QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

2019-20
ANNUAL
REPORT

To the families and friends grieving the death of a loved one,
we are ever mindful of your loss.

17 November 2020

The Honourable Shannon Fentiman MP
Attorney-General and Minister for Justice
Minister for Women
and Minister for the Prevention of Domestic and Family Violence
GPO Box 149
BRISBANE QLD 4000

Dear Attorney-General

In accordance with section 77 of the *Coroners Act 2003*, I am pleased to present the Coroners Court of Queensland Annual Report for the year ended 30 June 2020.

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

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

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

Yours sincerely

Terry Ryan
State Coroner

Acknowledgement of Country

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

Purpose

The Coroners Court of Queensland Annual Report provides information about the Court's structure and operations as well as financial and non-financial performance measures for the period 1 July 2019 to 30 June 2020. The report has been prepared in accordance with the requirements of the *Coroners Act 2003*. This report is accessible online at: https://www.courts.qld.gov.au/about/publications

Please note: content presented in this report was correct at the time of publication. Data provided is obtained from the Coroners Case Management System (CCMS).

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

Enquiries or further information

If you have any questions about this report, please contact:
Coroners Court of Queensland
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Telephone: (07) 3738 7050
Email: state.coroner@justice.qld.gov.au

If you would like any further information about the Coroners Court of Queensland, please visit our website:
https://www.courts.qld.gov.au/courts/coroners-court

Feedback

The Coroners Court of Queensland values your feedback on this report. Any comments can be provided to the through the *Get Involved* website: www.qld.gov.au/annualreportfeedback

WARNING

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

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

A list of support organisations is available on the Coroners Court of Queensland website: https://www.courts.qld.gov.au/courts/coroners-court.

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2019–20: IN REVIEW

Performance measures - cases

5,631
cases lodged

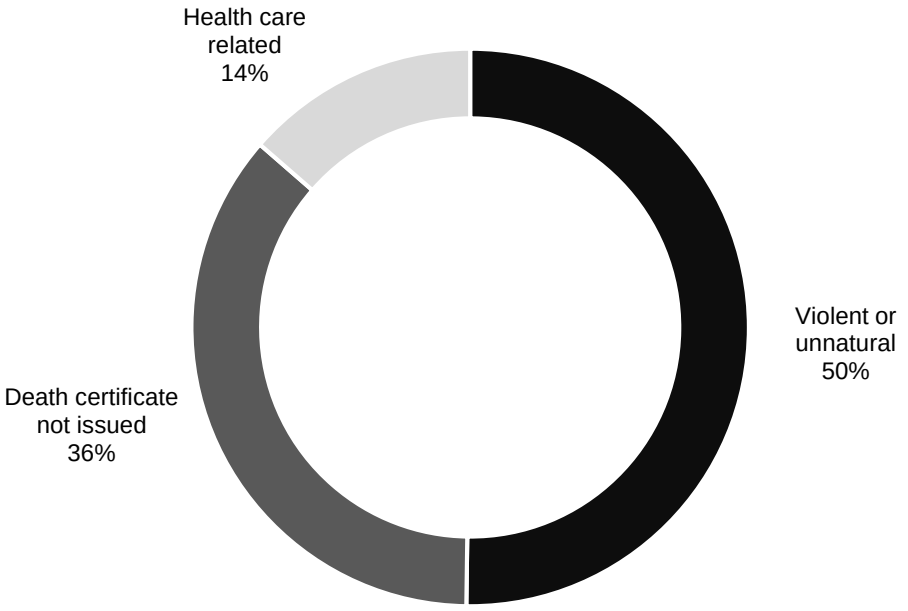
5,744
cases finalised

102.02%
clearance rate

14.81%
backlog indicator

Reportable types*

*refers to the primary three death types reported to the Court.



Timeframes

193
average days to finalise a case

80.43%
cases finalised in less than 12 months

Inquests and recommendations

28
inquests finalised

48
deaths investigated at inquest

68
recommendations made

State Coroner's Report

I am pleased to present the Annual Report of the Coroners Court of Queensland for 2019-20.

The past year gave rise to unprecedented challenges for the community with persistent threats to health and wellbeing posed by the coronavirus pandemic. The Coroners Court participated in early discussions with public health officials and the Chief Forensic Pathologist to plan for the possible impact of widespread community transmission of coronavirus on the coronial system.

While the anticipated number of coronavirus related deaths did not eventuate in Queensland, court operations were significantly affected with many staff embracing remote work arrangements during shutdown periods. Several inquest sittings were adjourned during the first six months of 2020, consistent with Public Health Directions on movement and gathering. The court also embraced the use of technology to conduct some inquests electronically.

