future deaths or otherwise relate to public health and safety.

Michael Leslie Burrell

Death in custody, natural causes

Findings delivered 20 June 2019
State Coroner, Terry Ryan

Michael Leslie Burrell, aged 58 years, died in palliative care in the Princess Alexandra Hospital (PAH) Secure Unit. He had been transferred there from the Wolston Correctional Centre (WCC) where he had been serving a term of imprisonment for manslaughter.

Mr Burrell had a significant medical history, which included the contraction of hepatitis C infection in the late 1970's. Following a car accident in 1997, he had his spleen removed and right leg amputated, for which he then suffered from recurrent leg infections.

THE INVESTIGATION

An investigation was conducted by the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). CSIU officers attended to the PAH and took photographs of the scene. Medical and correctional centre records were obtained as well as statements from nursing and medical staff.

An external autopsy determined the cause of death to be multifocal hepatocellular carcinoma, due to cirrhosis of the liver, due to hepatitis C infection. The pathologist commented on the presence of potentially toxic levels of an anti-depressant but it was not considered a factor that contributed to the death.

An independent medical review by the Clinical Forensic Medicine Unit was also sought by the Coroners Court. The PAH also conducted an internal clinical review which was provided to the State Coroner, it identified a number of 'contributing factors' or issues related to the death.

THE INQUEST

As Mr Burrell died in custody, an inquest was required by s27 of the Act. The State Coroner determined that the matter could proceed directly to submissions in lieu of oral evidence and tendered all the investigation material, medical records and reports into evidence. Queensland Corrective Services also provided written submissions for the State Coroner's consideration.

FINDINGS AND COMMENTS

In consideration of the internal review by the PAH and the independent medical report, the State Coroner acknowledged there were some shortcomings with respect to the PAH in the identification of abdominal pain on admission and in adherence to the initiation of a Code Blue.

"I also acknowledge that where the PAH's clinical review identified human errors as contributory factors, the identification of those factors should not be equated with a finding of fault on the part of the relevant clinical staff. It was necessary to assess the actions of those staff in the context of the circumstances at the time."

Ultimately, the State Coroner accepted that Mr Burrell's death was from natural causes and the medical care provided to him was appropriate.

The State Coroner was also satisfied with the response by the PAH to the factors and issues identified in their internal review. In those circumstances, the State Coroner did not make any recommendations.

Pasquale Giorgio

Death in custody, arrest for street offences, mental health concerns, homelessness, morbid obesity, positional asphyxia

Findings delivered 11 September 2018
Deputy State Coroner, John Lock

Pasquale Giorgio was 54 years of age when he was detained by police for public nuisance offences.

As he struggled with police during the arrest, he was taken to the ground, placed in a prone position and handcuffed. Police then placed him in the rear of a paddy wagon (POD). The Queensland Ambulance Service (QAS) were asked to attend as he was considered unwell.

Upon the direction of a more senior police officer, Mr Giorgio was taken from the POD and his handcuffs removed. He was unconscious and attempts to revive him by police, a medical practitioner passing by and the QAS were unsuccessful. He was declared deceased within 45 minutes of being approached by police.

Mr Giorgio had a long history of schizophrenia, and homelessness. He was treated by mental health authorities in South Australia and New South Wales.

The day prior to his death he had contact with police who attended to him as he was behaving oddly.

THE INVESTIGATION

The Queensland Police Service (QPS) Ethical Standards Command (ESC) investigated the death. ESC examined the actions of the attending police in relation to policy and legislation, obtained statements from of all attending police and QAS officers, as well as bodycam footage that was activated by police prior to approaching Mr Giorgio.

An expert review with respect to use of force, police arrest and control techniques/tactics was obtained. ESC investigators also sought a response from the QAS Medical Director in relation to response times to the incident. A review of Mr Giorgio's 'clinical course' from the time of his arrest to being declared deceased was further provided by the Medical Director.

The pathologist who performed the autopsy attended the scene to observe the body. The pathologist also had the benefit of a briefing by police about the events and body cam footage taken by the arresting officers.

Following a full autopsy together with neuropathology, toxicology and CT scans, the pathologist considered the cause of death to be a result of a "chain/linked series of events and/or interaction of factors". Those factors included pre-existing medical conditions and the consequences arising from being restrained in a prone position.

THE INQUEST

As Mr Giorgio died whilst under arrest by the police, his death was a 'death in custody' and an inquest was required under the Coroners Act.

The Deputy State Coroner called 12 witnesses to give oral evidence. The witnesses included the arresting officers, QAS first responders and the professionals commissioned to provide expert reports.

The focus of the inquest was on the events of 5 April 2016 and the interaction Mr Giorgio had with police on the day prior to his death.

FINDINGS AND COMMENTS

With respect to the day prior to the death, the Deputy State Coroner was satisfied there was not a missed opportunity by police to have taken him into custody for mental health issues.

The Deputy State Coroner considered whether there were alternatives to arresting Mr Giorgio. In view of the context of police attendance, the Deputy State Coroner commented that police acted in accordance with their training, legislation and policy when they lawfully arrested Mr Giorgio.

Whether Mr Giorgio should have been removed from the van earlier was examined at the inquest. The Deputy State Coroner agreed with the QAS Medical Director's opinion that while the actions of police were well-intentioned, in hindsight there was a missed opportunity to remove him from the POD and provide medical treatment.

"In this case, the officers were potentially in such a position but unfortunately did not recognise that Mr Giorgio needed that assistance. This was a tragic outcome not only for Mr Giorgio and his family, but also for the officers involved."

RECOMMENDATIONS

The Deputy State Coroner noted that those involved in the incident and those who reviewed it from a clinical and policing perspective agreed that better education and training would have benefited the arresting police officers.

In that context, the Deputy State Coroner made two recommendations:

1. Education specialists from both QPS and QAS jointly review the circumstances of Mr Giorgio's death and identify the most appropriate means for enhancing the ability of police officers to respond more effectively to similar circumstances in future.

2. The first aid capability of the QPS vehicle be reviewed to ensure they carry basic equipment such as mouth to mouth face masks.

As at 2 May 2019, the Deputy State Coroner was advised both recommendations were in progress.

Terrence Michael Malone

Death in custody, provision of disposable razors to prisoners, decision to suspend parole, mental health history, information sharing, suicide risk assessment.

Findings delivered 8 May 2019
State Coroner, Terry Ryan

Terence Michael Malone died at the age of 54 in his cell at the Brisbane Correctional Centre (BCC). He was found on his bed with a number of long cuts observed on the inner surface of his arms. A small dismantled razor blade was found on the sink and on the floor of his cell.

In the years preceding his death, Mr Malone became homeless, and increasingly involved with the criminal justice system for minor offending. He had a lengthy history of mental health treatment.

On 21 October 2014, Mr Malone was released to court ordered parole and referred and assessed by the Prison Mental Health Service (PMHS) a number of times.

At this time Mr Malone also entered a six week rehabilitation program to address his alcohol dependence. However, he was discharged seven days later when found with alcohol on his person.

