



QUEENSLAND
COURTS

Office of the State Coroner

Annual Report 2010–2011





**QUEENSLAND
COURTS**

OFFICE OF THE STATE CORONER

Brisbane Magistrates Court
363 George Street
Brisbane QLD 4000

PO Box 1649
Brisbane QLD 4001
DX 943

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

EM State.Coroner@justice.qld.gov.au

www.courts.qld.gov.au

20 December 2011

The Honourable Paul Lucas MP
Attorney-General, Minister for Local Government
and Special Minister of State
PO Box 15009
City East Qld 4002

Dear Attorney,

Section 77 of the *Coroners Act 2003* provides that at the end of each financial year the State Coroner is to give to the Attorney-General a report for the year on the operation of the Act. In accordance with that provision I enclose that report for the period 1 July 2010 to 30 June 2011.

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. Guidelines issued by me under section 14 of the Act are publicly available and can be accessed at <http://www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications>. I advise in the reporting period there were two guidelines issued under section 14 of the Act. The first was aimed at balancing the confidentiality provisions of the *Child Protection Act 1999* and the public nature of the inquest process and the second was directed towards first response police officers attending apparent natural causes deaths. More detail about these guidelines appears in the body of the report.

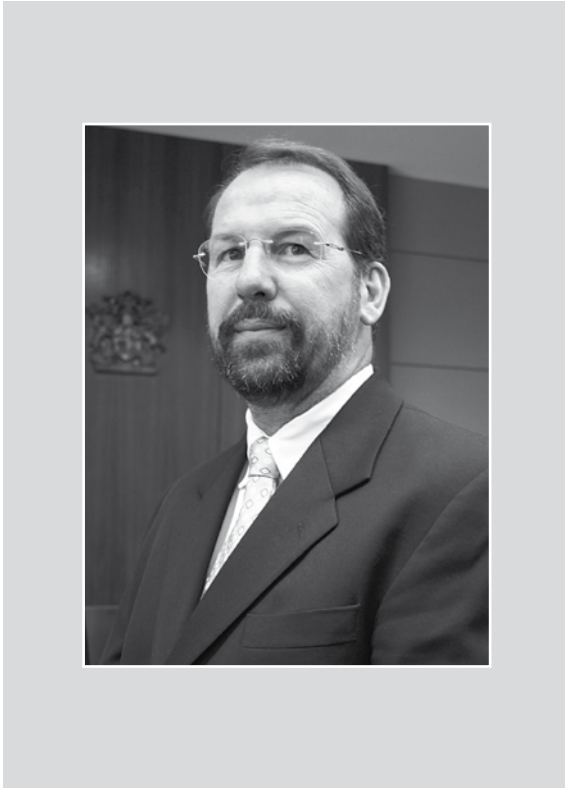
Yours sincerely

Michael Barnes
State Coroner

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State Coroner's overview



As with most of Queensland, coroners and their support staff were impacted by the adverse summer weather events. The South-East Queensland floods forced the Brisbane coroners and staff from our inner city offices. The senior staff of Queensland Health Forensic and Scientific Services (QHFSS) made available office space and equipment at their Coopers Plains facility.

Of course, our inconvenience was trivial compared to the loss of life and devastation caused by the floods but the collegiality shown by our QHFSS colleagues enabled us to continue to work with the police, pathologists, odontologists and forensic scientists to assist the bereaved.

The caseload of Queensland coroners continues to grow. In 2010–11, 4,416 deaths were reported, the highest number to date ever and a 45 per cent increase over the number of deaths reported in 2004–05 (the first full year of the operation of the Coroners Act 2003).

Despite coroners finalising more cases than in previous years, the number of pending cases has also grown. Of particular concern is the number of matters more than 24 months old. While many of these cases can not be closed because criminal prosecutions are pending, in other cases workload pressures are the cause of undesirable delay. However, the Attorney-General and the Chief Magistrate have responded by making further resources available. I am confident that reforms instituted since this reporting period will allow this issue to be addressed.

Coroners and their staff were involved in numerous other projects through 2010–11; I will mention just a few.

The Minister for Communities and the Attorney-General commissioned a review of coronial investigations of deaths occurring because of domestic or family violence. It found investigations largely focussed on criminal prosecution and not on the domestic and family violence preceding the death. Accordingly there was

limited systemic analysis of the context in which these deaths occurred and ways to prevent deaths. With support and resources from the Department of Justice and Attorney-General, the Department of Communities and the Queensland Police Service, an interdisciplinary team has been established within the Office of the State Coroner to analyse the circumstances in which family violence has led to death with a view to identifying opportunities for prevention. The effectiveness of the new approach will be evaluated after 12 months.

Coroners continue to contribute to public health and safety and the prevention of unnatural deaths via the recommendations they make in inquest findings. In 2010–11, 138 coronial recommendations were made. There is no obligation on any private or public body to respond to coroners' recommendations. However, I am pleased to report that all government departments seem to give appropriate consideration to recommendations relating to their areas of responsibility. Further, the Government has given impetus to the preventative focus of those recommendations by requiring all public sector bodies to advise the Attorney-General of their response to them so they can be included in a report tabled in Parliament. The most recent report was published in May 2011.

The coronial system also contributes to prevention by making its data available to approved researchers. As detailed in this report, 53 individuals or organisations investigating matters as diverse as suicide and scuba accidents have utilised coronial reports in their work.

The Office of the State Coroner has been directly involved in some of this work by virtue of Australian Research Council funded projects involving academics and other industry partners. Those research projects are also described in this report.

A coroner's work is essentially interdisciplinary: he or she is dependant upon investigators, pathologists, counsellors and medical and other specialists to provide the information needed to make the findings and preventative recommendations. Accordingly, I gratefully acknowledge the tremendous support given to me and my colleagues by the members of the Queensland Police

Service, and the pathologists, toxicologists, forensic scientists and counsellors of QHFSS. We also receive dedicated support and assistance from the doctors attached to the Clinical Forensic Medicine Unit. Without the cooperation and assistance of the professionals in these other agencies, coroners could not do their job.

In conclusion, I express my gratitude to and admiration of the staff of the Office of the State Coroner, the two regional coroner's registries and the coroner's clerks in magistrates court registries around the state. The volume, intensity and the often distressing nature of their work far exceeds that usually expected of administrative staff members. I acknowledge the fine leadership of the administrative staff by Ms Brigita White. I pay tribute to the work of my colleagues the magistrate coroners around the state, and the full-time coroners in Brisbane, Southport and Cairns. I am particularly grateful for the support and assistance provided to me by the Deputy State Coroner, Ms Christine Clements.

Our People

Director's report

The Director's responsibilities include managing the financial and administrative arrangements for the Office of the State Coroner (OSC), overseeing coronial operations in regional registries across the state and managing the interface between the OSC and the State Coroner, Deputy State Coroner and other full-time coroners and judicial officers.

The role of the OSC is to support the State Coroner to deliver a more consistent and efficient coronial system. The OSC maintains a register of reported deaths, supports Queensland's involvement in the National Coroners Information System (NCIS) and provides ongoing legal and administrative support to the State Coroner, Deputy State Coroner, Brisbane Coroner, Northern Coroner, Southern Coroner, local coroners and court staff. The OSC also ensures there is publicly accessible information available for families and others

regarding the coronial system and provides a central point of contact for coronial matters.

The OSC also supports the *Cremations Act 2003* and the *Burials Assistance Act 1965* and administers the burials assistance scheme and the conveyance of bodies programs through the management of contracts with funeral directors and local councils across the state.

The OSC comprises 30 staff members with 22 based in Brisbane, four in the Northern Coroner's office in Cairns and four in the Southern Coroner's office in Southport. In addition, in January 2011 the Domestic and Family Violence Death Review Unit (DFVDRU) was established within the OSC staffed by a police officer and researcher.

Major achievements of the office during 2010–11 include the establishment of a domestic and family violence death review process within the OSC; the successful implementation of significant enhancements to the Coroners Case Management System (CCMS) and the delivery of staff well-being workshops to regional coronial staff. The OSC finalised a major tender and evaluation process for contracts for the conveyance of human remains for autopsy and the burial or cremation of deceased persons under the burials assistance scheme. The OSC also commenced planning to host the annual Asia Pacific Coroners Society conference in Queensland in November 2011.

It cannot be forgotten that the beginning of 2011 was marked by the tragic loss of many lives in the floods. Staff at the OSC collaborated with coronial partners and worked hard to ensure that as far as possible, coronial processes did not create additional distress to families who lost loved ones during this tragedy. The OSC staff are to be congratulated for their dedication and compassion.

Courts where deaths are reported

As at 30 June 2011, there were 19 reporting centres across the state. The Deputy State Coroner and Brisbane Coroner are responsible for investigating deaths in the Greater Brisbane area including Caboolture, and Redcliffe.

The Southern Coroner investigates deaths in the area covering Rochedale South to the border of New South Wales, Beenleigh and Logan.

Deaths in the area from Thursday Island to Proserpine, north to the Papua New Guinea (PNG) border and west to the Mt Isa district are reported to the Northern Coroner.

Deaths are also reported to local coroners based at the following 16 Magistrates Courts.

Table 1: Magistrates courts where deaths are reported

Caloundra	Ipswich
Charleville	Kingaroy
Dalby	Mackay
Emerald	Maroochydore
Gayndah	Maryborough
Gladstone	Murgon
Gympie	Rockhampton
Hervey Bay	Warwick

In-house counsel assisting at inquests

Coroners are assisted by counsel assisting during an inquest. Outside Brisbane, police prosecutors often perform this role. In 2010-11, the Queensland Police Service Police Prosecution Corps assisted local coroners in six of the 46 inquests held across the state. Their contribution to the coronial process is greatly appreciated.

For some inquests police prosecutors are unable to appear as counsel assisting because there is a clear conflict of interest (for example, the death is a death in custody or the police investigation is an issue) or because the matter involves systemic reform in complex areas such as aviation, mining or health care. In these cases coroners will engage private counsel or use in-house lawyers to assist them at inquest.

Each of the five full-time coroners is assisted by a legal officer. These legal officers are increasingly performing the role of counsel assisting and during 2010–11 assisted in 23 inquests. Consequently, coroners can be supported by lawyers with specialised skills and experience in the jurisdiction and inquest costs are kept to a minimum.

In-house lawyers acted as counsel assisting in the following inquests during 2010–11:

Mr Peter Johns, Senior Lawyer to the State Coroner

- Tofia Josen Mataia
- Andrew John Bornen
- Gordon John Bellamy
- Jason Andrew Muir
- David Robert Petersen
- Marty Tanui Francis
- Clay Marsden Collinson
- Phillip Glenn Spicer
- Daniel James Clarke
- Christopher Steven Bell
- Edward Arthur Anthony Rawlins
- James Errol Tranby
- Phyllis Anne Crooks

Ms Ainslie Kirkegaard, Lawyer to the Deputy State Coroner

- Thomas Andrew Clumpoint

Ms Alana Martens, Lawyer to the Brisbane Coroner

- Brenda Elizabeth King
- Two-year-old child
- Kathleen Anne Conlan
- Bela Heidrich

Mr Anthony Mirotsos

- Hossam Mohamed Elshazly

Ms Helen Price

- Little Gungallida Girl

Ms Julie Collins

- Gregory Clifford Paterson
- James Andrew Bennett

Coroners Case Management System

The Coroners Case Management System (CCMS) is a purpose built case management system for coronial matters. It commenced operation on 1 July 2009.

The CCMS assists coroners with managing coronial files and ensure compliance with statutory requirements by using bring-ups and tailored reports. Users can generate forms and template letters using data entered into the CCMS and link received documents to the electronic file. These streamlined file management procedures reduce double data entry and the need to refer to hardcopy files.

The CCMS also interfaces seamlessly with the DJAG electronic document management system (eDOCS), ensuring that documents are stored in accordance with current legislative requirements for document management.

During 2010–11, significant enhancements were made to the CCMS to improve general useability, reporting functionality and case validation. The introduction of CCMS and these ongoing process improvements have assisted registry staff to cope with the increasing coronial workload.

The CCMS interfaces with the National Coroners Information System (NCIS), the national database of coronial information. Information about Queensland coronial cases is coded into the NCIS and is available to inform coronial investigations, research and policy development. From its inception, CCMS reduced the amount of duplicate data entry required by automatically uploading some case information and the police narrative to the NCIS. Since December 2010, autopsy reports and coronial findings have also been uploaded automatically to the NCIS. This has contributed to the improvement in case closure rates and timely the entry of Queensland data to the NCIS during 2010–11.

South Australia and Western Australia have expressed interest in adopting the system.

The OSC provides training and support to regional registries in coronial and CCMS procedures. Face to face training was delivered to court staff in March 2011.

Managing the provision of coronial autopsy and government undertaking services

The Director's responsibilities include overseeing arrangements for the transportation of deceased persons for autopsy under the Coroners Act and burials and cremations under the Burials Assistance Act. Funeral homes and local authorities across the state are contracted to provide the services following an open tender process. The state has been divided into 70 areas correlating to the Queensland Police Service (QPS) regions, districts and divisions with a contract for services in place for each area. The contracts are worth approximately \$2.64 million annually.

During 2010–11 the OSC completed a significant procurement tender process to ensure new contracts were in place on 1 December 2010 when the previous contracts expired.

An invitation to offer was released to market in January 2010. Offers were received and evaluated against criteria including staff; capability, capacity and experience; suitable vehicles and equipment; and pricing. Offers were evaluated by a panel consisting of the Director, OSC; the Detective Inspector of the QPS Coronial Support Unit; the Manager, Business Services Unit, Magistrates Courts Branch; and the Senior Procurement Officer, Tactical Procurement Team, Financial Services.