I acknowledge the significant efforts of Coroners Court staff under the leadership of the Director, Ms Raelene Speers, in supporting coroners to maintain continuity of service to the community during this period. Their commitment to grieving families whose loved ones have entered the coronial system is unwavering. I also thank our partnership agencies, Queensland Health Forensic and Scientific Services and the Queensland Police Service, for their support during the year.

The work of the Coroners Court is specialised, challenging and unrelenting. The dedication of my colleagues and court staff contributed to improved clearance rates in 2019-20. Although there was a small reduction in the number of deaths reported to coroners during the reporting period, the court continued to achieve a clearance rate in excess of 100%. Significantly, the backlog of cases aged over 24 months was reduced from 17% to 14%.

These achievements were supported by the provision of an extra $3.9M across the whole coronial system over four years in the 2019-20 State budget, in response to the Queensland Audit Office's 2018 *Delivering Coronial Services* Report and to increasing demand. The Coronial Services Governance Board has overseen the implementation of the QAO's recommendations. During 2020-21, a focus for the Board will be a plan for the delivery of regional forensic pathology services across the State and ongoing system governance.

Temporary funding has enabled the establishment of a second coronial registrar within the Coroners Court to respond quickly to apparent natural causes deaths and, where appropriate, divert them from the system. Additional temporary resourcing also strengthened case management support provided to coroners and improved responsiveness to families.

In order to embed the improvements in timeliness and responsiveness that have been achieved with the additional funding provided to the coronial system it is imperative that this funding be made recurrent in the next budget cycle. A significant number of staff within the court continue to be engaged on a temporary basis, making it difficult to retain those staff and implement longer term strategies to improve service delivery and support staff wellbeing.

I acknowledge the support provided to me and to the Coroners Court by the Chief Magistrate, Judge Gardiner. Judge Gardiner allocated acting Magistrate Carmody and Magistrate Roney to the court during 2019-20 to assist with workload demands.

March 2020 saw the retirement of Deputy State Coroner John Lock after over seven years in the role. I acknowledge the invaluable contribution he made to the Queensland justice system over 18 years as a magistrate, including 12 years as coroner and Deputy State Coroner. I thank Mr Lock for his leadership and support over the years, particularly in mentoring coroners new to the jurisdiction. I welcomed the appointment of Deputy State Coroner Jane Bentley in March 2020.

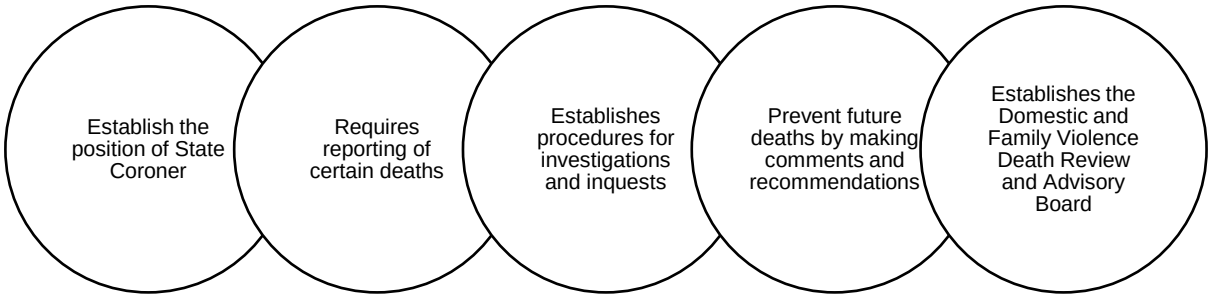
Queensland's Coronial System

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

Our purpose and functions

Not all deaths that occur in Queensland are reportable; only those considered to warrant scrutiny by virtue of the nature of the incident that triggered the death or due to the deceased person's particular vulnerability are reportable and investigated[1]. Coroners are responsible for determining whether a death referred is reportable or not.

Queensland's coronial jurisdiction operates in accordance with the functions outlined the *Coroners Act 2003* (Coroners Act). Broadly, the Coroners Act provides for a coronial system and other purposes as represented below:



Once a death is reported the process of investigating the circumstances of the death commences. Coroners are required to establish (if possible) who the deceased person was, when, where and how they died, and the medical cause of the death. A coronial investigation is an independent, impartial, open and transparent inquisitorial process.

Where an inquest is held coroners consider whether the death may have been preventable. Coroners can make comments and recommendations about systemic or policy or procedural changes that could contribute to improvements in public health and safety, or the administration of justice, or prevent or reduce similar deaths in future. Coroners are prohibited from making a finding that someone be held criminally or civilly liable for a death.