On 1 November 2014, he presented at the Toowoomba Hospital for the purpose of an Emergency Examination Order (EEO) under the Mental Health Act.

After Mr Malone failed to report or contact his parole officer, he was subsequently arrested on 5 November and taken to the Toowoomba watch house and returned to prison (his second period of incarceration). He died the following day.

THE INVESTIGATION

The death was investigated by the Queensland Police Service (QPS) Corrective Services Unit (CSIU). The cell was inspected, forensic evidence obtained, statements (including those from his family) gathered and other evidence including medical records, photographs and CCTV footage seized. The CSIU investigator did not consider the death suspicious and opined Mr Malone was alone in his cell at the time of his death. A full internal autopsy was conducted and confirmed the cause of death was from an incised would to the neck.

The Chief Inspector, QCS appointed investigators to examine the incident. Those investigators provided a copy of their report to the State Coroner.

The State Coroner sought an expert report from a consultant psychiatrist which provided an opinion on the adequacy and appropriateness of the mental care provided to Mr Malone in the six months leading up to his death and, the responses by the clinicians to the EEO in November 2014.

THE INQUEST

As Mr Malone died in custody an inquest was required. The State Coroner heard evidence from 18 witnesses and all investigation material was tendered at the inquest.

The focus of the inquest was to examine the appropriateness of decisions and responses in the week leading up to his death. Specifically, the EEO assessment at the Toowoomba Hospital, the health care provided at BCC, the decision to suspend his parole. The availability of razor blades to prisoners in Queensland correctional facilities was also examined.

This final issue was also explored jointly with the inquest into the death of Mr Appleton (case summary follows).

Representatives for Mr Malone's family were granted leave to appear and his daughter gave evidence at the inquest.

FINDINGS AND COMMENTS

It was submitted by the family that Mr Malone "fell through the cracks" at the Toowoomba Hospital, when he was being assessed a suicide risk. The State Coroner agreed with the family that there were systemic failings in the Toowoomba Hospital's response to Mr Malone.

In relation to the adequacy of the mental health care provided at the BCC the State Coroner noted:

> ***"In my view, it was necessary to consider more than Mr Malone's self-reporting in relation to current suicidal ideation and his recent history of suicide attempts. As his letter to his family prior to his suicide indicated, he was clearly in distress. He had a range of other concerns that were not identified or responded to, and contributed to his decision to end his own life. These ranged from not having reading glasses, the chronic pain from his shoulder injury and concerns about coping with alcohol withdrawal in prison."***

In relation to the decision to revoke Mr Malone's parole order, the family submitted in view of the circumstances the decision was hasty and premature. The State Coroner commented that though the course of action was open to Queensland Corrective Services, more could have been done by officers to engage with him before any breach action was taken.

The State Coroner was of the view that Mr Malone's death might have been prevented and that there is a need for enhanced approaches to responding to suicide risk in the correctional environment.

In those circumstances the State Coroner made six recommendations that centred on;

- the development of a policy in relation to the management of risks associated with the provision of razor blades to prisoners;
- a review of approaches to suicide risk assessment in the context of best practice;
- increased funding to enable enhancements in the prisoner IOMS system to enable risk assessment information to be displayed;
- increased funding to attract and retain experienced psychologists within custodial settings;
- his findings be provided to key agencies overseeing the Mental Health, Alcohol and Other Drugs Strategic Plan to inform responses to persons with co-occurring mental illness and substance use disorders who are at risk of entering or have entered the criminal justice system; and
- the Queensland Government consider a trial program for "Front End Services" of intake, health assessment and mental health assessment at the Brisbane City watch house that involves collaboration between relevant stakeholders including Queensland Corrective Services, QPS and the PMHS.

Garry Ronald Appleton

Death in custody, razor blade, provision of razor blades to prisoners, suicide risk assessment, information sharing

Findings delivered 8 May 2019
State Coroner, Terry Ryan

Garry Appleton was 48 years of age when he was found slumped in a sitting position in his cell at the Brisbane Correctional Centre (BCC). There was a large amount of blood throughout his cell and a dismantled disposable razor blade located.

Mr Appleton had a long history of mental health illness and imprisonment. He was arrested on a 'return to prison' warrant on 30 April 2015 relating to a breach of his parole.

On that day Mr Appleton was taken to the Ipswich Hospital Emergency Department for review of his previously diagnosed chronic obstructive pulmonary disease. During that review he reported hearing negative voices that morning. He was transferred to the Princess Alexandra Hospital Secure Unit and it was noted he had not taken his mental health medication for the past three days.

Mr Appleton was received to the BCC on 1 May 2015, he was placed in a protection unit, and assessed at being a low risk of suicide. On 7 May, before being transferred to another unit, he experienced a panic attack. After his transfer to another unit later that day his mental health deteriorated.

When medical staff arrived at his cell on 9 May he was semi-conscious. Despite prolonged resuscitation efforts he was declared deceased.

THE INVESTIGATION

The Queensland Police Service (QPS) Corrective Services Unit (CSIU) investigated Mr Appleton's death. The cell was examined and photographed, statements taken from senior staff, correctional officers and inmates, relevant records seized, an interrogation of the BCC's Integrated Offender Management System conducted and CCTV footage obtained.

The CSIU investigator did not consider the death suspicious and was satisfied he was alone in his cell at the time. The Chief Inspector, QCS appointed investigators to examine the incident. Those investigators provided a copy of their report to the State Coroner.

A full internal autopsy was conducted and confirmed the cause of death was from hypovolemic shock due to incised wounds to the arms. Coronary atherosclerosis and emphysema were noted as other significant conditions.

Similar to the investigation into the death of Mr Malone, the State Coroner sought an expert report from a consultant psychiatrist regarding the adequacy of mental health assessment and mental health care provided to Mr Appleton.

THE INQUEST

The focus of the inquest into Mr Appleton's death was the adequacy of the health care (including mental health care) provided to him from 30 April 2015. The adequacy of the Immediate Risk Needs Assessment (IRNA) process, which is required to be conducted

when a prisoner enters a facility was examined in detail.

As the inquest was heard conjointly with Mr Malone's matter, the State Coroner also examined the availability of razor blades to prisoners in Queensland correctional facilities.

FINDINGS AND COMMENTS

The State Coroner commented that although the IRNA assessment on 1 May 2015 was adequate, there was a failure to respond to Mr Appleton's significant deterioration in mental health and escalation of suicide risk after 7 May 2015 when he was transferred to another unit.

"Mr Appleton's death might have been prevented if, having regard to his dynamic risk factor and his mental health history including the specific nature of previous self-harm episodes, he had been prevented from having a razor blade issued to him by the prison or placed on an at risk observations regime".

The State Coroner found that although Mr Appleton died as a result of cutting his own forearms with a prison-issued razor blade, he was satisfied it was unintentional as a result of him calling for help after the self-harm incident.

The State Coroner restated the recommendations he made in the Terrence Malone inquest.