The tender process resulted in 70 contracts being entered into with 34 service providers for an initial three-year period (1 December 2010 to 30 November 2013) with the option of two further two-year extensions. The projected costs for the contracts over the full seven-year term are in the vicinity of \$20 million

which factors in conservative Consumer Price Index (CPI) and other unavoidable increases.

Ensuring the continuous and timely supply of these services presents a number of challenges in a decentralised state such as Queensland. The cost of providing these services is high especially in regional and remote areas and it is therefore important to ensure bodies are only transported for autopsy where necessary.

The transportation of bodies for the purpose of autopsy is necessitated by the Coroners Act which requires an autopsy to be performed where a reportable death is investigated by the coroner. There is an exception for cases where the coroner decides to stop investigating because, although the death is reportable, the cause of death is known and no further investigation is required. This often occurs for hospital related deaths that have been reported directly by medical practitioners using Form 1A. In these cases, because no autopsy is required the family can collect the body from the hospital mortuary. The State Coroner encourages medical practitioners and coroners to use the Form 1A process where appropriate.

For those cases where a coroner must order an autopsy the coroner may order an internal or external autopsy. Autopsies are performed by forensic pathologists, pathologists or government medical officers (GMOs) who are credentialed to perform autopsies. As a rule, external autopsies can be performed by GMOs but pathologists perform internal autopsies. Under the State Coroner's guidelines, the more complex autopsies (e.g. multiple deaths, suspicious deaths, child deaths, deaths during childbirth and deaths in custody) are required to be conducted by a forensic pathologist. Forensic pathologists are only located at Brisbane, the Gold Coast, Toowoomba, Nambour, Rockhampton, Townsville and Cairns. Specialist pathologists who can perform other less complex internal autopsies are located at Bundaberg and Maryborough. An ongoing challenge for the coronial system is the availability of pathologists to perform autopsies in regional areas.

Because GMOs are more likely to be available locally, transportation costs may not be as high when an external autopsy is conducted. The State Coroner has issued guidelines encouraging coroners to order external autopsies where appropriate. The Chief Forensic Pathologist has also been actively involved in triaging cases with coroners in regional and remote areas to ensure internal autopsies are not performed unnecessarily.

One of the categories of reportable death is that a death certificate has not been issued and is not likely to be issued. If police are unable to contact a doctor to issue a medical certificate, and determine that a certificate is not likely to be issued the death must be reported to a coroner and the body transported to a mortuary. Often a death certificate is issued shortly after the body has been transported.

The State Coroner has issued guidelines aimed at reducing the number of deaths from natural causes unnecessarily reported into the coronial system. The guidelines encourage first response police officers who attend the scene of an apparent natural causes death to allow families to contact a private funeral director where it appears the death is expected and is not otherwise reportable. It is not necessary for the death certificate to have been issued.

The OSC is also responsible for administering funds for coronial autopsies performed by GMOs and pathologists not employed by Queensland Health Forensic and Scientific Services (QHFS). Queensland Health sets the fees for services provided by these GMOs and pathologists.

Communication, stakeholder relations and business improvement initiatives

During 2010–11, the OSC continued to engage successfully with its major coronial partners: the QPS whose officers investigate on behalf of the coroners and Queensland Health, who provides forensic and counselling services for coroners. Each of these agencies is represented on the Interdepartmental

Working Group, chaired by the State Coroner, which meets to review and discuss statewide policy and operational issues.

During 2011, the State Coroner and the OSC collaborated with our major coronial partners to develop the program for the annual Asia Pacific Coroners Society conference to be held in Queensland in November 2011. The Asia Pacific Coroners Society comprises coroners from all Australian states and territories and New Zealand. The society holds an annual conference which is hosted by coronial offices in the various jurisdictions in turn. The Royal Commission into Aboriginal Deaths in Custody was a major impetus for coronial reform across Australia. Given that 2011 marks the 20th anniversary of the Commission, the conference's theme is Australasian coronial systems 20 years after the Royal Commission into Aboriginal Deaths in Custody: achievements and challenges.

The OSC worked closely with Queensland Health's Patient Safety and Quality Improvement Service (PSQ), which coordinates coronial issues within Queensland Health to improve information available to clinicians about the coronial process. In particular, the service promotes the obligation of clinicians to provide information to the investigating coroner.

The PSQ developed a fact sheet for coroners to promote the services offered by the service, including advice about clinical pathways, Queensland Health policies and procedures and other information that may assist a coroner in investigating a death.

The OSC also liaised with the QPS Coronial Support Unit to improve the timeliness and quality of police investigation reports. The CCMS enhanced reporting capability enables outstanding police investigation reports to be more actively monitored. The QPS Operational Procedures Manual specifically requires police to provide a supplementary report to the coroner every 28 days until a report is finalised and District Officers have been reminded of this obligation. In addition, coronial matters now form part of the Priorities and Performance Indicators considered as part of the Operational Review process for District Officers.

The OSC convenes tri-annual meetings with funeral directors' associations, the QPS Coronial Support Unit and representatives of QHFSS who provide mortuary and counselling services. These meetings provide a forum to discuss issues and develop constructive relationships aimed at improving families' experience of the coronial system.

In March 2011, Psychologist Penny Gordon conducted a staff well-being workshop for OSC staff, and for staff performing coronial work in regional registries. Ms Gordon is a recognised authority on vicarious trauma, and the workshop was very well received by staff. Consideration is being given to offering the workshops on an annual basis.

In addition to the CCMS enhancements other business improvement initiatives during 2010–11 included revising template letters sent to families to provide more timely advice about the cause of death and information about obtaining updated death certificates from the Registry of Births, Deaths and Marriages. Letters were also revised to encourage families to raise any concerns at an early stage of the investigation.

The OSC also reviewed information available on its website. All publications, forms, inquest findings and relevant contact details are accessible on <http://www.courts.qld.gov.au/courts/coroners-court>

Implementing a domestic and family violence death review process

A domestic and family violence death review process was established following a review of coronial investigations of deaths occurring as a result of domestic or family violence. The review found the coronial investigation was largely focussed on the criminal prosecution and not on the domestic and family violence preceding the death. Accordingly, there was limited systemic analysis of the context in which these deaths occurred, and ways of preventing other deaths.

The death review process involves:

- establishment of a Domestic and Family Violence Death Review Unit (DFVDRU) within the OSC consisting of a principal researcher, police officer and research assistant/case coordinator (who commences in August 2011) to review domestic and family violence related deaths and provide investigative assistance to coroners including advising coroners about any systemic gaps in agency responses to prior domestic or family violence and opportunities to prevent future deaths. QPS, DJAG and the Department of Communities jointly fund the DFVDRU.
- establishment of a Domestic and Family Violence Death Review Expert Advisory Group to provide advice to the State Coroner about systemic issues and opportunities to prevent future deaths. The Expert Advisory Group consists of government and non-government representatives with experience in the area of domestic and family violence.

Since its establishment in January 2011, the DFVDRU has developed draft guidelines for the investigation of domestic and family violence related deaths and developed amendments to Form 1 Police Report of Death to improve the quality of information available in relation to these deaths. The DFVDRU has also created a database of domestic and family violence related deaths since 2006.

Death review processes have also been established in New South Wales, Victoria and South Australia. A national network has been established with a view to collecting consistent data and sharing information about each death review process.

The DFVDRU has been providing investigative assistance to coroners in relation to deaths reported since May 2011.

The death review process will be subject to review after 12 months with a decision to be made about whether to continue the process for a further two years.

Police related deaths memorandum of understanding

In his findings in the inquest into the death of Mulrunji, the Deputy Chief Magistrate recommended changes to the way police related deaths are investigated.

As a result, the State Coroner met with the Chair of the Crime and Misconduct Commission (CMC) and the Commissioner of the QPS. It was agreed that a group of police officers attached to the OSC could best investigate these matters. This conclusion was based on the State Coroner having the primary responsibility for the investigation of such deaths and the power to refer matters requiring possible disciplinary action to the CMC or the QPS.

It was also agreed the proposed arrangement would best address the public policy considerations brought into focus by such deaths, namely:

- the maintenance of public confidence in the impartiality of the investigations;
- the desirability of transparency in the process;
- the need for appropriate investigative expertise; and
- the opportunity for remedial responses and accountability measures to be taken in a timely fashion.

As a result, a draft Memorandum of Understanding was developed and a number of meetings have occurred with the intent of implementing the in-principle agreement.

While negotiations were proceeding the Queensland State Government commissioned the Webbe Report - a review of police complaints, discipline and misconduct system. As part of its response to the report the government has committed to the transfer of primary responsibility for the investigation of police related deaths to a unit attached to the Office of the State Coroner.

Work to resolve the practical, logistical and legal issues raised by the proposal is continuing.

Coroners and their support staff – roles and responsibilities

Full-time coroners

There are five full time coroners - the State Coroner, Deputy State Coroner, Brisbane Coroner, Northern Coroner and Southern Coroner.

During 2010–11, 69.2 per cent of reportable deaths in Queensland were reported to a full-time coroner.

State Coroner

The State Coroner, Mr Michael Barnes, was reappointed on 1 July 2008 for a period of five years. 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.

In order to discharge this coordination function, the State Coroner has issued guidelines under s14 of the Coroners Act to coroners and to persons carrying out functions under the Act. The State Coroner's Guidelines were issued in 2003 but are subject to ongoing review in light of developments in coronial practice.

In 2010–11, the State Coroner commenced a major review of guidelines in relation to autopsies in partnership with the Chief Forensic Pathologist, coroners and pathologists. The draft guidelines recognise that autopsies are invasive and costly and should be limited to the extent necessary to enable coroners to make findings under s45 of the Coroners Act. The guidelines encourage coroners and pathologists to consider whether a death certificate can be issued and to order external autopsies where possible. The guidelines also detail requirements for consulting with families and processes for retaining prescribed tissue. These revised autopsy guidelines are in the final stages of consultation and will be issued during 2011–12.

During 2010–11, the State Coroner issued a guideline aimed at balancing the confidentiality provisions of the Child Protection Act 1999 and the public nature of the inquest process. The guideline provides that

where a child's death raises issues about their care arrangements the inquest notification will name the child and note that the inquest will consider the care arrangements. However, coroners are encouraged to consider making a non-publication order to ensure the child's name is not reported in the media. Coronial findings should not include confidential information obtained from Child Safety Services unless that information is necessary to support and make sense of the coroner's findings. Coronial findings should not contain information that could identify another child in care.

The State Coroner also issued a guideline for first response police officers attending apparent natural causes deaths. In such cases if the death is not unexpected, and police form the view that a cause of death certificate is likely to be issued, and the death is not otherwise reportable the officers may advise the family that the death is not a coronial matter and that they can contact a private funeral director to make funeral arrangements. It is hoped that this guideline will minimise the number of deaths from natural causes unnecessarily reported into the coronial system.

The State Coroner's guidelines can be accessed at: <http://www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications>

The State Coroner also provides daily advice and guidance to coroners in relation to specific cases and liaises with other professions and organisations involved in the coronial process, for example, police, pathologists and counsellors.

Only the State Coroner or Deputy State Coroner may investigate deaths in custody and deaths happening in the course of or because of police operations. The State Coroner also conducts inquests into the more complex deaths that, if dealt with by a local coroner, would take him or her out of general court work to the detriment of the local court diary.

During the reporting period, the State Coroner sat in Ipswich, Emerald, Dalby, Southport, Maroochydore, Nambour, Kingaroy, Townsville and Cairns. During 2010–11, 88 matters were reported to the State Coroner.

The State Coroner conducted 15 inquests and finalised 42 investigations without proceeding to inquest.

Deputy State Coroner

The Deputy State Coroner, Ms Christine Clements, was reappointed on 11 December 2008 for a further five years. Together with State Coroner, the Deputy State Coroner may investigate deaths in custody and deaths happening in the course of or because of police operations. The Deputy State Coroner also acts as the State Coroner when required.

In 2010–11, 701 matters were reported to the Deputy State Coroner. The Deputy State Coroner finalised 703 investigations including three following an inquest.

Brisbane Coroner

The Brisbane Coroner, Mr John Lock, was appointed as a full-time coroner in January 2008. Mr Lock assists the Deputy State Coroner to investigate deaths reported in the greater Brisbane area. In 2010–11, 733 matters were reported to the Brisbane Coroner. The Brisbane Coroner finalised 720 investigations including four following an inquest.

Northern Coroner

Mr Kevin Priestly was appointed as the full-time Northern Coroner in March 2008. The Northern Coroner is based in Cairns and is responsible for investigating deaths in the Far Northern region spanning from Cairns, south to Proserpine, west to Mt Isa and north to the border with PNG. In 2010-11, 565 deaths were reported in the region and 518 matters were finalised including four following an inquest.

Southern Coroner

Mr John Hutton was appointed as the full-time Southern Coroner in August 2008. The Southern Coroner is based in Southport and is responsible for investigating deaths in the area covering Rochedale South to the border of New South Wales, Beenleigh and Logan. In 2010–11, 592 deaths were reported in the region and 584 matters were finalised including one following an inquest.

Local Coroner

The Coroners Act provides that every magistrate is a coroner. Other than deaths in custody, which must be investigated by either the State Coroner or Deputy State Coroner, police report deaths to the coroner nearest to the place of death. In 2010–11, 1,360 deaths (30.8 per cent of all Queensland reportable deaths) were reported in the regions and 1,461 matters were finalised. Local coroners conducted 19 inquests.

Coroners' investigations

Reportable deaths

Under the Coroners Act reportable deaths, as defined in section 8 of the Act, must be reported to a coroner. Section 7 of the Act requires anyone becoming aware of an apparently reportable death to report it to the police or a coroner.

Section 8 defines the categories of reportable deaths as deaths where:

- the identity of the person is unknown;
- the death was violent or otherwise unnatural;
- the death happened in suspicious circumstances;
- the death was a 'health care related' death;
- a cause of death certificate has not been issued and is not likely to be issued for the person;
- the death was a death in care;
- the death was a death in custody; or
- the death happened in the course of or because of police operations.

Unidentified bodies

Even if there is nothing suspicious about the death, unless the identity of the deceased can be established with sufficient certainty to enable the death to be registered, the death must be reported to a coroner. Various means such as fingerprints, photographs, dental examinations or DNA are used to identify the person.

Violent or unnatural

Car accidents, drownings, electrocutions, suicides and industrial and domestic accidents are all reported to coroners under this category. The coroner investigates the circumstances of death to determine whether it should be referred to a prosecuting authority or whether an inquest is warranted with a view to developing recommendations to reduce the likelihood of similar deaths.

Suspicious circumstances

Suspicious deaths are reported to coroners to enable their circumstances to be investigated. If police consider that there is sufficient evidence to make criminal charges in connection with the death they may do so and the holding of an inquest must be postponed until those charges are resolved.

Health care related deaths

The 2009 amendments to the Coroners Act clarified the circumstances in which medical deaths are reportable and made it clear that a failure to provide health care is captured. Section 8(3)(d) which required the reporting of a death that was not reasonably expected to be the outcome of a health procedure was replaced by a new s8(3)(d) which requires the reporting of health care related deaths. Health care related death is defined in s10AA of the Act.

Health care has a broad definition and means a health procedure or any care, treatment, advice, service or goods provided for the benefit of human health. A health procedure includes any dental, medical, surgical, diagnostic or other health related procedure, including giving an anaesthetic or other drug.

A death is health care related if the health care caused or contributed to the death and before the health care was provided an independent person would not have expected the person to die. A failure to provide health care is health care related if the failure to provide care caused or contributed to the death and when the health care was sought an independent person would have expected health care to be provided. Deciding whether a death that occurs in a medical setting

should be reported and if so determining how it should be investigated poses considerable challenges for coroners.

Cause of death certificate has not issued and is not likely to be issued

Medical practitioners are obliged to issue a cause of death certificate if they can ascertain the “probable” cause of death. The degree of certainty required is the same as when they are diagnosing an illness. Doctors are prohibited from issuing a cause of death certificate if the death appears to be one that is required to be reported to a coroner, so this category focuses on deaths which do not appear unnatural, violent or suspicious but which are uncertain in their cause. They are reported to a coroner so that an autopsy can seek to discover the pathology of the fatal condition.

Deaths in care

Deaths of categories of vulnerable members of society (namely children in the care of the Department of Communities, the mentally ill and the disabled) are reported to a coroner, irrespective of their cause.

The OSC now has an arrangement with the Office of Fair Trading, Disability and Community Care Services and Queensland Health to provide a list of the residential disability services that fall within the meaning of section 9(1)(a)(i), (ii) and (iii) of the Coroners Act. This information is updated regularly and posted on the OSC intranet site for use by magistrates and registry staff. The information is also forwarded to the QPS and Queensland Health facilities to assist with determining if a death is reportable.

During the reporting period, 48 deaths in care were investigated.

Deaths in custody

This term is defined in section 10 of the Act to include those who are at the time of their death actually 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 State or Commonwealth legislation (excluding the Education (General Provisions) Act 2006 and the Mental Health Act 2000).

Detention in watch-houses, prisons etc is clearly covered but the section also extends the definition by reference to the legal context that makes the physical location of the deceased irrelevant. For example, a sentenced prisoner who is taken to a doctor or a hospital for treatment is still in custody for the purposes of the Coroners Act.

During the reporting period, 15 deaths in custody were reported and investigations into 14 deaths in custody were finalised. It is mandatory for an inquest to be held for deaths in custody.

Deaths that happened in the course of or as a result of police operations

Deaths occurring in the course of or because of police operations will include an innocent bystander killed while police are attempting to detain a suspect. During the reporting period, eight such deaths were reported and findings in relation to one death were finalised. These deaths can only be reported to the State Coroner or Deputy State Coroner and an inquest must be held unless the coroner is satisfied the circumstances do not require an inquest.

Indigenous remains

The Coroners Act recognises the sensitivity of Indigenous remains. When dealing with Indigenous burial remains, a balance must be struck between the need to ensure the death was not a homicide and the need to avoid the unnecessary disturbance of the remains. As soon as it is established that remains are Indigenous burial remains, the coronial investigation must cease and management of the site is transferred to officers from the Indigenous Cultural Heritage Unit of the Department of Environment and Resource Management and representatives of the traditional owners of the land where the remains were found.

Once a coroner has established the remains are in fact Indigenous burial remains, section 12 of the Act precludes a coroner from investigating further, unless the Minister directs. During the reporting period, two matters were investigated by coroners where the remains were confirmed as Indigenous burial remains.

Purpose of coronial investigations

The purpose of a coronial investigation is to establish, the identity of the deceased, when and where they died, the medical cause of death and the circumstances of the death. Coroners also consider whether changes to policies or procedures 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. Inquests are held so that coroners can receive expert evidence on which to base such recommendations.

Autopsies

Coroners usually order an autopsy as part of the coronial investigation to assist with determining the cause of death and/or to assist in identifying the body.

The Coroners Act requires coroners to specify whether the examining doctor should undertake a full internal autopsy, a partial internal autopsy focusing on the likely site of the fatal disease or injury or an external examination only. It also recognises that many members of the community have strong objections - sometimes based on religious beliefs - to invasive procedures being performed on the bodies of their deceased loved ones. Coroners are required to consider these concerns when determining the extent of the autopsy ordered.

Although family members may not prevent an autopsy being undertaken if a coroner considers it necessary, a coroner who wishes to override a family's concerns must give the family reasons. The coroner's decision can then be judicially reviewed. No such review applications were lodged during 2009–10 and family concerns have been able to be assuaged with the assistance of coronial counsellors from QHFSS.

The CCMS reporting functionality has improved the accuracy of data about autopsies ordered since 1 July 2009. In previous years, precise figures were not available and a sample analysis was performed. Available data from 2008–09 to 2010–11 about autopsies is provided in tables two and three.

During 2010–11, there was a reduction in the number of autopsies performed overall. This is likely to be due to the increasing use of the Form 1A process to report deaths in a medical setting. The State Coroner encourages medical practitioners and coroners to use the Form 1A process where appropriate.

There was also an increase in the proportion of external and partial or targeted internal autopsies ordered. The State Coroner has issued guidelines encouraging coroners to order external autopsies so that bodies are not transported and invasive autopsies performed unnecessarily. The increase is also attributable to the availability of a CT scanner at QHFSS that uses specialist x-ray and computer technology to produce three-dimensional images of the internal organs. This greatly improves the information available without resorting to an internal autopsy.

Table 2: Percentage of orders for autopsy issued by type of autopsy to be performed

Type of autopsy ordered	2008-09	2009-10	2010-11
External autopsy	6.58%	11.64%	16.42%
Partial internal autopsy	15.57%	12.54%	19.83%
Full internal autopsy	77.82%	75.82%	63.75%
Order on cremated remains	0.03%	0%	0%

Table 3: Number of orders for autopsy issued by type of autopsy to be performed

Type of autopsy ordered	2008-09	2009-10	2010-11
External autopsy	208	349	473
Partial internal autopsy	492	376	571
Full internal autopsy	2,459	2,274	1,836
Order on cremated remains	1	0	0
Total	3,160	2,999	2,880

Measuring outcomes

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

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

Clearance rate

There has been a significant growth in demand for coronial services. From 2004–05 to 2006–07 there was a steady 3 per cent annual increase in deaths reported. However, the annual increase has been higher in ensuing years. In 2007–08 the number of reportable deaths increased by 9.2 per cent from 3,149 to 3,514. During 2008–09, there was increase of 6.57 per cent with reported deaths reaching 3,745. In 2009–10 there was a 13.64 per cent increase in deaths reported bringing the number of deaths reported to 4,256. In 2010–11 there was a further 3.8 per cent increase in deaths reported bringing the number to 4,416.

The number of investigations finalised also increased over this period to 4,408. In 2010–11, coroners finalised 663 more matters than in 2009–10 and achieved a clearance rate of 99.8 per cent. This is just short of the Report on Government Services target of 100 per cent. However, finalisations have not kept pace with lodgements and the number of pending cases has grown.

There are a number of reasons for the increase in lodgements including increasing population and

changing demographics and increasing awareness and expectations of the coronial jurisdiction. The increase also coincides with the period following the Queensland Public Hospitals Commission of Inquiry and the introduction of the Health Quality and Complaints Commission Review of Hospital-related Death Standard on 1 July 2007 (this standard mandates a review of hospital deaths and deaths in the community within 30 days of a hospital admission). Clinicians are now more aware of the obligation to report certain deaths to the coroner. There are also heightened public expectations of health care and a greater willingness to scrutinise treatment provided.

The flow-on effect has been that treating clinicians are more likely to report deaths following health care to the coroner and doctors generally may be less willing to issue death certificates for their patients without coronial authorisation.

The increase in medical matters reported to the coroner since 2007–08 can be tracked by looking at the increase in Form 1As which can be used by medical practitioners to report deaths to coroners. Table 4 shows a statewide increase of 180 per cent in the form's use since 2007–08 and a further 20 per cent increase in 2010–11. The bulk of these matters are reported to Brisbane coroners where the state's major tertiary hospitals are located.

Table 4: Form 1As

Financial year	Form 1As statewide	Form 1As Brisbane
2007-08	314	223
2008-09	423	295
2009-10	732	482
2010-11	880	514

Many matters reported to coroners are, following review of medical records and circumstances of death, found to be not reportable or reportable but not requiring autopsy and further investigation. During 2010–11 of the 4,408 deaths finalised 878 were found not to be reportable within the meaning of s8(3) of the Coroners Act.

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

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 risks of taking shortcuts.

As at 30 June 2011, 320 or 11.7 per cent of pending matters were more than 24 months old up from 205 or 7.57 per cent in 2009–10. This figure exceeds the national benchmarking target of zero per cent largely due to the increasing number of lodgements and the more rigorous investigation required under the Coroners Act. The finalisation of a coronial investigation depends on the finalisation of autopsy and toxicology reports and the outcome of police or other expert investigations. In addition, the coronial investigation is postponed pending the outcome of any criminal proceedings.

As at the end of the reporting period, of the 320 matters that were older than 24 months, 53 per cent (170 matters) were waiting for police or other expert investigations or the outcome of criminal proceedings. Excluding outstanding reports (police and others) and

criminal prosecutions, 150 matters i.e. 5.5 per cent of pending matters are older than 24 months.

Appendix 2 details the lodgements and finalisations during the reporting period.

Coronial investigators – a multi-agency approach

The QPS Coronial Support Unit coordinates the management of coronial processes on a statewide basis within the QPS. Four police officers located within the OSC in Brisbane provide direct support to the State Coroner, Deputy State Coroner and Brisbane Coroner as well as assisting regional coroners as required. Officers located at the QHFSS facility at Coopers Plains attend autopsies and assist in the identification of deceased persons and preparation of documents for autopsy. This unit also liaises with coroners, investigators, forensic pathologists, mortuary staff and counsellors. The Coronial Support officers bring a wealth of experience and relevant knowledge and are actively involved in reviewing policies and procedures as part of a continuous improvement approach.

QHFSS is responsible for providing a coronial autopsy service and a specialist pathology and toxicology investigation service to coroners.

The Coronial Counselling Service based at QHFSS provides information and counselling services to relatives of the deceased. This service is staffed by very experienced professional counsellors who play a very important role in explaining the coronial process to bereaved families, working through families' objections to autopsy and organ/tissue retention and supporting families during inquest hearings.

The full time coroners have been greatly assisted by the clinical expertise provided by the CFMU. Government medical officers (GMOs) are available on an "as needed" basis to assist the coroner's preliminary assessment of a reported death, particularly those that occur in clinical settings.

GMOs from CFMU review the report of the death and the deceased person's medical records, and then alert the coroner to any clinical issues requiring further follow up or independent clinical expert opinion. GMOs are available to assist regional coroners on request.

The QPS Coronial Support Unit, the CFMU, the Coronial Counselling Service and QHFSS are integral parts of the coronial process. The dedication, commitment and professionalism of these agencies are greatly appreciated by the OSC, as well as the families of the deceased.

Monitoring responses to coronial recommendations

When a matter proceeds to inquest, a coroner may make recommendations aimed at preventing similar deaths in the future. This is one of the most important objectives of a modern coronial system. Many of the recommendations made by coroners during 2010–11 are highlighted in the Inquests section in this report.

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

The first report, released in 2009, detailed responses to recommendations made during 2008. It contained responses to recommendations made during 2009 was published by DJAG in May 2011.

The report can be accessed at the DJAG website: http://www.justice.qld.gov.au/__data/assets/pdf_file/0008/73844/3512_Gov-response-to-coronial-recommendations-2009-WEB.pdf

Genuine researchers

The coronial system is an important source of information for researchers who in turn provide an invaluable resource for coronial systems in their

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

As a rule, researchers may only access coronial documents once the investigation is finalised. In 2009, s53 of the Coroners Act was amended to allow access to documents on open files with the consent of the State Coroner. The State Coroner may only 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.

In May 2011, the State Coroner authorised the Australian Institute for Suicide Research and Prevention (AISRAP) to access documents on open files. Since 1991, suicide statistics have been kept in the Queensland Suicide Register that is managed and maintained by AISRAP with funding from Queensland Health. The decision to grant access to documents on open files was made after considering the public benefits of accurate and timely statistics about suicide. It will ensure the Queensland Suicide Register accurately reflects the number of suicides in Queensland improving its usefulness to the development and evaluation of public policy. This is the first time that approval has been given to documents held on open files.