Hamid Khazaei

Death in custody, asylum seeker detained under the Migration Act 1958 (Cth), transfer to regional processing centre, clinical deterioration, sepsis, arrangements for medical transfers from regional processing centres, health care in regional processing countries

Findings delivered 30 July 2018
State Coroner, Terry Ryan

Hamid Khazaei was a detainee at the Manus Island Regional Processing Centre (MIRPC). He became ill and presented to the International Health and Medical Services (IHMS) clinic on Manus Island on 23 August 2014 with flu-like symptoms and a small lesion on his leg. He was unable to be treated. His condition rapidly deteriorated and was eventually transferred to the Pacific International Hospital (PIH) in Port Moresby three days later. At the PIH his condition continued to deteriorate, they did not have the necessary skills or equipment to deal with his presentation. He was transferred by medevac the following day to the Mater Hospital in Brisbane. No handover about his clinical management at the PIH was provided. He was 24 years of age when he died on 5 September 2014.

THE INVESTIGATION

The State Coroner received medical records, statements and other relevant material related Mr Khazaei from IHMS and International SOS Australasia, the Department of Immigration and Border Protection, PIH, Mater Health Services, Transfield Services and expert reports (further detail below).

A full internal autopsy and associated toxicology testing, CT scans and a review of Mr Khazaei's clinical records was conducted. The forensic pathologist explained the primary cause of his brain death was hypoxic-ischaemic encephalopathy, which is correlated with cardiac arrest, of which the underlying cause being severe sepsis.

THE INQUEST

As Mr Khazaei, an Iranian citizen was detained under the *Migration Act 1958* an inquest into his death was mandatory as he died in custody in Queensland. In the lead up to the inquest there were several pre-inquest conferences held between August 2015 and June 2016 to settle the issues to be explored at the hearing.

The issues for examination focused on the adequacy of medical care provided to Mr Khazaei from 23 August 2014, the adequacy of the transfer arrangements, including the decision to transfer to PIH rather than an Australian hospital, the adequacy of the policies and processes in place relating to recording of medical observations and treatment of sepsis and medical evacuation and the adequacy of any steps taken by the involved entities to prevent a similar death from occurring in the future.

The State Coroner heard from 32 witnesses, including two court appointed experts, who addressed specific questions in relation to the emergency medicine and retrieval aspect and the intensive care aspect of the investigation.

At the conclusion of evidence the State Coroner received submissions comprising of hundreds of pages at the conclusion of evidence.

FINDINGS AND COMMENTS

The State Coroner found that Mr Khazaei's death was preventable. Having regard to the evidence the State Coroner noted there was a significant delay in responding to his critical care needs at the PIH which led to a cardiac arrest after which Mr Khazaei's condition became irretrievable. The State Coroner provided a summary of the conclusions reached in his findings in relation to the issues identified in the inquest, noting:

"Having regard to those conclusions, it would be possible to characterise the circumstances that led to Mr Khazaei's death simply as a series of clinical errors, compounded by failures in communication that led to poor handovers and significant delays in his retrieval from Manus Island.
However, attributing responsibility for those events solely on failures by individual clinicians tasked with his care and others responsible for arranging his transfer from Manus Island is not helpful when looking for ways to prevent similar deaths from happening in future. It is important to consider the broader context in which Mr Khazaei's death occurred in order to find ways to prevent similar incidents".

RECOMMENDATIONS

The State Coroner noted that the inquest into Mr Khazaei's death highlighted practical and operational issues associated with delivering an appropriate standard of health care in a remote offshore processing centre and that the level of medical care he was entitled to receive was not adequate. In those circumstances the State Coroner made eight recommendations to prevent similar deaths from occurring in future.

On 29 September 2019 the State Coroner received a response to the recommendations from the Department of Home Affairs with input received from the Attorney-General's Department.

Public interest inquests

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

Bryan Hodgkinson

Finalisation of adjourned 1988 inquest, circumstances of the cause of death, identification of the person responsible, utility of the Coroners Act 1958 to a modern coronial investigation, Coroners Act 203 transitional provisions

Findings delivered 18 December 2018
Central Coroner, David O'Connell

Bryan Hodgkinson was located deceased in very violent circumstances on a rural road in bushland about 30 km south of Bundaberg on 8 September 1987. He was a taxi driver and had been working that evening. Mr Anthony Beer was charged with certain offences arising out of the incident, but no person was ever charged with Mr Hodgkinson's murder.

The police investigation remained opened with a significant review conducted in 2014. An inquest was part heard in 1988 and adjourned to a date to be fixed. The State Coroner, under the *Coroners Act 1958* directed it be completed.

The Central Coroner commented that it was unfortunate for the family that under the 1958 legislation, Mr Beer is not compelled to give evidence, particularly in light of allegedly making certain statements as to what occurred that evening.

"These cases require something additional to their investigation in an effort to resolve them and give the families the answers that they deserve. The Coroners Act 2003 has the enhanced coronial procedures to obtain the truths sought. The families deserve this, the public deserves this, and so I will recommend that this issue be placed before the Attorney-General as soon as possible for consideration, and implementation".

The Central Coroner was unable to reach a conclusion on the evidence as to which of the two main persons of interest was responsible for Mr Hodkinson's death. In the circumstances, the Central Coroner did not make a referral to charge any person for any Criminal Code offence.

As at 5 July 2019, the Attorney-General was considering the results of consultation with key legal stakeholders about their view on the recommended change.

Joseph Mark Scaturchio

Reopening, coronial investigations, jet ski collision, jet ski racing, pro stock race, collision, cavitation, additional contact, race bumping, unhooked, forensic recording analysis, engine control unit ECU, MoTeC data, MoTec report and analysis, I2 analysis software, PWC (personal water craft)

Findings delivered 24 June 2019
Brisbane Coroner, Graham Lee

Joseph Scaturchio died competing in a jet ski race on the Gold Coast in April 2012. The death was initially finalised by non-inquest findings. Mr Scaturchio's family via their legal representative requested the matter be re-opened and further investigation conducted on the basis of new evidence, that being a report prepared by a mechanical engineer that refuted the preferred scenario of how the death occurred.

The State Coroner directed the investigation be re-opened and Coroner Lee determined an inquest be held to examine the conflict between the conclusions reached about the cause of the death.

An inquest was held over two days with a number of expert witnesses called and enhanced video footage closely examined. Coroner Lee also heard concurrent evidence *(giving of evidence by two or more persons in the same field of expertise)* to determine the cause of the collision, the point of contact and the cause of Mr Scaturchio's chest injuries.

Coroner Lee found that Mr Scaturchio died following a collision between his jet ski and that of another competitor, Mr Lewis. It was determined the most likely scenario is that prior to that collision, another competitor's (Mr Aswar's) jet ski bumped/tapped Mr Scaturchio's in the entry of the fourth buoy turn.

This bump was likely slight and Coroner Lee considered that contact resulted in a directional change that was outside his control and not from his error. He then unavoidably and fatally impacted with Mr Lewi's jet ski.

"I find on the balance of probabilities that Mr Scaturchio did not spin out or over rotate his PWC prior to the incident or at the time of the incident. I further find on the evidence available, no rider error on the part of Mr Scaturchio that contributed to this terrible incident".