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 s53 of the Coroners Act during the reporting period:

Professor Christopher Semsarian

The Molecular Cardiology Group at the Centenary Institute, headed by Professor Semsarian, is a world leader in the study of genetic heart diseases and the complications of such diseases that include sudden death.

Professor Semsarian's study of cardiac death in children and young adults aims to find out the causes of the sudden cardiac death including possible genetic causes. The clinical and genetic findings will be used to evaluate

relatives of the deceased person. This will allow new (and earlier) diagnoses and treatment of surviving relatives.

Associate Professor Charles Naylor

Associate Professor Naylor sought approval as a genuine researcher on behalf of medical and dental practitioners at Forensic Pathology, QHFSS to facilitate the publication of case reports relating to coronial cases in the public interest. Publication of the case reports will assist with promoting awareness of individual cases and their wider significance for coroners, pathologists and forensic dental practitioners. The case reports will be published in professional journals or presented at professional meetings.

Ms Donna McGregor, Dr Laura Gregory, Mr Matt Meredith and Miss Nicole Lottering

The Queensland University of Technology (QUT) Bachelor of Applied Science Honours in Life Sciences is a one-year research based qualification. This genuine researcher application is to facilitate research to complete this qualification by honours student Ms Lottering who is being supervised by Ms McGregor and Dr Gregory (lecturers in Anatomy, QUT) and by Mr Meredith (Senior Radiographer at QHFSS).

The research project examines the applicability of the Suchey-Brooks method for aging the pubic symphyseal surface of the Caucasian population. This technique is widely employed within the international forensic anthropology community to estimate the age of unknown skeletal remains. Recent studies have demonstrated that the method is reliable but error rates specific to the population should be established. No such studies have been conducted within Australia.

To achieve the aims of the research study, a significant number of deceased individuals need to be assessed for statistical analysis. These numbers cannot be achieved through forensic skeletal casework due to the small numbers reported annually.

These new researchers brought to 53 the number authorised to access coronial documents. The full list of these researchers can be found at Appendix 4.

Research projects

In addition to assisting external researchers by allowing controlled access to coronial documents, the OSC has also been involved in undertaking research into coronial issues.

Details of the current projects are set out below.

Trends and predictors of suicide in Australian children

This project is being led by the Australian Institute of Suicide Research and Prevention. The State Coroner and senior officers from Queensland Health, Mental Health Branch, the Department of Education, Training and the Arts and the Queensland Commission for Children and Young People and Child Guardian are collaborating with the lead investigator.

The goal of this project is to obtain a better understanding of factors surrounding child suicide in Australia, with a focus on Queensland, by using aggregated and individual level data. This is in order to evaluate the magnitude of the problem and to develop recommendations for suicide prevention among Australian children under the age of 15 years. The project will include an international perspective analysing aggregated time-trends. An additional component of the project focuses on the impact of the child's suicide on the psychosocial functioning of parent survivors.

The project is funded by the Australian Research Council for three years to the extent of \$78,500.

Managing family objection to autopsy in the Australian coronial system

The Coroners Act 2003 enables families to object to invasive autopsies being performed on their relatives. However a review of autopsy orders indicates the rate at which coroners now accede to family objections varies significantly by location, experience and motivation for objection, to the extent that a 14 per cent external-only autopsy rate in urban South-East Queensland can exist

alongside a 1 per cent rate in Townsville. The evidence suggests the influence of police, counsellors and pathologists in the coroner's decision-making is, at best unclear, and at worst, contradictory and inappropriate. By the use of structured, in-depth interviews with all the main stakeholders in the coronial process, this research will investigate what motivates coronial personnel to take family objections to internal autopsy into account, or conversely, to ignore them.

Researchers from the School of Justice Studies, Queensland University of Technology are collaborating with the State Coroner, the Chief Forensic Pathologist, the Chief Forensic Counsellor and a detective inspector from the QPS.

The aim will be to establish an integrated and consistent approach to the role of family objection in coronial systems that can be applied Australia wide. This will:

- increase consistency of the death investigation process;
- enhance communication between stakeholders and the community;
- reduce unnecessary use of personnel and other resources and significantly reduce costs; and
- create a coronial practice e-resource for dealing with family objection to be used by practitioners as both a training resource and a resource to ensure consistency of approach.

The Australian Research Council has granted \$180,000 over three years to investigate these issues.

Influences on farmer suicide in Queensland and New South Wales

Researchers from the Australian Institute of Suicide Research and Prevention and the University of Newcastle will lead an investigation into the prevalence and instigators of suicide among farmers in Queensland and New South Wales. The industry partners, as they are termed, are the State Coroner, Queensland Health, the Department of Communities, the Centre for Rural and Remote Mental Health Queensland, the New South Wales Centre for Rural and Remote Mental Health, the

Hunter New England Local Health Network, and the New England Division of General Practice.

The aims of this study are to:

- determine the prevalence of suicide within farming related occupations of Queensland and New South Wales;
- determine the risk factors (as well as cultural and attitudinal factors regarding stigma, end of life issues, and help seeking) associated with suicide in farming related occupations of Queensland and New South Wales;
- determine the developmental process, including the sequence of events and risk factors associated with suicide in farming related occupations over the life span;
- use empirically based research findings to inform existing practices in suicide prevention for farming communities.

The major outcome associated with this project will be increased understanding about suicide within the farming occupation. Of particular importance, will be the knowledge gained from the methodological approach to data collection (i.e. life chart approach) which will illustrate the concatenation of events experienced by farmers over the life span and prior to death, as well as relationships between these events and suicide.

The Australian Research Council has approved funding to the extent of \$145,000 over three years.

Inquests

This section contains a summary of coronial investigations into all deaths in custody, as required by s77(2)(b) of the Act, and other inquests of note conducted during the reporting period. The complete inquest findings are posted on the Queensland Courts website at: <http://www.courts.qld.gov.au/courts/coroners-court/findings>

Deaths in custody

During the reporting period, the State Coroner conducted four inquests into deaths that occurred in the context of an attempted intercept by police:

Gordon John Bellamy

On 20 December 2008, Gordon Bellamy was killed when his motorcycle struck a tree at high speed in Emerald. At the time of death, he had been disqualified from driving. Seconds before his motorcycle had struck and injured a pedestrian and less than two minutes earlier, Mr Bellamy's erratic driving had attracted police attention.

They attempted to intercept him and, when he failed to comply with their directions, the officers followed for a short distance as he rode off at high speed.

Pending the arrival of QPS Ethical Standards Command (ESC) investigators from Brisbane and local police secured the incident scene and arranged for it to be photographed and examined by a Scenes of Crime Officer. The investigation was informed by a Forensic Crash Unit analysis and statements were taken from civilian and police witnesses. The police vehicle and Mr Bellamy's motorcycle were mechanically inspected.

Both officers involved in the attempted interception were breath tested and provided urine samples for further testing. They were interviewed 12 hours after the incident by the ESC investigator and the officer who drove participated in a walk through re-enactment of the incident.

The State Coroner found that neither the officers involved in the incident, nor their superiors, had followed the QPS policy that requires members directly involved in a fatal police related incident to be isolated from each other until they have provided a version of events to investigators. Instead, the two officers collaborated in the preparation of a handwritten account soon after the incident.

The State Coroner was satisfied this was not done with the intention of colluding to concoct or conceal evidence, but rather the officers striving to give a truthful and accurate account of what happened.

This blemish aside, the State Coroner was satisfied the investigation was thorough and provided all the necessary evidence.

The State Coroner found that Mr Bellamy lost control of his motorcycle after striking the pedestrian. He considered the excessive speed at which Mr Bellamy was riding and his extreme intoxication to be the main causes of the fatal crash but commented the actions of the pedestrian Mr Bellamy hit also played a role.

Considering the QPS pursuit policy in use at the time of the incident, the State Coroner concluded the officers' attempt to intercept Mr Bellamy was entirely appropriate but there was no justification for them to commence a pursuit. This meant the officers were obliged to abandon the attempted interception once Mr Bellamy rode off when the officers pulled up behind him, and the officers reasonably believed Mr Bellamy was attempting to evade them. In this case, the officers' pursuit was not authorised because of the lack of evidence Mr Bellamy had committed more than traffic offences.

The State Coroner considered the officers were mindful of the pursuit policy during the incident even though they did not apply it correctly in this case. He found that any departure from the policy continued only while the officers travelled about 300 metres and for less than a minute. The State Coroner did not see any need to refer the officers' actions for consideration of disciplinary action.

The State Coroner noted the QPS Safe Driving Project Team was continuing to evaluate the current QPS pursuit policy in conjunction with recommendations previously made by him.

Marty Tanui Francis

Marty Francis was a 19-year-old who died in the early hours of 4 October 2008 when he lost control of his motor vehicle at high speed while attempting to evade police.

Mr Francis' death was investigated by the QPS ESC. Forensic examination of the scene was undertaken by a local accident investigator until replaced by an

independent accident investigator from Brisbane. ESC investigators managed the scene remotely once they were notified of the incident. The police officer involved in the pursuit provided breath and urine specimens for drug and alcohol testing and participated in a formal record of interview and subsequent video-recorded “walk and drive through” interview. The investigation involved interviews with all other police officers on duty in the local district at the time of the accident and statements taken from eyewitnesses to Mr Francis’ movements that evening. The police vehicle and Mr Francis’ vehicle were mechanically inspected. The investigation obtained audio recordings of the Dalby police communications that evening and the police officer’s training records and relevant QPS pursuit policy documents. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

The State Coroner found Mr Francis had been drinking heavily at a sports club function on the evening of 3 October 2008. He subsequently took his V8 Commodore out for a ride in the early hours of 4 October. A police officer on single patrol attempted to intercept Mr Francis for a random breath test. Mr Francis did not stop, so the officer followed him, activating his lights and siren. Both vehicles reached speeds of over 100km/hr in an 80km zone during the pursuit. The officer decided to terminate the pursuit, turned off his lights and sirens and radioed Dalby Station to this effect. Towards the end of this radio communication, the officer saw Mr Francis’ vehicle lose control and flip over. He called for an ambulance but Mr Francis was declared dead at the scene.

The State Coroner found Mr Francis was travelling in excess of 100km/hr when he lost control of the vehicle. He was heavily intoxicated and not wearing a seatbelt.

Considering the then current QPS pursuit policy, the State Coroner concluded the officer engaged in a pursuit when he followed Mr Francis and accelerated after him and although the pursuit was arguably permitted by the policy, it would have been best avoided. The State Coroner commented that while it may have been preferable for the pursuit to be abandoned 30-60 seconds sooner, there was no flagrant breach of the

policy and he did not consider the officer’s delay in deactivating the lights contributed to the crash.

The inquest revealed the officer had not received training in the pursuit policy (implemented statewide on 1 January 2008). The State Coroner did not consider this was more than an isolated problem, which he noted QPS had since taken steps to address.

The State Coroner noted the officer tried at least three times to make radio contact with the station during the pursuit, as required by the policy but was not successful. As at October 2008, the shift supervisor was unable to hear any communications when he was away from the radio room or his office, which were the only places that had fully functioning radios. The State Coroner noted this problem has since been addressed by the addition of communications equipment to the Dalby watch-house. The State Coroner did not make any recommendations in this matter.

Clay Marsden Collinson

Mr Collinson was a 28-year-old man who died when he lost control of his motorcycle and crashed, while attempting to evade police on 10 April 2009.

Mr Collinson’s death was investigated by the QPS ESC. Pending ESC arrival, the investigation was managed by the Duty District Officer. The investigation included obtaining breath and urine samples for drug and alcohol testing from the police officer involved in the incident; a forensic analysis of the scene; a forensic crash analysis and a mechanical inspection of Mr Collinson’s motorcycle. The officer participated in a formal record of interview and interviews were conducted with eyewitnesses. The investigation obtained radio transmissions between the officer and the Sunshine Coast Communications Room and records relating to Mr Collinson’s driving history and the motorcycle. The investigation was informed by clinical opinion regarding the likely effect of drugs detected in Mr Collinson’s blood samples. The State Coroner was satisfied this matter was thoroughly and professionally investigated.

Mr Collinson’s 900cc motorcycle was unregistered and he was not licensed to drive a motorcycle with an engine

size over 250cc. Mr Collinson came to the attention of police performing stationary radar duties in the 60km/hr speed zone. The officer recorded Mr Collinson's speed at 96km/hr. The officer set off after Mr Collinson and followed him through a local township and then increased his speed and activated his lights and sirens with the intention of intercepting the motorcycle. Mr Collinson immediately accelerated away rapidly. The officer disengaged from the pursuit some 10-15 seconds later and abandoned the attempted intercept. Mr Collinson continued driving at speed, nearly colliding with another vehicle. He lost control of the motorcycle and crashed shortly afterwards. Despite resuscitation efforts, Mr Collinson was unable to be revived.

The State Coroner found that excessive speed and probably the effects of cannabis contributed to Mr Collinson losing control of the motorcycle when he failed to negotiate a left-hand bend in the road.

Considering the then current QPS pursuit policy, the State Coroner concluded the officer was entitled to follow and attempt to intercept Mr Collinson. He found the officer did not engage in a pursuit of Mr Collinson and his actions did not directly contribute to the crash.

The inquest heard evidence of the frequency of serious crashes at the incident site. The State Coroner recommended the Sunshine Coast Regional Council review the adequacy of existing road signage to warn motorists of the unusually dangerous road conditions in that location.

Phyllis Anne Crooks

Phyllis Anne Crooks was a 50-year-old woman who died from injuries sustained on 12 December 2009 when her motor vehicle collided with another vehicle being driven on the wrong side of the Bruce Highway at Woree. The driver of the other vehicle was evading police at the time of the collision.

Mrs Crooks' death was reported to the State Coroner as a death in the course of a police operation. Her death was investigated by the QPS ESC, though initially the ESC chose not to take control of the investigation because Mrs Crooks' had not died at that

stage. Consequently, the initial stages of the police investigation were conducted by officers from Cairns Criminal Investigation Branch who, under direction by the Regional Crime Coordinator, interviewed the officers involved in the attempted intercept. The ESC assumed responsibility for the investigation once it became apparent Mrs Crooks was unlikely to survive her injuries.

The investigation was informed by a forensic crash analysis. Blood samples of both drivers involved in the collision were analysed. Urine samples from both officers involved in the incident were analysed. The officers participated in video-recorded "walk through" interviews. The investigation was informed by interviews with other police and civilian witnesses; recordings of police radio communications and other related documentation.

The State Coroner noted that while there was evidence the two officers briefly discussed their recollection of events before they were interviewed, there was no evidence of collusion or that this compromised the integrity of the investigation.

The incident was also investigated by the CMC, who referred a complaint to the ESC that one of the officers involved in the lead up to the collision had, in breach of the QPS pursuit policy, performed a blocking manoeuvre when attempting to intercept the vehicle with which Mrs Crooks later collided and further that a junior officer had been told to "shut up" about his knowledge of this allegation. These allegations were not substantiated.

The State Coroner found the vehicle that collided head-on with Mrs Crooks was travelling at 153km/hr at the time of the collision. The 21-year-old driver of that vehicle was significantly affected by alcohol. He was subsequently convicted of manslaughter and dangerous operation of a motor vehicle and sentenced to 13 years imprisonment in respect of Mrs Crooks' death.

The State Coroner found that an earlier attempted intercept of the driver precipitated his criminally dangerous drunken driving that caused Mrs Crooks' death. Having regard to the then current QPS pursuit

policy, the State Coroner concluded that there was a pursuit, when it commenced the officer had seen the driver travelling very quickly on the wrong side of the divided highway and the officers involved complied with the pursuit policy.

The State Coroner noted the QPS pursuit policy was undergoing review to consider recommendations made in previous inquests and consequently did not make any further comment or recommendations.

The State Coroner conducted five inquests during the reporting period into deaths that occurred in the course of a person being detained and/or restrained by police or custodial officers:

Andrew John Bornen

Andrew Bornen was a 16-year-old youth who, on the evening of 7 February 2009 was roaming streets near his home in an intoxicated state. Witnesses reported him to have interacted with a number of residents in a strange but not aggressive manner, although he was seen by at least two people to be carrying a baseball bat. Another resident saw Andrew in his front yard and believed he was carrying a machete. This caused the resident to call police and report the incident.

Officers responding came across Andrew on a nearby road. They alighted from their unmarked vehicle and called to him. They say he adopted a threatening posture and so one drew his firearm and the other drew a Taser. They instructed Andrew to drop his weapon and get down on to the ground. Andrew complied and lay on the roadway. One officer handcuffed him while the other went to activate the flashing coloured lights on their vehicle. As this was occurring another vehicle came along the same road and despite the attempts of the officer who had handcuffed Andrew to warn the driver to stop, she failed to do so and struck Andrew killing him almost instantly. CPR was attempted until the ambulance arrived but Andrew could not be revived. He died at the Ipswich Hospital Emergency Department later that evening.

The incident scene was quickly secured pending the arrival of officers from the QPS ESC 90 minutes later.

The ESC investigation involved Scenes of Crime and Forensic Crash Unit analysis and incorporated a visual and audio recording of a “walk through” of events with the officers and a subsequent re-enactment under the same moon phase conditions. The investigation was supplemented by information from the Ipswich City Council about the lighting in the area and traffic volume. The State Coroner was satisfied the matter had been thoroughly and professionally investigated.

The State Coroner found that:

- Andrew did not display any aggression to the attending officers and when confronted by them, immediately complied with their commands. This involved him dropping the bat and prostrating himself in the middle of the southbound lane of the roadway;
- the officers could and should have turned on the flashing lights before they alighted from the vehicle;
- the driver of the car that hit Andrew was driving at or below the speed limit and did not see the officer who was warning her to stop until she was too close to stop, even though she was keeping a reasonable look out and was not affected by drugs or alcohol; and
- Andrew died from internal injuries received when struck by the motor vehicle.

The State Coroner made a referral to the Director of Public Prosecutions in this matter on the basis that the actions of the first response officers were a substantial and significant cause of Andrew’s death and considering the evidence of the volume of traffic likely to be using the road and the limited visibility at night, a jury might accept the officer should reasonably have foreseen that by handcuffing Andrew on the road they were placing him in danger of being run over.

The State Coroner noted QPS had made changes to scenario training and local standard operating procedures to limit the incidence of detainees being handcuffed on a roadway. The State Coroner

recommended that the QPS Uniform Review Committee consider changes to standard QPS uniforms that would enhance visibility of officers at night.

Alan Kent Dyer

On 31 May 2008, Mr Dyer's former partner called 000 to report that he had set fire to the house they shared. When police arrived, they were confronted by Mr Dyer who was brandishing a large knife and shouting threats to kill. He moved quickly towards the two officers in the front yard. They retreated down an embankment in front of the house but one of them tripped and fell. Mr Dyer continued to approach them. The other officer drew his service weapon and shot Mr Dyer in the stomach. He died at the scene.

Mr Dyer's death was investigated by the QPS ESC. Local police took control of the scene. The first response officers' weapons were seized and both officers were breath tested. The officers were isolated and separated prior to them participating in formal records of interview. The investigation involved a detailed forensic examination of the scene; ESC investigators conducted extensive interviews and video re-enactments with both of the officers; interviews or statements were taken from civilian and police witnesses; a ballistic examination of the officer's weapon was undertaken and Mr Dyer's medical records were obtained. The State Coroner was satisfied the matter was investigated thoroughly and professionally and commended the investigating officer for his detailed investigation report.

Mr Dyer had a history of depression that resulted in two suicide attempts. Mr Dyer engaged with the Gold Coast Mental Health Service in 2006 and his care thereafter was managed by his general practitioner until his last contact in January 2008. It appears Mr Dyer was not medicated for some months prior to his death.

On the day of his death, Mr Dyer was agitated after an altercation with his partner. He drank heavily during the day, later returning to their home where he set fire to a wardrobe. He became agitated again after his partner told him she had called the police. He retrieved a large ornamental knife and made comments to the effect he

would stab the police if they came. He then chased the occupants out of the house.

Not long after police and emergency services personnel arrived, Mr Dyer emerged from the house holding the knife and yelling loudly. He advanced very quickly towards the police officers yelling words to the effect that he would kill them all. This was when the officers retreated backwards and one of them fell and the other, knowing he could retreat no further and fearing for his safety, drew his firearm and fired one shot.

The State Coroner found that Mr Dyer died as a result of being shot by a police officer he attacked with the intention of causing the officer to kill him ("suicide by cop"). The State Coroner did not make a referral to the Director of Public Prosecutions in this matter as he considered the officer who shot Mr Dyer reasonably apprehended his life was at risk and reasonably concluded he could only avert that risk by shooting Mr Dyer. He found the officer to have acted lawfully and reasonably and not to have created the danger that prompted him to shoot the person who did.

The State Coroner did not consider that use of a Taser would have been feasible in this case, as it would have been unreasonably dangerous to allow a person attacking with knife to get within the distance required for an effective Taser deployment.

The State Coroner was satisfied there was no opportunity to involve a mental health intervention coordinator or take any other steps under the QPS Mental Health Intervention Project that may have de-escalated the incident.

The State Coroner considered the attending officer reacted to a volatile and deadly emergency with admirable precision. However, in view of the inherent danger in managing incidents such as this, the increasing frequency with which they are likely to occur and the tendency for officers to become desensitised to such risks, the State Coroner recommended that Operational Skills and Tactics Program review this incident with a view to using it as a training scenario.

Tofia Josen Mataia

On 18 October 2008, Mr Mataia had been in custody at Capricornia Correctional Centre (CCC) for almost two months when, without warning or provocation, he assaulted two corrective services officers. He engaged in a prolonged struggle with up to six officers. He was restrained, handcuffed and marched by several officers to a cell in the detention unit. He was placed on the ground, face down with hands secured behind his back and held by five officers while they attempted to negotiate the removing of the handcuffs. This involved the officers exerting downward pressure on his back and legs, including one officer kneeling in the middle of Mr Mataia's back. Mr Mataia was in this position for about two minutes before it was noticed that he had stopped breathing and the restraint was released. CPR was administered but Mr Mataia could not be revived.

The State Coroner was critical of aspects of the initial response by detectives from the Rockhampton Criminal Investigation Branch to Mr Mataia's death. No attempt was made to isolate the corrective services officers who had been involved in the incident. It seems likely that in two cases the corrective services officers collaborated in preparing their reports. The clothes worn by the officers were not seized until four or five hours after the death, providing an opportunity for contamination of their evidentiary value. Two of the corrective service officers refused to be interviewed by police at all and they each prepared scant written reports.

Mr Mataia's death was investigated concurrently by QPS Corrective Services Investigation Unit (CSIU) and the Chief Inspector of Queensland Corrective Services ('QCS investigation'). The State Coroner considered the QCS investigation to have incorporated a thorough review of relevant policy and procedure. He considered Mr Mataia's death to have been thoroughly and professionally investigated and commended the CSIU investigating officer for providing a comprehensive investigation report.

The State Coroner noted Mr Mataia had been diagnosed with schizophrenia, during a period of detention under relevant mental health legislation in New South Wales in

2005. Mr Mataia was transferred to his brother's care in Cairns in late November 2007 as an involuntary patient. He had demonstrated a propensity for unprovoked violence while in detention and was under a community Involuntary Treatment Order (ITO) when he was taken into custody on charges of breaking and entering and wilful damage on 18 August 2008. He was subsequently charged with serious assault after an unprovoked assault on a police officer in the watch-house and remanded in custody. The court was not made aware of the ITO.

Mr Mataia was initially remanded in custody to Lotus Glen Correctional Centre (LGCC), where he was referred for a mental health assessment. Before this could be done, Mr Mataia was transferred to CCC after an unprovoked assault on a corrective services officer at LGCC. A subsequent mental health assessment conducted by a psychiatrist concluded he suffered from drug-induced psychosis. His ITO status was never made known to CCC. Mr Mataia was initially made the subject of a safety order that kept him in the CCC detention unit until late August 2008. He remained out of trouble until the unprovoked assault on 18 October 2008.

The State Coroner found that had Mr Mataia's ITO status been brought to the court's attention during his last appearance, it is likely he would have been transferred to an authorised mental health service where his treatment would have been different to that received in prison.

The State Coroner found that Mr Mataia suffered a fatal cardiac arrest because of the combined effects of severe coronary atherosclerosis, obesity, schizophrenia, a violent struggle and prone restraint.

Although the State Coroner found that more likely than not the force used by corrective services officers contributed to Mr Mataia's death, he did not make a referral to the Director of Public Prosecutions, as he accepted the officers did not intend to cause serious harm to Mr Mataia and could not have reasonably foreseen his death, given their limited and inadequate training in relation to positional asphyxia.

The State Coroner criticised the nurses' failure to conduct a formal clinical assessment of Mr Mataia on their arrival at the scene; for not taking a more active role in managing the resuscitation efforts and for forgetting to bring a defibrillator to the scene.

The inquest examined the apparent failure of:

- the authorities to recognise that when Mr Mataia came into custody on the last occasion he was the subject of a current ITO;
- prison authorities to cause any mental health assessment to be undertaken until nine days after he came into custody;
- prison authorities to manage his seclusion and release into the general prison population in accordance with relevant policies and legislation;
- prison mental health staff to access Mr Mataia's mental health records from the Cairns Mental Health Service;
- CCC mental health staff to alert QCS staff to aspects of his mental health history relevant to his management;
- QCS staff to ensure all corrective services officers dealing with Mr Mataia were aware of the special danger he posed;
- QCS to adequately train corrective services officers in the dangers of restraint asphyxia and the need to monitor prisoners' health during extended restraint;
- Queensland Health to ensure the nurses at the CCC were adequately trained in the use of their equipment;
- QCS to ensure its policies provided for the immediate calling of an ambulance when a medical emergency was discovered; and
- the CCC senior managers to adequately ensure QCS policies concerning scene and evidence preservation were adhered to.

The State Coroner commended QCS and Queensland Health for making extensive changes to address most of these deficiencies since Mr Mataia's death. These include

the adoption of the Consumer Integrated Mental Health Application (CIMHA) which allows access to statewide mental health clinical information (with negotiations underway between QCS and Queensland Health about availability within correctional facilities); implementation of case conference meetings at CCC; improved systems at CCC for dissemination of prisoner information to corrective services officers; development and implementation of policy and training about the risks of restraint asphyxia; improved training standards for CCC nursing staff and development of a contingency plan at CCC.

The State Coroner recommended that:

- QCS ensure all senior managers are aware of the limited number of officers authorised to make and cancel Safety Orders and of the requirement that upon the cancellation of such an order consideration be given to the need to make an Intensive Management Plan;
- the QCS Commissioner cause all correctional centres to amend their policies to ensure whenever an employee of a correctional centre has reason to believe a medical emergency exists, he or she should be required to call the ambulance without waiting for a nurse from the health centre to come and examine the prisoner;
- the QCS Commissioner seek the assistance of the CSIU to review existing policies at all correctional centres and where necessary assist in the provision of training to corrective services officers to ensure the integrity of a death in custody investigation is not compromised by the initial response of officers at the scene;
- the QCS Commissioner consider seeking to have the Corrective Services Act 2006 amended to require any person suspected of having information about a death in a correctional centre to provide that information to CSIU officers with the proviso that any information provided can not be used against them in criminal or disciplinary proceedings.