Coroner Lee recommended that the Australian Jet Sporting Boat Association consider amending its rules and implement the requirement for all race participants to utilise waterproof on-board cameras attached to individuals, helmets, or jet skis for both preparation/trial and race lap events.

At the time of publication the CCQ had not received a response to the recommendation.

Lucas Tran

Sudden Infant Death Syndrome (SIDS), risk factors for SIDS, Family Day Care home, sleep and supervision policies, amendments to National Quality Framework and National Law

Findings delivered 17 April 2019
Deputy State Coroner, John Lock

Lucas Tran died suddenly at five months of age in the residence of his family day care educator (Ms X) and her assistant (Mr Y). The Queensland Ambulance Service were called to the house at about 10:38 am that morning, Lucas was not moving, not awake and not breathing. Despite advanced resuscitation attempts he was declared life extinct at 11:24am.

At autopsy the forensic pathologist found no specific findings to explain the death but concluded it was consistent with a diagnosis of Sudden Infant Death Syndrome (SIDS).

The Queensland Police Service (QPS) conducted initial investigations at the residence during which they and the ambulance officers discovered seven children (six under school age) in different rooms of the house. Ms X and Mr Y were only permitted to care for four children. The house was described as hot and uncomfortable with no fans or air conditioner running, untidy, medications scattered in the main play area and what appeared to be mould in the room Lucas slept in.

The Deputy State Coroner heard from eleven witnesses at the inquest to determine the circumstances of Lucas' death. A non-publication order was made to ensure Ms X and Mr Y's son (Master Z) was not identified as well as any other children present in the home that day.

The Deputy State Coroner found that at some point that morning Lucas was put down to sleep in a partially erected porta cot with a loose towel covering him. That day it was warm and the room he was in had limited ventilation. There was at least a 30 minute period in which he was not observed.

"It is not possible to say that any of the risk factors raised here and which were present were directly causal to Lucas' death, as that is the nature of a SIDS diagnosis.
What can be said is recommendations as to sleeping environment and supervision to reduce risk factors thought to have some connection to SIDS have been developed over many years for a reason and these polices were not applied in the tragic circumstances of Lucas' death".

The Deputy State Coroner made three recommendations. The first directed to the QPS and the Department for them to consider implementing a Memorandum of Understanding or some other protocol regarding the sharing of information that may be relevant to each of their separate investigatory responsibilities, for incidents that arise in a child care environment.

The second and third recommendations were directed to the Ministerial Council and the Australian Children's Education Quality Authority to require, Family Day Care Educators to hold a Certificate III in Children's Services before they commence caring for children and information about safe sleeping practices/SIDS and complaints mechanisms be given to parents of children who attend Family Day Care.

As at 2 October 2019 recommendation two and three were agreed to and implementation is under consideration.

Darrell Gene Simon

Missing person, delay in finding body, search, whether suicide or suspicious

Findings delivered 19 December 2018
Deputy State Coroner, John Lock

In May 2016, human skeletal remains were located on a remote part of a property formerly owned by Darrell Simon. Examination of the scene and the skeletal remains suggested the individual may have died as a result of hanging - there was a noose and rope hanging from the tree, clothing on the ground beneath the noose, and some neck bones found within the noose. Forensic examination of the remains identified them as those of Mr Simon.

Mr Simon had been missing since November 2014 when he had left for his usual morning bike ride. A bike matching the description of his was located in February 2016, 60-70 metres from where the remains were located. Despite numerous police searches and inquiries over weeks and months, police were unable to locate any evidence to explain his disappearance.

In consideration of the unusual circumstances surrounding his death including his remains not being found on the property during initial searches, some 18 months after he was reported missing, concerns from the family that the death may have been related to a money dispute, the Deputy State Coroner held an inquest.

The inquest examined the searches conducted by police with SES volunteers shortly after Mr Simon was reported missing and in the months following. A review of the search by QPS following the discovery of the skeletal remains was also conducted. The Deputy State Coroner also attended the property with the legal representatives prior to the inquest. It became clear in evidence that only half the property was searched as there was a fence diving the eastern and western halves into two areas.

The Deputy State Coroner ultimately found that Mr Simon died by hanging with an intent to take his life in the context of financial stressors related to the foreclosure of his property. The Deputy State Coroner was satisfied he was already deceased by the time he was reported missing.

The Deputy State Coroner found the police investigation was comprehensive but search of the property had failings which compounded the grief felt by family and friends who waited 18 months for his remains to be found.

"The fact the ground search was conducted over only half the property was very regretful and should not have happened. The assumptions made about the boundaries of the property was one thing, but the failure to crosscheck after the search with the GPS tracking and making sure the whole of the property had been searched, compounded the issue. What seems to have been accepted in the retrospective review of the search that the mistake was made due to accepting the property had a fence dividing the eastern and western halves in two approximately equal sized areas".

The Deputy State Coroner made three recommendations directed to the QPS. The first that where internal reviews are conducted about the adequacy of police investigations, the findings of that review are provided to the coroner. Two of the recommendations related to land searches, including the QPS consider the adequacy of resources, information and training provided to its officers and ensure they have access to high quality maps and GPS tracking data and they consider whether communication improvements can be made between SES and QPS at the conclusion of a search to ensure vital information is relayed to QPS.

As at 2 May 2019, implementation of recommendation one was in progress. Recommendations two and three were implemented.

Baby M

Death of newborn infant within 6 hours of birth – Group B Streptococcal disease (GBS), infant dropped on her head minutes after birth, prescribed antibiotics not administered as directed, cause(s) of death, prevention of future deaths in similar circumstances

Findings delivered 21 September 2018
Central Coroner, David O'Connell

Shortly after she was born, Baby M suffered an acute injury when a nurse fell whilst carrying her to another birthing suite as a medical apparatus for ventilation support was unavailable. She died approximately five hours later. The parents had a number of concerns about their daughter's death. Due to the complexity of the medical issues involved the Central Coroner determined an inquest was required to resolve those.

The Central Coroner examined the extent to which a number of conditions may have contributed to her death, the adequacy of the prenatal care provided (or omitted), whether the equipment in the Gladstone Hospital birthing suite was adequate, including whether staffing levels at the hospital contributed to the events and the adequacy of the care and treatment provided to Baby M immediately after birth.

The forensic pathologist gave evidence at the inquest and found an 'overwhelming sepsis and two fractures injuries to the skull'. On review of the evidence the Central Coroner found the cause of death to be as a result of:

1(a) Intracranial and intrapulmonary haemorrhage; due to
b. 1(b) Traumatic head injury as a result of a fall from height; due to
c. 1(c) Group B Streptococcus infection (Sepsis).

In relation to the pre-natal care it was noted there were deficiencies and missed opportunities. In particular, to schedule an induction of her delivery earlier (one to two weeks) in the pregnancy which may have resulted in the sepsis being either non-existent or far less developed in Baby M.

The medical equipment in the birth suite was found to be adequate but the resuscitation table was inoperable due to a mismatched hose and mask. The Central Coroner found staffing levels were appropriate. In response to the care provided immediately following Baby M's birth the Central Coroner noted failing with regard to best practice.