Phillip Glenn Spicer

Phillip Glenn Spicer was a 53-year-old man who died on 21 January 2009 after inflicting severe razor cuts to his neck in the presence of police officers who attended in response to concerns about his increasingly aggressive behaviour.

Mr Spicer's death was investigated by the QPS ESC. The initial scene management was overseen by the Regional Duty Officer while paramedics were still in attendance. The scene was forensically examined and both attending officers provided breath and urine samples for drug and alcohol testing. The investigation was informed by an audio recording of the incident; interviews with both first response officers, other attending officers and Mr Spicer's family members and neighbours; and review of Mr Spicer's medical and ambulance records.

The State Coroner noted a two-hour delay in breath testing the attending officers and they were allowed to drive from the scene to the police station together and unsupervised, before senior officer directed they be separated. Both officers admitted discussing aspects of the incident with each other. The State Coroner found there was no suggestion of collusion in this case. He was otherwise satisfied this matter was investigated thoroughly and professionally.

The State Coroner noted that while Mr Spicer had never been treated for a mental health condition, his behaviour over 20 and 21 January indicated he was suffering a psychotic episode at the time of the incident. He exhibited agitation and delusional thoughts and became increasingly aggressive, culminating in him retrieving a straight-edged razor from the bathroom that he threatened to use on himself.

His daughter-in-law initially contacted police to seek advice about what help could be obtained for Mr Spicer. This initiated a welfare check. She called 000 shortly after this call, as Mr Spicer had become very agitated, made threats to attack his son if approached and attended the neighbours with the razor.

By the time police arrived, Mr Spicer had returned to the house. He held the razor to his neck threatening to

attack anyone who came near him. The audio recording of the incident shows the attending officers attempting to calm Mr Spicer. He advanced on them, challenging them to defend themselves. One officer deployed capsicum spray. Mr Spicer retreated then quickly and repeatedly cut his neck with the razor. One of the officers managed to dislodge the razor. The officers handcuffed him so they could render first aid while they called the ambulance. Despite paramedic treatment, Mr Spicer died at the scene.

The State Coroner found that no available treatment was likely to have saved Mr Spicer given the severity of his wounds. The State Coroner found that the attending officers appropriately and effectively performed ongoing risk assessments during the incident and the use of capsicum spray and handcuffs was entirely appropriate.

The State Coroner did not consider it would have been reasonable for the attending officers to withdraw and seek the assistance of mental health service personnel in this case, as there was no opportunity for external consultation.

The State Coroner recommended the Commissioner of Police consider officially recognising the bravery of the officer who dislodged the razor from Mr Spicer's grip.

Daniel James Clarke

Daniel Clarke was a 36-year-old man with a serious mental illness who died on 4 March 2009 after shooting himself in the head during a siege, with police in attendance, at remote rural property near Kingaroy.

Mr Clarke had suffered a serious psychiatric condition for many years and was subject to a forensic order at the time of his death. His treating psychiatrist notified police of concerns about Mr Clarke's condition on 3 March 2009. Police attended and a stand-off developed between them and Mr Clarke. Police negotiators made little progress over the ensuing 20 hours until a gunshot was heard and Mr Clarke was found dead.

Mr Clarke's death was investigated by the QPS ESC. The scene was initially accessed by Specialist Emergency Response Team (SERT) officers before being handed

over to general duties officers who secured the scene until the arrival of forensic officers. A detailed forensic examination of the scene and the body was undertaken, including a gunshot residue analysis. The initial investigations were overseen by District Officers who had also been involved in overseeing some aspects of the police response to the siege. The State Coroner accepted that while this was not ideal their initial oversight role did not compromise the investigation.

The investigation was informed by interviews with officers involved in the incident (several police negotiators, SERT operatives and their commander, senior officers managing the scene and the Kingaroy officer initially alerted to concerns about Mr Clarke), Mrs Clarke and mental health staff who treated Mr Clarke. The investigation obtained records relating to Mr Clarke's mental health treatment and management of his forensic order. The investigation examined the origin of the shotgun found at the scene and a full Weapons Act audit was conducted on other firearms found at the property. The investigation also involved a review of the negotiations that had taken place during the siege. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

The State Coroner found that Mr Clarke died from a self-inflicted gunshot wound to the forehead. Post mortem toxicology results show Mr Clarke was not affected by amphetamines or alcohol at the time of his death.

The State Coroner concluded that the mental health personnel involved in the management of Mr Clarke's forensic order made appropriate attempts over a lengthy period to assist him to lead a relatively normal life despite his chronic serious mental illness. Mr Clarke's rapid deterioration in the last weeks of his life could not have been anticipated and was not as obviously serious as the inquest revealed it to be. The State Coroner did not consider this was due to any neglect or departure from appropriate standards by the treating team.

The State Coroner considered the resolution of this incident was made very difficult by Mr Clarke's reluctance to engage to any substantial degree. The

evidence showed he was almost entirely hostile to attempts by police negotiators to speak with him.

The State Coroner considered the tactic adopted by the negotiation cell to "wait him out" was an appropriate one, given understandable concerns for the safety of officers who might be required to approach Mr Clarke and the likelihood this would cause Mr Clarke to immediately attempt suicide. The State Coroner concluded the incident was appropriately managed and executed and commended the incident commander, the SERT commander and all of the negotiators on their efforts.

While the State Coroner considered the debriefing of Mr Clarke's mother when she emerged from the house several hours before the siege commenced was inadequate, he did not consider there was any failure to give adequate consideration to her being allowed to make direct contact with Mr Clarke. The State Coroner observed there were compelling factors militating against this occurring.

The State Coroner also considered that the debriefing of a family friend was inadequate, as it deprived the negotiators of information relevant to determining whether direct contact between the friend and Mr Clarke may have been appropriate.

The State Coroner did not consider that third party contact should necessarily have been undertaken more readily merely because the subject of the siege was suffering from mental illness and was paranoid about police.

However, the State Coroner observed this was the third inquest involving a siege during which a person has emerged from the stronghold and only been cursorily debriefed. This, coupled with failure to debrief adequately another possible source of relevant information caused the State Coroner to recommend that incident management policies be reviewed to ensure adequate emphasis is placed in the need to debrief comprehensively witnesses who may have intelligence relevant to the management of a siege.

During the reporting period, the State Coroner and the Deputy State Coroner conducted three inquests into prisoner deaths by hanging at Arthur Gorrie Correctional Centre:

Jeremy Dylan Barker

Jeremy Barker was a 27-year-old prisoner on remand at Arthur Gorrie Correctional Centre (AGCC) who, four days after his arrival at AGCC, was found hanging from a bed sheet in the toilet of the prison medical centre.

Mr Barker's death was investigated concurrently by the QPS Corrective Services Investigation Unit (CSIU) and the Chief Inspector of Queensland Corrective Services ("the QCS investigation"). The scene was forensically examined and statements were taken from relevant corrective services officers. Medical centre staff and prisoners in the medical centre at the time of Mr Barker's death were also interviewed. The CSIU investigators provided a comprehensive report and the State Coroner commended the QCS investigation for providing a robust, comprehensive report. These reports were supplemented by inquiries by the Office of the State Coroner (OSC) relating to the management of other prisoners in the medical centre at the time of Mr Barker's death. The State Coroner was satisfied the contributions of each agency sufficiently informed the investigation and inquest.

Mr Barker had a history of mental illness with diagnoses of depression and bipolar disorder. He was the subject of an ITO in August 2007, absconded from the Gold Coast Hospital and was subsequently apprehended by police in Maryborough, where he was admitted to the Mental Health Unit as a classified patient until early October 2007. On discharge, he was transferred to the Southport watch-house. He expressed suicidal ideation (by hanging if he had the opportunity) while in watch-house custody and was referred to the Prison Mental Health Service (PMHS) for monitoring and treatment and taken to AGCC on 17 October 2007.

Upon reception at the AGCC, Mr Barker was correctly assessed as being at risk of self-harm and in need of frequent observation. He was placed on 15-minute

observations and seen by a psychiatrist the next day, who recommended Mr Barker be placed in the medical centre. He was subsequently accommodated in a six-bed medical ward occupied by two other prisoners.

Mr Barker was noted by his fellow prisoners to be depressed on the day of his death. They found him hanging in the toilet some 20-30 minutes after he had gone there to smoke a cigarette. There was a sheet tied around his neck and to exposed bars on the inside of the toilet window. He was unable to be revived despite resuscitation efforts.

The State Coroner noted the exposed bars in the toilet window provided a convenient facility for a prisoner intent on suicide and further, prison authorities had been warned explicitly that Mr Barker had expressed an intention to commit suicide by hanging if the opportunity arose.

The State Coroner found the risks of this combination of circumstances were well known to AGCC's accommodation managers as they had been raised in July 2007 and again in August 2007 when another prisoner had attempted to hang himself in the other medical ward by securing a ligature to the bars on the windows. The QCS investigation and the State Coroner found there was no meaningful response to those concerns. The State Coroner noted the bars in both wards were covered with Perspex soon after Mr Barker's death.

The State Coroner found that despite Mr Barker being on 15-minute observations, no corrective services officer went to the ward after 2pm, an hour before he was found hanging in the toilet. The State Coroner noted that as a consequence of Mr Barker's death, AGCC has reviewed the observation policies to require all corrective services officers undertaking that duty to sign an acknowledgement that they have read the policy and understand what is required of them; an extra corrective services officer is rostered on whenever there are prisoners requiring observation and arrangements are being brokered with PMHS to provide training for correctional officers in dealing with prisoners suffering from mental illness.

The State Coroner considered individual and systemic failures combined to allowed Mr Barker's death to occur. Noting individuals had been counselled and systems reviewed, the State Coroner did not make any coronial comment.

Jason Andrew Muir

Jason Muir was a 36-year-old man who was found hanging in his cell at AGCC on 25 September 2008. He had previously exhibited suicidal ideations but by June 2008 was considered sufficiently well to join the general prison population.

Mr Muir's death was investigated concurrently by the QPS Corrective Services Investigation Unit (CSIU) and Chief Inspector of Queensland Corrective Services ('the QCS investigation'). The scene was appropriately secured as crime scene and a thorough forensic examination of the cell was performed. Custodial and prison medical records were seized along with documents found in Mr Muir's cell. Statements were taken from relevant corrective services officers and all prisoners in the unit where Mr Muir was accommodated. The CSIU investigation concluded that there was no evidence to suggest another person's involvement in the death. The Deputy State Coroner, in her capacity as Acting State Coroner, found that the CSIU investigation had been conducted professionally and appropriately. The Deputy State Coroner noted the QCS investigation identified areas of AGCC policy and procedure requiring improvement.

The Deputy State Coroner noted that Mr Muir came under the care of the PMHS shortly after his arrival at AGCC in mid February 2008. He was subsequently assessed as being at risk of self-harm and thereafter was supervised by a risk assessment team. This involved Mr Muir being placed under regular observations until 12 June 2008, when he was returned to the general prison population. His condition had improved alongside a gradual increase in his anti-psychotic medication.

Mr Muir was initially placed in a newer "suicide resistant" block. However, on 21 August 2008, after an

altercation with another prisoner, he was transferred to an older style cell that had accessible horizontal bars above the door.

In the early hours of 25 September 2008, Mr Muir fashioned a noose from strips of bed sheeting cut with a disassembled safety razor and used it to hang himself from the horizontal bars. He was discovered during a headcount at 4am that morning.

The Deputy State Coroner was satisfied that:

- notwithstanding Mr Muir's extensive psychiatric history, no staff member at AGCC ought reasonably to have been aware that he was likely to take his own life that morning;
- AGCC staff reacted promptly and appropriately when Mr Muir was discovered hanging;
- there was no causal link between Mr Muir's failure to take one dose of his medication on the day before his death and his subsequent suicide; and
- AGCC has since developed policy and procedure to identify and monitor prisoners with an elevated baseline risk of self-harm and ensure they are accommodated appropriately.

The Deputy State Coroner noted the subsequent implementation of an automatic referral and review process for prisoners who decline medication for three days. This is being implemented statewide.

The Deputy State Coroner endorsed comments made by the State Coroner in previous inquests urging the Department of Community Safety to take the steps necessary to make cells safe. The inquest heard evidence from the Director of Correctional Infrastructure Management Branch to the effect that the elimination of hanging points is a priority for the Department of Community Safety but is limited by available financial resources.

The inquest heard there were 380 cells at AGCC that need modification to make them suicide resistant and this involved capital expenditure in the order of \$50 million to remove louvres, install toughened glass and install air conditioning. The Deputy State Coroner

reflected upon coronial comment she made in respect of a hanging death in custody that occurred in very similar circumstances in 2001 to the effect that "...there are obvious and basic physical issues to be addressed as a matter of urgency. Otherwise, further coronial comment and recommendation is of no value in seeking to prevent deaths in the future".

Christopher Steven Bell

Christopher Bell was a 27-year-old man who was found hanging in his cell at AGCC on 18 March 2010.

Mr Bell's death was investigated concurrently by the QPS Corrective Services Investigation Unit (CSIU) and the Chief Inspector of Queensland Corrective Services ('the QCS investigation'). The scene was immediately secured and forensically examined. The CSIU investigation obtained Mr Bell's prison records and information about Mr Bell's criminal and psychiatric history. The investigation was informed by statements from all relevant AGCC and PMHS staff and prisoners in the unit where Mr Bell was accommodated. These investigations were supplemented by independent psychiatric opinion obtained by the Office of the State Coroner. The State Coroner was satisfied this matter was investigated thoroughly and professionally and commended the QCS investigation report as rigorous and independent.