"The care given from birth to four minutes post birth was deficient as there was no ventilation support given, not even from the 'Ambu' bag present on each resuscitation table. I never received a convincing explanation44 as to why it was not used. This was a glaring omission in best practice".

The Central Coroner noted that a number of proactive steps had been taken by the hospital and recommendations to prevent future deaths had already been identified and implemented by the hospital board. Some elementary recommendations were made by the Central Coroner with regard to resuscitation tables, availability of bassinets and trolleys in birthing suites and for expectant mothers to be informed about the incidence and issues relating to sepsis.

Andrew John Thwaites

Dive death investigation, recreational diving, carbon monoxide toxicity, drowning, contamination of breathing air from within electric air compressor, ignition of lubricating oil within over heated compressor, maintenance, filtration, ASA breathing air standards, testing for contamination

Findings delivered 24 July 2018
Brisbane Coroner, Christine Clements

Andrew Thwaites an experienced diver set out on 10 August 2016 with his partner and a group of divers (14 in total) to the eastern side of Moreton Island. Conditions that day were considered perfect for diving. Mr Thwaites and his partner completed their first dive (50 minutes in total) without issue.

About ten minutes into their second dive at around 1:30pm, Mr Thwaites indicated via hand signals he felt unwell and intended to surface. They commenced the ascent together but his partner lost sight of him about 15 meters from the surface when they took different paths around a rock pinnacle. She thought she saw him on the anchor line of another boat and alerted someone aboard the boat. It soon became apparent he was not aboard either vessel and was 'missing'. His body was recovered from the sea-bed by police divers the next day. Coroner Clements focused the inquest on how he came to die and what caused his death.

Mr Thwaites was wearing a dive computer which reported at around 12 minutes into the dive, he was at 1.7 metres for about 30-60 seconds before descending. At about the fourteenth minute he remained at between 29.7 and 29.9 metres.

The pathologist opined that Mr Thwaites died to due drowning and had been impaired or incapacitated by high levels of carbon monoxide and carbon dioxide that were detected by police in his dive cylinder. In this regard, expert evidence from a diving specialist and hyperbaric medicine and occupational physician was heard at inquest who concluded the root cause of Mr Thwaites death was carbon monoxide toxicity. Coroner Clements agreed with this opinion.

In evidence it was found that Mr Thwaites and his partner were using their own four cylinders which had been filled on 13 July 2016 from a compressor at a club they were members of. It was determined his second dive cylinder had 2,366 parts per million of carbon monoxide when the recommended upper level is 5 parts per million.

Coroner Clements found that the source of contamination of Mr Thwaites air cylinder was the air compressor from the Underwater Research Group of Queensland Inc., the club he was a member of.

"Some members of the Club were aware from about 6 August 2016 that the compressor was making an unusual noise, and was not efficiently filling tanks. A 'blown gasket' was presumed. The compressor remained in use on 13 July and was subsequently repaired on 18 July 2016. The compressor was used on 27

July, 1 August and 3 August but ultimately failed and the compressor seized on 8 August 2016. The members of the club using the compressor to fill their diving tanks had no understanding or appreciation of the potential risk of contamination of air from the poorly maintained compressor".

Coroner Clements noted Mr Thwaites death was tragic and unavoidable. In that regard, 13 recommendations were made to prevent similar deaths from occurring in future. A number of the recommendations centred on breathing air compressors.

As at 2 May 2019, the implementation of recommendation three which was directed to the police service dive squad that they be equipped with suitable initial testing device capability of air quality, prior to formal testing, was in progress.

Holly Winta Brown

Adequacy of emergency medical response and care, remote event, mass gathering event, primary health care clinic, Laura, Cook Shire Council, Torres and Cape Hospital and Health Service, Queensland Ambulance Service, nurses, fatigue leave, medical emergency, event management, risk assessment, female 17 years, myocardial scarring, past myocarditis, undiagnosed rheumatic fever, telecommunications blackspot, automated external defibrillator, event planning, risk assessment, approvals process, interagency approach, state wide mass event planning reform, Holly's Law

Findings delivered 12 June 2019
Northern Coroner, Nerida Wilson

Holly Brown, 17 years of age when she attended the Laura Rodeo and Races weekend with her family. While camping at the grounds, she felt unwell, vomited and had chest pain. She was unable to be roused by her parents and soon became unresponsive.

An off-duty nurse co-ordinated the medical response which lasted over two hours. Nurses from the Laura Primary Health Clinic attended and contributed to resuscitation efforts while they awaited emergency services to arrive. Queensland Service Ambulance paramedic arrived 1 hour and 20 minutes of being deployed via Triple 0, which was about two hours after Holly had gone into cardiac arrest. She was unable to be resuscitated.

Coroner Wilson convened an inquest and heard from 23 witnesses to examine the adequacy of the medical response provided to Holly and what, if anything, could be done to prevent future deaths in similar circumstances.

Holly's cause of death was found to be a fatal arrhythmia caused by heart muscle scarring as a result of a previously undiagnosed rheumatic fever. Coroner Wilson found that no emergency medical service was available at the grounds and an AED and adrenaline was not available on scene for approximately 50 minutes when local clinic nurses arrived.

Coroner Wilson commented the equipment and care provided was inadequate to effect chain of survival protocols. Further it was noted the emergency medical response was inadequate, the Laura Clinic was not adequately resourced, staffed or equipped to provide emergency medical services for a mass event. Coroner Wilson further found there was a lack of formal guidance and protocols for all stakeholders in relation to event planning and risk assessment, which contributed to the inadequate medical response.

"Holly may not have survived even with advanced life support in, or out, of hospital. However, in this case, no one, not the event organisers, the TCHHS, nor anyone who assisted, or witnessed the tragedy, and especially Holly's parents can look back on Holly's death and know that all that could and should have been done, was".

In those circumstances, Coroner Wilson recommended that an interagency executive group be convened to consider reform for mass gathering events in Queensland and specifically formulate protocols for an out of hospital emergency medical response at the Laura Rodeo and Race Event. Coroner Wilson recommended Holly's name be attributed to the standardised process.

At the time of publication a response had not been published.

Daniel James Morcombe

Missing child, suspected death, police investigation, compelled evidence from persons of interest, resumption of inquest after murder conviction.

Findings delivered 5 April 2019
State Coroner, Terry Ryan

On 7 December 2003, Daniel Morcombe walked from his family home to catch a bus from the Kiel Mountain Road overpass to a shopping centre at Maroochydore. When the inquest into his disappearance began in October 2010, no account of Daniel's movements from the overpass had proven reliable to locate him, or to commence criminal proceedings against any person.

Brett Peter Cowan a person of interest gave evidence at the inquest. His account of events was implausible and the investigation focussed on him. The Queensland Police Service implemented an operation that resulted in Mr Cowan making admissions about his role in Daniel's disappearance and death. He also took police officers to the place he had killed Daniel which resulted in his skeletal remains being recovered. Mr Cowan was subsequently arrested and convicted of Daniel's murder.