Mr Bell suffered from schizophrenia. The nature of his psychosis made it difficult for him to live in communal accommodation. He had been extradited to Queensland in October 2009 and was remanded in custody. His initial assessment in the Southport watch-house recorded his long-term history of schizophrenia, symptoms of psychosis, previous suicide attempts and recent suicidal ideation. It noted Mr Bell's concern about longer-term incarceration and being confined with others for lengthy periods. Mr Bell was transferred to AGCC the next day.

The initial risk and needs assessment performed by the AGCC psychologist concluded Mr Bell did not meet the criteria to be classified as a prisoner with an elevated base-line risk of suicide or self-harm. He was referred

to the PMHS for further assessment and treatment. The triage assessment noted current suicidal ideation but this information was not passed on to the custodial staff responsible for Mr Bell or the AGCC psychologist. Mr Bell was subsequently reviewed by a psychiatrist but despite medication, his psychotic symptoms showed no signs of improvement. Mr Bell was considered for transfer to the High Secure Inpatient Service but removed from the waiting list when it was decided to increase his medication dose before commencing a trial with clozapine. His condition was noted to improve over the next few months.

There were no noticeable changes to Mr Bell's demeanour or daily routine prior to him being found hanging in his cell on the morning of 18 March 2010. He had fashioned a noose from strips of bed sheet and secured it to exposed horizontal bars above the cell door. Despite resuscitation efforts, Mr Bell was unable to be revived.

The State Coroner found there were no indications that should have prompted intervention to prevent Mr Bell's death. The State Coroner was satisfied that both the initial assessment of Mr Bell's custodial needs and the initial psychological assessment were adequate. He considered Mr Bell received competent psychiatric care. The State Coroner was satisfied there were good clinical reasons to delay Mr Bell's admission to the High Security Inpatient Service and once the results of increasing his medication were assessed, his condition was such that transfer was no longer indicated.

The State Coroner was satisfied that most of the recommendations made by the QCS investigation were being implemented, namely:

- amendment of QCS and AGCC At-Risk Management Procedures to ensure watch-house records/assessments are reviewed as a matter of course during an Initial Risk and Needs Assessment (IRNA) and for the IRNA pro forma to incorporate an additional section on watch-house records to confirm these have been reviewed;

- review of current and proposed policies, procedures and agreements to ensure they sufficiently facilitate the sharing of information between the Prison Mental Health Service, QCS and/or private prison providers;
- review of the elevated base-line risk procedures;
- QCS to issue a direction to all centres including AGCC that when allocating prisoners to secure accommodation, prisoners who have a self-harm flag must be placed in modern suicide resistant cells unless other reasonable factors warrant against it; and where this allocation does not occur, the reason for the decision must be recorded.

The inquest highlighted the inherent difficulty in trying to prevent prisoner suicide by identifying those most likely to do so and providing them with special treatment including accommodation in suicide resistant cells. The inquest noted expert evidence to the effect that even the best risk analysis tools are of limited value.

The State Coroner commented that Mr Bell's death and other deaths can be attributed in part to the failure of successive State Governments over the past 20 years to fulfil a commitment to implement the recommendation of the Royal Commission in Aboriginal Deaths in Custody that hanging points be eliminated from watch-houses and prison cells. The State Coroner acknowledged the substantial cost involved in doing so and noted that further funding will soon be made available to continue the process of building new suicide resistant cells and retro-fitting screens over exposed bars in old cells at AGCC.

The remaining three death in custody inquests examined the adequacy of the medical and emergency treatment provided to prisoners in a custodial setting:

Thomas Andrew Clumpoint

Mr Clumpoint was a 40-year-old Indigenous man who died suddenly at the Townsville Correctional Centre (TCC) on 12 June 2009. He had been undergoing treatment and review at the Townsville Hospital for

head and neck cancer. Mr Clumpoint's cell did not have a working intercom. Prison staff and other prisoners in the unit were aware of this situation. Mr Clumpoint declined attempts made by staff to move him into the prison medical centre or into another cell with a working intercom. Consequently, Mr Clumpoint was permitted to sleep with his cell door open and a fellow prisoner in the unit agreed to keep an eye on him and keep his own door unlocked at night in case Mr Clumpoint needed help.

At 5:00am on 12 June 2009, Mr Clumpoint started having trouble breathing. A fellow prisoner tried to summon help via the intercom but received no response because the call was garbled at the receiving end in the Master Control Room. Mr Clumpoint collapsed and stopped breathing. Another prisoner called for help from an intercom in another cell. Corrective Services staff responded within several minutes and performed CPR until the nurse arrived five minutes later with a defibrillator but Mr Clumpoint was unable to be revived.

Autopsy revealed Mr Clumpoint died from laryngeal stenosis caused by laryngeal oedema due to squamous cell carcinoma of the head and neck.

Mr Clumpoint's death was investigated concurrently by the QPS Corrective Services Investigation Unit (CSIU) and the Chief Inspector of Queensland Corrective Services ('QCS investigation'). The QCS investigation identified shortcomings in the TCC's response to Mr Clumpoint's collapse. It concluded that although the corrective services officer who received the intercom calls was central to some of those, they were indicative of system deficiencies that affected the prison's ability to deal with a contingency situation. The QCS investigation made recommendations aimed at improving incident management at TCC and other recommendations with statewide application. The Deputy State Coroner found the QCS investigation to be a timely and thorough review of the incident. Its findings and recommendations substantially informed the police investigation. The Office of the State Coroner supplemented the findings of the CSIU investigation with an opinion from the Queensland Health Clinical

and Forensic Medicine Unit about the adequacy and appropriateness of the medical and emergency treatment provided to Mr Clumpoint.

The Deputy State Coroner found Mr Clumpoint received a reasonable and appropriate level of medical treatment for his condition and corrective services staff were sufficiently aware of his condition.

The Deputy State Coroner found that delays in the emergency medical response to Mr Clumpoint's collapse did not contribute to his death, given the severity of the upper airway obstruction revealed at autopsy was such that no resuscitative measures available outside a hospital environment (where an emergency percutaneous tracheotomy could only be performed) would have been successful in this case.

The Deputy State Coroner noted the following operational changes implemented by QCS in response to Mr Clumpoint's death:

- amended operational procedures directing how cell intercoms are to be checked on a weekly basis, tested and maintained and how faults are to be reported and recorded;
- amended operational procedures directing that a secure accommodation cell identified as having a faulty intercom must not be used for prisoner accommodation;
- the designation, in some correctional centres, of "special carers' units" proximate to prison medical centres where prisoners not requiring intensive nursing and medical care can be assisted by willing peer support;
- direction to General Managers to establish local practices to ensure inaudible or garbled intercom calls are responded to in a timely and appropriate way;
- refresher training for staff who perform Master Control duties;
- immediate allocation of a corrective services officer to clinical staff who respond to a medical emergency (at TCC); and

- risk analysis and review/development of contingency plans and implementation of an annual contingency situation training program at TCC.

The Deputy State Coroner commended QCS for taking action at both a local and whole-of-agency level to address deficiencies identified in this case. Although the Deputy State Coroner did not make any recommendations, she observed that overall contingency planning is an area requiring statewide review and direction and should be a matter of priority.

Edward Arthur Anthony Rawlins

Edward Rawlins was an 81-year-old man who died on 17 April 2010 from natural causes while accommodated in a special needs unit at Wolston Correctional Centre (WCC). At the time of his death, Mr Rawlins had been imprisoned continuously for 54 years.

Mr Rawlins' death was investigated by the QPS Corrective Services Investigation Unit (CSIU). The scene was secured and examined forensically. The investigation obtained Mr Rawlins' correctional records and hospital records. The investigation was informed by statements from custodial officers, prison medical staff and other prisoners who had dealt with Mr Rawlins before his death. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

At the time of his death, Mr Rawlins was accommodated in a block catering specifically for prisoners requiring constant care and assistance with daily activities. Care and assistance is provided by a fellow prisoner as a designated carer. Mr Rawlins was suffering multiple chronic health conditions and was left partially paralysed and wheelchair-bound after suffering multiple strokes in 2006.

Mr Rawlins was found unresponsive in bed by his designated carer on the morning of 17 April 2010. Despite resuscitation efforts, Mr Rawlins was unable to be revived.

The State Coroner found that nothing could have been done to save Mr Rawlins, who died suddenly from natural causes. The State Coroner was satisfied the hospital care provided to Mr Rawlins in the months prior to his death was adequate and appropriate.

James Errol Tranby

James Tranby was a 64-year-old Indigenous prisoner from the Townsville Correctional Centre (TCC) who initially presented to hospital with a fish bone lodged in his rectum and died in hospital 14 days later on 17 December 2008 after undergoing six operations.

Mr Tranby's death was investigated by local Townsville police. The investigation was informed by statements from clinical staff from both Townsville Hospital and the prison medical centre. The Office of the State Coroner subsequently obtained an independent clinical review from the Queensland Health Clinical Forensic Medicine Unit and an independent colorectal surgical opinion.

On the evening after Mr Tranby was sentenced and transferred to TCC, he reported significant abdominal pain. He was transferred to hospital and underwent surgery the next day to remove a 2cm fish bone from his rectum. He was discharged back to TCC the following morning.

Mr Tranby was returned to the hospital emergency department the next day with abdominal and rectal pain and unable to pass urine or a stool. A catheter was inserted and he was sent back to TCC with advice to remove the catheter in a few days.

Mr Tranby was returned to hospital two days later with a grossly distended abdomen. He was reviewed by a urologist and his care then transferred back to the surgical team for investigation of an possible ischiorectal or perirectal abscess. Mr Tranby's ongoing abdominal pain and distension led to a laparotomy being performed on 10 December 2009. The procedure revealed signs of infection but did not find the source. Mr Tranby was put on antibiotic support for 48 hours and transferred to ICU for monitoring.

An abdominal washout on 12 December 2009 revealed purulent peritonitis and necrosis of the peritoneum.

Mr Tranby underwent further abdominal surgery over the next three days but the sepsis continued. It was determined during surgery on 16 December that Mr Tranby's condition was not survivable and consequently life sustaining measures were withdrawn and Mr Tranby died the next morning. Autopsy confirmed the cause of death as abdominal sepsis due to peritonitis.

The State Coroner concluded that:

- the 32-hour delay in commencing the initial surgery increased the risk of an infection developing but there was no evidence the delay resulted from dilatory conduct by hospital staff; and
- Mr Tranby's chances of survival would have been improved had surgical examination of his abdomen occurred sooner. The 24-hour delay was caused by an error of judgement by a first-year registrar who did not seek urgent review by the consultant on the evening of 8 December or the following morning.

The State Coroner noted Mr Tranby's wife was not notified of his condition until he was in a coma in ICU. He considered this matter highlighted the inadequacy of QCS policy governing when a prisoner's nominated contact person should be advised the prisoner is to undergo a medical procedure and recommended QCS review the policy to ensure as far as is possible it accommodates the unexpected outcomes of relatively minor procedures and cases involving a progressive deterioration.

Inquests of Public Interest

John Douglas Simpson-Willson (Brisbane Coroner, John Lock)

John Douglas Simpson-Wilson died from head injuries inflicted by a person who had recently been released from prison. The perpetrator made admissions firstly to his treating psychiatrist and later to police. He was subsequently found by the Mental Health Court to be of unsound mind when he killed Mr Simpson-Willson.

The inquest examined issues including the circumstances in which the perpetrator's mental health status was assessed and treated while he was in custody; the role and obligations of Queensland Corrective Services (QCS) when dealing with a prisoner who has expressed an intention to commit acts of violence upon release and the status and treatment of prisoners with intellectual disabilities.

The coroner found the perpetrator received virtually no treatment for his condition while in custody, mainly because there was no capacity to do so. The regional correctional centre was not able to provide appropriate programs and the PMHS and Disability Services Queensland were not resourced to make up the gap.

The coroner identified a range of systemic factors that prevented the psychiatrists involved in the perpetrator's care in custody from referring him to an authorised mental health service for assessment. The coroner also identified systemic deficiencies in the perpetrator's pre-release and discharge planning that failed to address shared concerns about the perpetrator's intentions to commit future violence.

The coroner made recommendations directed to the State Government, QCS and Disability Services Queensland aimed at:

- better enabling the PMHS to meet service demand and to provide services comparable with those available to the general community;
- providing prisoner access to the Medicare rebate scheme;
- improving the routine intake screening process to identify prisoners with impaired cognitive functioning;
- improving service delivery to, and management of, prisoners with impaired cognitive functioning;
- improving data collection and analysis about prisoners with impaired cognitive functioning;
- ensuring substitute decision makers are involved in pre-release planning and decisions regarding the release of adult prisoners with impaired decision making capacity;

- substantially improving communication between prison staff, Offender Health Services and PMHS about prisoners with mental illness.

Little Gungallida Girl (Northern Coroner, Kevin Priestly)

Little Gungallida Girl was a four-year-old Indigenous child who died during her third presentation to Doomadgee Hospital with flu-like symptoms.

The inquest examined the adequacy of the medical and emergency treatment provided to her by nursing and medical staff. The Northern Coroner found that:

- the nursing reviews on each of her three presentations were adequate in light of her presentation on each occasion;
- the medical officer's diagnosis and treatment of her condition during the third presentation was reasonable and appropriate;
- there was no clinical need to consider medical evacuation or consultation with a paediatrician; and
- the child's condition deteriorated acutely and unexpectedly. There was no medical intervention reasonably available at Doomadgee Hospital that could have prevented her death and further, she was unlikely to have survived if she was transferred to Mt Isa Hospital.

The Northern Coroner noted the Mt Isa Health Service District was in the process of implementing a range of improvements to the provision of health services at Doomadgee.