The investigation into Daniel's disappearance was the largest criminal investigation in the history of Queensland. There were over 22,000 job logs, the police report and annexures was over 10,000 pages, over 100 police officers were involved, 10,000 individuals interviewed, 14 people were summoned to attending hearings at the Crime and Misconduct Commissions (as it was known) and a covert police operation involving 36 undercover police from Queensland, Western Australia and Victoria was implemented.

The adequacy of the immediate police response to the report Daniel was missing was examined at inquest. The State Coroner found that although it was unfortunate police policies in place at the time, gave officers a discretion in relation to recording whether a child was missing it was highly unlikely the creation of a missing person message would have altered the QPS response that evening.

With respect to the adequacy of the police investigation, and being mindful of hindsight bias and outcome bias, the State Coroner agreed with submissions from the family and counsel assisting that more could have been done to focus on Mr Cowan in the early stages of the investigation.

"It is clear that Daniel was killed within one hour of his abduction, well before his parents reported him missing on the evening of 7 December 2003. The response to Daniel's disappearance by the Queensland Police Service cannot be said to have contributed to his death in any way. The only person responsible for Daniel's death was Mr Cowan".

The State Coroner noted positive changes had been made to police policies and procedures to respond to missing children and homicide investigations since Daniel's disappearance. Further, that the community's awareness of crimes against children has been heightened since which can be attributed to the advocacy and work of Mr and Mrs Morcombe and the Daniel Morcombe Foundation. In that regard the State Coroner made two recommendations:

- that the Queensland Police Service's Operational Procedures Manual be amended to mandate an independent review in circumstances of a homicide or suspicious high risk missing person investigation remaining unsolved for a period of twelve months after the commencement of the investigation and;
- the Queensland Government amend the Criminal Code to ensure a time limit is imposed on the testing of human remains in circumstances where the prosecution and defence fail to reach agreement on the identity of the deceased.

As at the time of publication a response to the recommendations had not been published.

Joshua Ryan Statis

Health care related death; paediatric cardiac surgery; Queensland Paediatric Cardiac Service; congenital aortic stenosis; fourth-time sternotomy & redo Konno; right ventricular outflow tract (RVOT) patch; CardioCel; wound management; sternal wound infection; mediastinitis; surgical debridement; VAC dressing; persistent post-debridement fevers and tachycardia; acute bleed from sternotomy wound 18 days post-operatively; after hours surgical assessment of acute bleed; Massive Transfusion Protocol; after hours theatre team call-in; emergency cardiac surgery; rupture of RVOT patch; catastrophic cardiac bleed

Findings delivered 24 October 2019
A/Coroner, Ainslie Kirkegaard

Joshie Statis was born with a severe congenital heart condition requiring three open heart surgeries before he was two years old. On 26 November 2015

he was admitted to the Lady Cilento Children's Hospital (as it was known) for complex open heart surgery which he underwent three days later. He was returned to theatre on day 16 post-operatively for exploration and surgical debridement of a superficial infection of his wound which had started to ooze on day 9 post-operatively. Joshie was investigated and treated for persisting fevers and tachycardia over the following two days, most likely caused by the wound infection. He developed an acute bleed through the wound, he died in theatre two hours later on 16 November. He was 12 years old.

His death was reported as a health care related death and a preliminary medical review identified concerns about aspects of his post-operative and emergency management. Joshie's parents also had concerns about his clinical management at the hospital. A Root Cause Analysis (RCA) commissioned by a review team in the hospital who had no involvement in Joshie's care, also identified a number of factors contributing to his death.

During the course of the investigation A/Coroner Kirkegaard also engaged an expert cardiothoracic surgeon to provide a report and was further informed by a joint expert review report from those with expertise in paediatric cardiac surgery provided by the hospital's legal representatives. At inquest evidence was heard from surgical, medical and allied health care staff involved in Joshie's care as well as three clinical experts and family members. The opinions in the expert reports were examined at length at the hearing.

A/Coroner Kirkegaard identified at inquest a number of shortcomings in the clinical documentation practises within the Queensland Paediatric Cardiac Service and a missed opportunity for the cardiac surgical team to have understood the seriousness of the acute bleed sooner.

"At the outset, the absence of any documentation by the cardiac surgical team (other than operation reports and consent forms) was very concerning to me. However, the evidence given by witnesses from the cardiology and cardiac surgical teams involved in Joshie's care has clarified that while a dearth of written communication by the surgeons was the accepted culture and practice within the paediatric cardiac service at that time, there was ongoing and effective oral communication between the teams throughout Joshie's admission".

In that regard A/Coroner Kirkegaard made two recommendations directed at Queensland Health. The first that Children's Health Queensland consider developing a wound inspection guideline for the cardiac surgical service to ensure consistency in documenting wound features that be may indicative of infection. The second that Children's Health Queensland formally review the cardiac surgery theatre team call-in process.

As at 2 June 2019 the Minister for Health and Minister for Ambulance Services advised the first recommendation would be fully implemented in 2019 and the second recommendation had been implemented.

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Higher courts decisions relating to the coronial jurisdiction

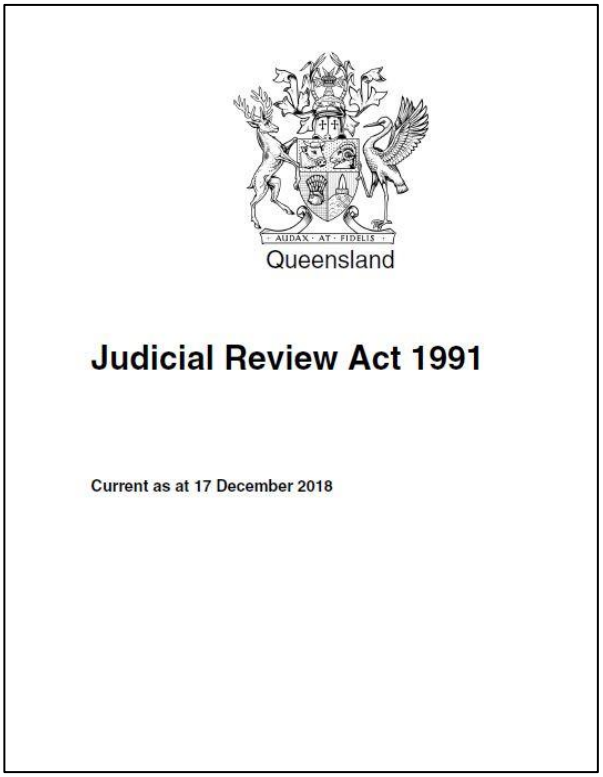
The *Coroners Act 2003* establishes mechanisms for the administrative review of investigation and inquest outcomes, including a right to:

- review a coroner's decision about whether a death is reportable (s11A); or
- whether an inquest should be held; or
- review inquest and non-inquest findings; or
- re-open an inquest or non-inquest investigation.

These avenues are intended to provide families with an efficient and cost-effective way to examine any concerns about the way a coronial investigation has been conducted or the basis of a coroner's findings.