The Northern Coroner recommended that Queensland Health develop a guideline for health staff dealing with cultural sensitivity issues surrounding the death of a person in an Indigenous community and communication about the death with families.

**Malcolm MacKenzie, Graham Peter Brown and Robert Wilson
(Rockhampton Coroner, Magistrate Annette Hennessy)**

The Rockhampton Coroner held an inquest into multiple deaths occurring in two motor vehicle accidents in Central Queensland. Both incidents involved mine workers who were driving home at the end of their shifts. The inquest examined issues including the extent to which fatigue was a contributory factor in each accident.

The coroner found fatigue to be one of a number of contributing factors to both accidents. The coroner noted evidence that the proportion of fatigue-related crashes in the central region, an area including the Bowen Basin with its coal mining activities, is significant in comparison with the rest of the state.

The coroner also commented on deficiencies in the police investigations of both accidents, noting most were the result of a lack of resources, support and training rather than due to the abilities of any individual officer.

The coroner made a suite of recommendations directed to agencies including QPS, Queensland Transport, the Mines Inspectorate, Q-Comp, the State Government, the Australian Transport Council and the Ministerial Advisory Council, aimed at:

- allocating permanent Forensic Crash Unit officers to regional Queensland;
- increasing general police resources in the Central Region;
- improving the identification and investigation of fatigue-related crashes;
- improving data collection and analysis of fatigue-related crash statistics;
- involving the Mines Inspectorate in the investigation of road crashes involving persons travelling to and from a mine;
- developing a standardised definition of fatigue;
- developing ways to detect and respond to drivers who are impaired by fatigue, including the creation of specific powers for police to

stop drivers suspected of being fatigued and developing a fatigue-specific driving offence;

- identifying and remedying “fatigue hot spot” locations;
- developing best practice fatigue management guidelines for road transport authorities, road users and public and private sector employers across Queensland;
- assessing the appropriateness of competency-based fatigue training or other measures for the mining industry;
- implementing and enforcing compliance with a fatigue management standard within the mining industry;
- better identifying and managing risk to workers and the public from shiftwork, commuting and fatigue;
- clarify workers compensation cover for fatigue-reducing rest breaks before commuting on public roads;
- monitoring the safety of Central Queensland roads;
- prioritising the Dysart-Middlemount Road for upgrade and widening;
- enhancing the effectiveness of public education campaigns about driver fatigue and driver inattention; and
- addressing driver fatigue as a critical public safety issue.

**Sanglin Chung, Moira Therese McGreevy, Glen Raymond McGreevy, Rachel Gai Purdy, Cory James Whitmore and Mark Hamilton
(Gympie Coroner, Magistrate Maxine Baldwin)**

The Gympie Coroner held an inquest into multiple deaths occurring on a 15km stretch of the Bruce Highway south of Gympie over the period 2008-2009. The inquest considered the findings of forensic crash analyses, Department of Transport and Main Roads crash investigation findings and independent civil engineering opinion obtained by the Office of the State Coroner.

The coroner concluded that the road design, construction and surfacing of this stretch of highway is acceptable and of sufficient standard but considered the high volume of traffic in this area means the margin for error is minimal.

Consequently, the coroner recommended that, pending completion of the highway upgrade and the creation of a dual lane carriageway in both directions:

- the speed limit remain reduced especially for wet weather conditions;
- the painted median strip project continue to effectively narrow the lanes to provide greater margin for error against oncoming traffic and encourage a lower vehicle speed; and
- audio tactile marking devices are installed on the centre lines to minimise the chance of a lapse in concentration leading to vehicles crossing into the oncoming lane.

**Travis Noel Graham
(Toowoomba Coroner, Magistrate Kay Ryan)**

Mr Graham was 31-year-old man who died on 12 July 2008 from an overdose of quetiapine (Seroquel) with alcohol. Mr Graham suffered from mental illness and had a history of overdosing on prescription medications.

The inquest considered issues including the prescribing and dispensing processes in operation at the time of Mr Graham's death and whether Seroquel should be dispensed in restricted quantities.

The coroner found the prescribing doctor who ceased prescribing Seroquel several months prior to Mr Graham's death failed to take positive action to ensure Mr Graham could not have the prescription further dispensed.

The coroner made a suite of recommendations aimed at:

- restricting the quantity in which Seroquel is supplied;
- developing a national database to enable pharmacists to identify over-dispensing of prescription medication;

- amending federal privacy laws to enable PBS information about a patient to be disclosed to an approved supplier of medication to the patient;
- developing a process to prevent cancelled or withdrawn prescriptions being dispensed; and
- establishing a mechanism by which pharmacists can access real time information about the status of authority prescriptions.

**Bela Heidrich
(Rockhampton Coroner, Magistrate Annette Hennessy)**

Bela was a newborn baby who asphyxiated several hours after her birth at the Rockhampton Hospital on 27 February 2008 while she was bed-sharing with her mother for breastfeeding purposes.

The inquest examined issues including the appropriateness of the decision to allow breastfeeding in bed, whether mother and child were monitored appropriately while this occurred and the adequacy of relevant Queensland Health bed sharing and co-sleeping policies.

The coroner found that although it was appropriate and within then current policy for the mother to breastfeed lying down in bed, the supervision provided by the midwife was inadequate.

The coroner noted previous coronial recommendations about the dangers of extremely tired and medicated mothers bed-sharing with newborn babies and considered evidence about Queensland Health's response to those recommendations.

The coroner made recommendations directed to Queensland Health aimed at:

- enhancing awareness by hospital staff and all prospective and new parents of the potential dangers of bed-sharing and co-sleeping;
- ensuring facilities that provide birthing services have specific policy dealing with bed-sharing and co-sleeping;

- enhancing existing policy by better framing the levels of supervision required in the breastfeeding policy and by incorporating requirements to conduct a risk assessment before a mother is permitted to breastfeed lying down and to document the level of supervision required if this occurs;
- reviewing the appropriateness of student midwives and endorsed midwives being required to work a full case load;
- ensuring staff who participate in a root cause analysis receive feedback about the outcomes;
- improving the accuracy of medical record keeping; and
- achieving synchronisation of hospital clocks.

Appendix 1

Operating expenses 2010/2011

Employee related expenses	\$2,242,388.91
Autopsies	\$649,932.95
Burials/Cremations	\$907,948.49
Conveyances	\$1,727,862.40
Fees for private counsel	\$424,277.24
Crown Law fees	\$81,473.74
Travel costs	\$102,447.90
Conferences	\$3,526.80
Other supplies and services	\$376,443.05
NCIS Grant	\$96,457.36
TOTAL	\$6,612,758.84
Funds recovered (burials assistance contributions)	\$369,486.73

Appendix 2

Number of coronial cases lodged and finalised in the 2010-11 financial year and the number cases pending as at 30 June 2011

Court location	Number of deaths reported to the coroner	Number of coronial cases finalised			Number of coronial cases pending			Total
		Inquest held	No inquest held	Total	Less than or equal to 12 months old	Greater than 12 and less than or equal to 24 months old	Greater than 24 months old	
Brisbane	1,826	23	1,771	1,794	673	204	115	992
Bundaberg	151	1	167	168	52	10	7	69
Cairns	583	4	526	530	340	167	80	587
Caloundra	61	0	56	56	29	3	1	33
Charleville	39	0	33	33	15	3	2	20
Dalby	24	0	54	54	11	8	8	27
Emerald	49	0	35	35	25	2	0	27
Gayndah	7	0	9	9	4	1	0	5
Gladstone	48	0	57	57	23	5	2	30
Gympie	32	6	41	47	11	6	2	19
Hervey Bay	67	0	70	70	25	1	1	27
Innisfail	0	0	0	0	0	0	1	1
Ipswich	136	2	144	146	72	18	3	93
Kingaroy	40	1	45	46	16	4	4	24
Mackay	104	0	116	116	46	15	6	67
Maroochydore	177	1	188	189	59	13	12	84
Maryborough	46	0	45	45	21	1	2	24
Murgon	5	0	3	3	2	2	1	5
Rockhampton	169	5	178	183	50	12	6	68
Southport	647	1	622	623	299	59	63	421
Toowoomba	0	1	3	4	0	0	0	0
Townsville	0	1	0	1	0	0	0	0
Warwick	205	0	199	199	88	4	4	96
Total	4,416	46	4,362	4,408	1,861	538	320	2,719

Appendix 3

Presentations

State Coroner

OPI forum, Investigating police related deaths, Melbourne July 2010

QUT LWN151 Health Law. “The State’s supervision of death”, August 2010

QUT JSB986 Death investigations,” Inquests”, October 2010

International Association for the Prevention of Suicide, Asia Pacific Regional Conference, Shakespeare v Morgagni – why coroners and suicidologists see suicide differently, November 2010

Asia Pacific Coroners Society annual conference 2010, Re-thinking resort to internal autopsy, November 2010

ATSB QPS Aviation crash investigators course, Contextual challenges of aviation crash investigations, February 2011

RBWH Neonatal Seminar, Coroners’ involvement in neonatal deaths, February 2011

UQ School of Medicine, The Queensland coronial system, February 2011

OPI, A new approach to investigating deaths in police custody, May 2011

QUT Faculty of Law Prize night, Who’s truth? May 2011

Medico Legal Society of Queensland 2011 conference, A crime by any other name is not a crime, September 2011

QNU Professional Seminar “The coroner and hospital deaths, November 2011

Deputy State Coroner

The Deputy State Coroner made several presentations to the major teaching hospitals in the Brisbane area throughout this reporting period including:

Law and Nursing Conference, This is a case for the coroner, August 2010

Royal Brisbane and Women’s Hospital Aged Care Conference, June 2011

Brisbane Coroner

St Vincent’s Hospital 30 July 2010

Palliative and Supportive Care, Mater Hospital 29 November 2010

Royal Brisbane and Women’s Hospital 7 December 2010

Queensland Public Interest Clearing House 9 December 2010

Community Acute and Post Acute Symposium, Northlakes Health Centre 30 March 2011

Patient Safety Seminar 31 March 2011

Injury Prevention Conference, Injury in Queensland - Results and Recommendations 7 June 2011

Appendix 4

Register of approved genuine researchers

Chairperson	Queensland Maternal and Perinatal Quality Council
Chairperson	Queensland Paediatric Quality Council
Chairperson	Committee to Enquire into Peri-operative Deaths Queensland Health
Director (Rob Pitt)	Queensland Injury Surveillance Unit
Director (Prof Diego De Leo)	Australian Institute of Suicide Research and Prevention
Director (Prof Nicholas Bellamy)	Centre of National Research on Disability and Research Medicine
Director (Assoc Prof David Cliff)	Minerals Industry Safety and Health Centre
Dr Douglas Walker	
Deputy Team Leader Safety and Education Branch	Australia Transport Safety Bureau
Director (Prof Mary Sheehan)	Centre for Accident Research and Road Safety - Queensland
Dr Charles Naylor Chief Forensic Pathologist QHSS	Australian Research Council
Dr Belinda Carpenter Criminologist QUT School of Justice Studies	Australian Research Council
Dr Glenda Adkins Criminologist QUT School of Justice Studies	Australian Research Council
Director (Assoc Prof Robert Hoskins)	Queensland Health Clinical Forensic Medicine Unit
Dr Ben Reeves	Paediatric Registrar Mackay Base Hospital
Dr Beng Beng Ong	Queensland Health Scientific Services
Dr Nathan Milne	Queensland Health Scientific Services
Dr Peter O'Connor Ms Natalie Shymko Mr Chris Mylka	National Marine Safety Committee
Dr Nathan Milne	Queensland Health Scientific Services
Dr Beng Beng Ong	Queensland Health Scientific Services

Manager (Strategy and Planning)	Maritime Safety - Queensland
Dr Luke Jardine	Royal Brisbane and Women's Hospital
Dr Yvonne Zurynski	Australian Paediatric Surveillance Unit The Children's Hospital at Westmead
Director of Neonatology – Dr John Whitehall and Dr Yoga Kandasamy	Department of Neonatology Townsville Health Service District
Dr Nathan Milne	Queensland Health Scientific Services
Dr Beng Beng Ong	Queensland Health Scientific Services
Professor Ian Thomas Director of CESARE	Centre for Environmental Safety and Risk Engineering
Dr Margot Legosz	Crime and Misconduct Commission
National Manager for Research and Health Promotion (Dr Richard Charles Franklin)	Royal Life Saving
Lance Glare (Manager BCQD Building Legislation and Standards Branch)	Building Codes Queensland Division (BCQD)
Michelle Johnston	School of Pharmacy, University of Queensland
Dr Damian Clarke	Paediatric Neurology Department Mater and Royal Children's Hospital
Professor Grzebieta, Hussein Jama and Rena Friswell	NSW Injury Risk Management Research Centre - UNSW
Director - John Lippmann OAM	Divers Alert Network Asia Pacific
Michelle Hayes	Department of Communities
Associate Professor Alexander Forrest	Queensland Health Scientific Services
Professor Christopher Semsarian	Centenary Institute - Molecular Cardiology Group
Professor Tim Prenzler, Doctor Louise Porter, Kirsty Martin and Alice Hutchings	ARC Centre of Excellence in Policing and Security (CEPS)
Professor Christopher Semsarian	Centenary Institute - Molecular Cardiology Group
Associate Professor Charles Naylor	Queensland Health Forensic and Scientific Services
Ms Donna McGregor, Dr Laura Gregory, Mr Matt Meredith, Miss Nicolene Lottering	QUT / Queensland Health Forensic and Scientific Services

Law Courts Complex
304 George Street,
Brisbane QLD 4000

PO Box 15167,
City East QLD 4002
DX 40168

PH 61 7 3247 4279
FX 61 7 3247 4206

www.courts.qld.gov.au