Pursuant to section 30 of the *Coroners Act* a person dissatisfied with a decision by a coroner not to hold an inquest, may apply to the State Coroner or the District Court. If the State Coroner declines the application, the person may apply to the District Court for an order that an inquest be held.

The following section contains a summary of a decision pursuant to the *Judicial Review Act 1991* handed down during the reporting period in response to the State Coroner declining an application that an inquest be held.



All Queensland judicial review decision are posted on the Queensland Courts website at: https://www.courts.qld.gov.au/courts/coroners-court.

Stephen John Davis
(Applicant)

v

Terry Ryan, State Coroner
(Respondent)

Decision 10 September 2018

This decision involved a judicial review application to the District Court by Mr Stephen John Davis for an order pursuant to section 30(6) of the Coroners Act 2003 (the Act) that an inquest be held into the death of his wife, Mrs Kristine Davis pursuant to section 30(4) of the Act. The application for judicial review was dismissed by Judge Lynham in the District Court.

Mrs Kristine Davis was 61 years of age when she died on 7 August 2013. The death was initially reported to Coroner Jane Bentley who finalised the coronial investigation without inquest on 8 November 2013. Coroner Bentley noted the following in her findings regarding the circumstances of Mrs Davis' death:

"*On the morning of 7 August 2013 Mr and Mrs Davis went grocery shopping. Mrs Davis was uncharacteristically quiet. They returned home, had a coffee and, at about 11am, Mr Davis went downstairs. Mrs Davis stayed upstairs and unpacked the groceries.*

At about midday Mr Davis went upstairs but could not find Mrs Davis. He went down an external set of stairs and found Mrs Davis hanging by the neck from a white rope tied around of the supporting posts of the staircase. He tried to undo the knot before returning upstairs and obtaining a knife which he used to cut the rope. Mr Davis immediately started CPR and called 000. Queensland Ambulance officers attended and also attempted to resuscitate Mrs Davis but were unable to do so. She was pronounced deceased at 12.41pm.

Police conducted an investigation and concluded there were no suspicious circumstances. An autopsy confirmed Mrs Davis died from hanging. Her death was suicide. There was no overt evidence of a neurological disorder of the brain or any other significant disease"[23]

[23] Form 20A Coroner's findings and notice of completion of coronial investigation 8 November 2013.

Mr Davis disagreed with Coroner Bentley's findings and requested further investigations be conducted, particularly in regard to concerns he had about the treatment provided to his wife and submitted there was a public interest in establishing whether the procedures for the treatment of long-term sufferers of depression be reviewed/improved. Coroner Bentley confirmed on 2 December 2013 that she would seek further material in relation to the medication and treatment provided to Mrs Davis. These further investigations included obtaining medical records from the Bowen Hospital, from her general practitioner, her treating Psychiatrist, Dr Graham Futter and a Mental Health Review.

Around this time, carriage of the investigation transferred to the former Northern Coroner, Mr Kevin Priestly. The coroner provided Mr Davis with a copy of a report prepared by Dr Futter. The report addressed specific questions asked of him by the coroner. Further concerns were raised by Mr Davis in response to Dr Futter's report and he made further submissions to the coroner that additional material be obtained and investigations conducted.

On 3 September 2015, Coroner Priestly wrote to Mr Davis with his proposed findings, which included a summary by a forensic medical officer who reviewed the psychotropic medications prescribed to Mrs Davis. That review generally concurred with the treatment path adopted by Dr Futter.

Mr Davis responded to those draft findings, advising his concerns had not been addressed. Coroner Priestly then engaged Dr Jacinta Powell, a Consultant Psychiatrist on 12 January 2016 to report on the matter and concerns raised by Mr Davis.

Dr Powell opined that with the benefit of hindsight it would have been very unlikely that Mrs Davis' suicide could have been predicted to occur. However, concerns were raised regarding the lack of comprehensive clinical assessment undertaken. A review of the medications prescribed by Dr Futter was also undertaken by Dr Powell. Ultimately she opined that the medication strategy undertaken was not unreasonable but it was unclear what, if any, alternative treatment methods has been discussed with Mrs Davis.

Dr Powell's report was provided to Dr Futter for comment and response. He provided further insight into the reasons behind the medication regime he placed Mrs Davis on. He advised he advised Mrs Davis that other treatment options were available but they did not explore those in detail.

Mr Davis continued to raise concerns about the treatment provided by Dr Futter, the progress of the investigation and the nature of the experts engaged by the court to inform the coroner's investigation. Mr Davis considered a risk management expert be consulted and provided the coroner with a list of experts in that regard. Mr Davis also provided the coroner with a report by Psychiatrist, Dr McLaren who at the request of Mr Davis provided an opinion about the possibility of medications provided to Mrs Davis inducing sudden, unexpected suicide attempts without warning.

On 30 June 2016, Coroner Priestly finalised his investigation and declined Mr Davis' request that an inquest be held. The findings noted that Mrs Davis died due to hanging, that her death was suicide and that no further investigation into her clinical management was necessary.

On 4 July 2016, Mr Davis applied to the State Coroner for an order to hold an inquest into the death of his wife. On 10 February 2017, the State Coroner, Mr Terry Ryan wrote to Mr Davis declining his application and providing reasoning for this decision. Mr Davis engaged in further correspondence with the State Coroner seeking he reconsider his decision but ultimately the State Coroner refused the request.

In determining this application, Lynham DCJ was bound by section 30(8) of the Act which prescribes an inquest may be ordered only if satisfied *"it is in the public interest to hold the inquest"*. The decision examines in detail various case law with respect to the meaning of the term *"in the public interest"*, particularly the extent to which considerations around drawing attention to a death may prevent future deaths in similar circumstances.

On 10 September 2018, DJC Lynham stated the following in response to the application:

Here, having regard to the objects of the Act contained in section 3 as well as the considerations prescribed in section 28(2), I am not persuaded that the matters raised by Mr Davis allow me to conclude that it is in the public interest to hold an inquest into his wife's death. The death of Mrs Davis was tragic. I have a great deal of sympathy for Mr Davis and commend him for seeking to have remediated the shortcomings which have been identified in the course of the coroner's investigation relating to the treatment of his wife.

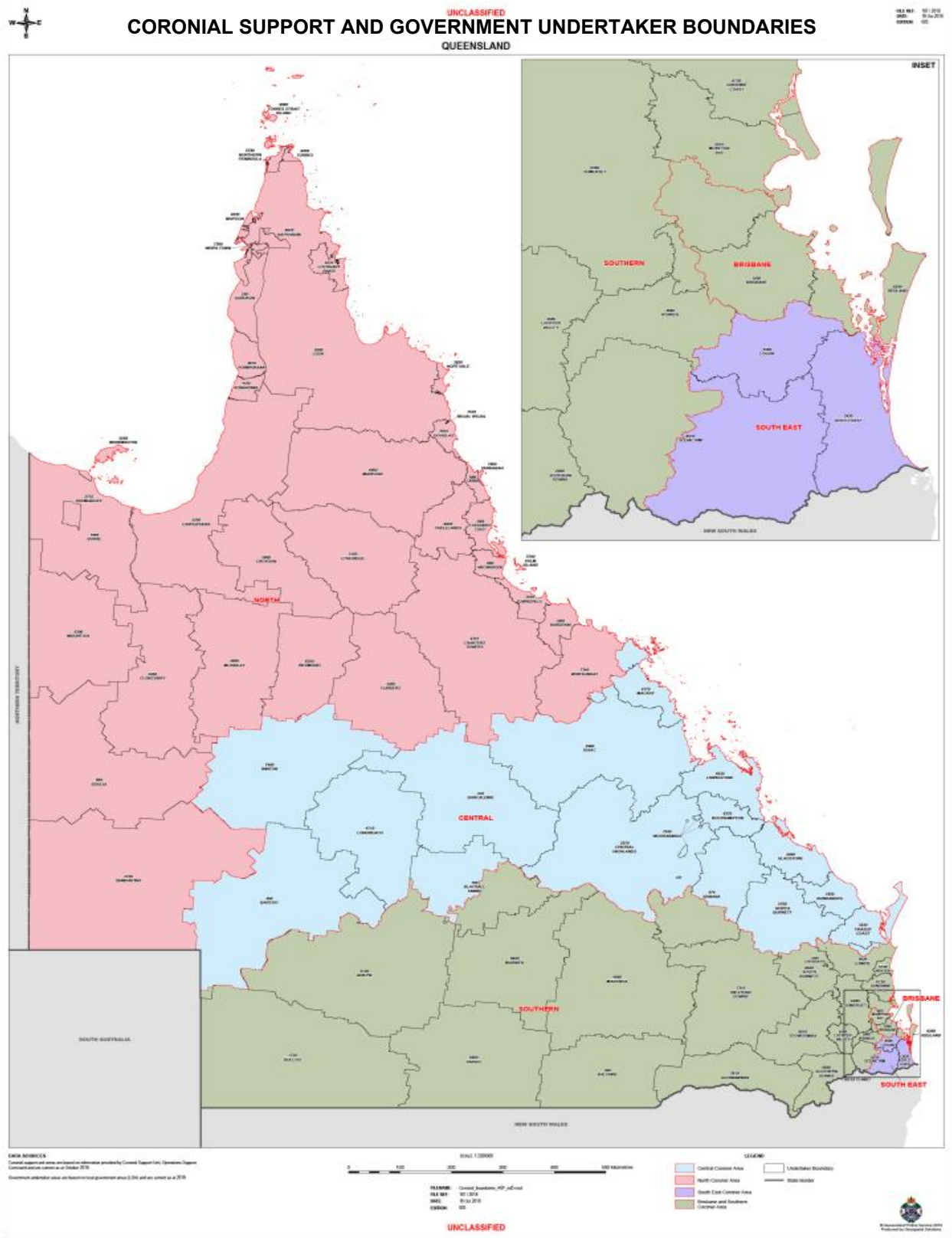
However I am ultimately in agreement with the State Coroner Mr Ryan that whilst it would be possible to hold an inquest into the death of Mrs Davis, the non-binding nature of any recommendations that might be made were an inquest held and the likelihood that they would not receive widespread support within the medical profession weigh against the holding of an inquest.

In the circumstances I am not satisfied pursuant to section 30(8) of the Act that it is in the public interest to hold an inquest into the death of Mrs Davis. I order that the application be dismissed. [24]

On 8 April 2019, Mr Davis filed an application to the Court of Appeal for Lynham DCJ's decision to be dismissed. The application was dismissed on 3 December 2019.

[24] Davis v Ryan [2018] QDC decision 10 September 2018

APPENDIX 1[25]



[25] Map available - https://www.courts.qld.gov.au/courts/coroners-court

APPENDIX 2

Presentations by Coronial Registrar, Ainslie Kirkegaard

Darling Downs Hospital & Health Service Grand Rounds – 19 July 2018 – *When to make THAT phone call…*

Redcliffe Hospital Department of Emergency Registrar Training – 26 July 2018 - *When to make THAT phone call…*

Royal Flying Doctors Service Senior Medical Officer workshop – 27 July 2018 - *When to make THAT phone call…*

QPS Coronial Support Unit annual conference – 24 July 2018 – N/A

Gladstone Hospital Grand Rounds – 1 August 2018 - *When to make THAT phone call…*

Caboolture Hospital Grand Rounds – 5 September 2018 - *When to make THAT phone call…*

Australian College of Perianaesthsia Nurses (ACPAN) National Conference 2018 Brisbane – 19 October 2018 – *What to expect from a coronial investigation*

CCQ Counsel Assisting – 15 November 2018 – *A day in the life of the Coronial Registrar*

UQ Autopsy Symposium – 8 February 2019 – *Never fear: (if) the Coroner is here!*

Hervey Bay Hospital Grand Rounds – 13 February 2019 - *When to make THAT phone call…*

Wesley Hospital – 20 February 2019 - *When to make THAT phone call…*

Hummingbird House – 26 February 2019 – *Document! Document! Document!*

Greenslopes Private Hospital – 8 March 2019 - *When to make THAT phone call…*

Ipswich Hospital Intern Program – 11 April 2019 - *When to make THAT phone call…*

Statewide Paediatric Critical Care Pathway project – 30 April 2019 – *From the Coronial Perspective*

St Vincent's Private Hospital Brisbane – 15 May 2019 - *When to make THAT phone call…*

Princess Alexandra Hospital Perioperative Nurses – 28 May 2019 – *Perioperative deaths: what to do? when to call?*

Mt Isa Hospital – 11 June 2019 - *When to make THAT phone call…*

Mater Medical Oncology Service – 28 June 2019 - *When to make THAT phone call...*

APPENDIX 3

Presentations by the Domestic and Family Violence Death Review Unit

Princess Alexandra Hospital Health Symposium - August 2018 - *Learning from Tragedy: the role of health practitioners in responding to domestic and family violence*

Queensland University of Technology guest lecture - August 2018 - *Overview of the Queensland domestic and family violence death review process*

Women's Legal Service – DV Practitioners Forum - November 2018 - *Learnings from the domestic and family violence death review process in Queensland*

Griffith University MATE Bystander Conference - November 2018 - *Learnings from the domestic and family violence death review process in Queensland*

Integrated Service Response Managers and High Risk Team Coordinators Forum - December 2018; May 2019 - *Statistical overview of domestic and family violence suicides in Queensland*

STOP DV Conference - December 2018 - *Statistical overview of domestic and family violence deaths in Queensland*

ANROWS Using the National Risk Assessment Principles - March 2019 - *Overview of the Queensland domestic and family violence death review process*

Policelink Domestic and Family Violence Awareness Day - May 2019 - *Learnings from the domestic and family violence death review process in Queensland*

Queensland Police Service High Risk Team Coordinators - May 2019 - *Responding to domestic and family violence in culturally and linguistically diverse and Aboriginal and Torres Strait Islander communities*

Darling Downs Hospital and Health Service Grand Rounds Presentation - May 2019 - Learnings *for health practitioners from the Queensland domestic and family violence death review process*