Our partner agencies

The coronial jurisdiction is multidisciplinary supported by our two key coronial partner agencies:

Queensland Police Service (QPS)

QPS officers attend the scene of the death and obtain information from family, friends and witnesses and assist during a coronial investigation. Management of coronial processes on a state-wide basis within the QPS is coordinated by the Coronial Support Unit (CSU). CSU officers are co-located within most CCQ offices and at the Coopers Plains mortuary, where they attend autopsies and liaise with forensic pathologists and mortuary staff. The Disaster Victim Identification Squad is also part of the CSU and are responsible for the removal and identification of deceased persons from mass fatalities, air and natural disasters

[1] Refer to Appendix 1 for further information about the types of reportable deaths.

Queensland Health (QH)

QH Forensic and Scientific Services (QHFSS) provides coronial mortuary, forensic pathology and toxicology and coronial nursing services for cases delivered out of the QHFSS complex in Brisbane. Coronial autopsies are performed in QHFSS mortuaries which are located in Brisbane (Coopers Plains), Gold Coast University Hospital, Toowoomba Hospital, Rockhampton Hospital, Townsville Hospital and Cairns Hospital.

Coronial Family Services, also based at the QHFSS, complex provide information and counselling support to relatives of deceased, work through objections to autopsies, organ and tissue retention and inform families of postmortem examination findings.

Forensic Medicine Officers (FMO) within the Clinical Forensic Medicine Unit (CFMU) provide independent clinical advisory services, including toxicology interpretation, expert opinions and advice about issues requiring further investigation. FMOs are based in Brisbane, Southport and Cairns.

Our Coroners

Queensland has seven specialist coroners located across the State in Southport, Brisbane, Mackay and Cairns. During 2019-20, the Chief Magistrate allocated a part-time magistrate, Ms Christine Roney and an acting magistrate, Ms Robyn Carmody to work in the coronial jurisdiction.

During the reporting period the CCQ farewelled Magistrate John Lock who resigned from the role of Deputy State Coroner in March 2020 and retired from the general magistracy in August 2020.

State Coroner – Terry Ryan

State Coroner Terry Ryan was appointed as a magistrate and to the position of State Coroner in July 2013. After being admitted as a solicitor in 1991, he worked in private practice before returning to the Queensland Government where he had initially commenced his career as a social worker in the fields of child protection and youth justice. Magistrate Ryan holds a Bachelor of Social Work, Bachelor of Laws, Master of Laws and a Graduate Diploma in Legal Practice.

In the period 2001 to 2010 Magistrate Ryan served as the Director of the Strategic Policy Unit and as the Assistant Director-General, Strategic Policy, Legal and Executive Services. From 2010 up until his commencement with the Coroners Court, Magistrate Ryan was the Deputy Director-General of the Department of Justice and Attorney-General (DJAG).

Magistrate Ryan is the Chair of the Domestic and Family Violence Death Review and Advisory Board. He is also the current President of the Asia-Pacific Coroners Society.

Deputy State Coroner and South Eastern Coroner – Jane Bentley

Magistrate Bentley commenced her legal career at Legal Aid Queensland (formerly known as the Public Defenders Office. She holds a Bachelor of Laws (Honours). In 1994 she was admitted as a barrister of the Supreme Court. From 1996 to 1999 Magistrate Bentley worked within the QPS as a legal officer before commencing with the National Crime Authority up until 2001.

In April 2010 Magistrate Bentley was appointed to the Magistrates Court of Queensland and held the position of Northern Coroner within the Coroners Court in the period 2013 to 2014. On 20 March 2020 she was appointed as the Deputy State Coroner for five years and is based in Southport.

Brisbane Coroner – Christine Clements

Prior to commencing in the Magistrates Court of Queensland, Magistrate Clements was responsible for the Bundaberg Legal Aid Office and worked as a barrister and solicitor in private practice in South Australia. Magistrate Clements was appointed as magistrate in 2000 and has worked exclusively in the coronial jurisdiction since 2002 when she was appointed as a coroner. Magistrate Clements was the inaugural Deputy State Coroner, holding the position from 2003 for 10 years. In December 2013 Magistrate Clements was appointed as a Brisbane Coroner.

Brisbane Coroner - Don MacKenzie

Magistrate MacKenzie joined the Coroners Court as Brisbane Coroner in July 2019 and was appointed for two years. Prior to being appointed as a magistrate in 2017, Magistrate MacKenzie practiced at the private bar in Brisbane and had twenty-five years as a trial advocate prosecuting and defending many hundreds of jury trials and appeals. Magistrate MacKenzie studied law at the University of Queensland, earned a Master of Laws from Griffith University, and was admitted as a barrister in the Queensland Supreme Court in 1993. Magistrate MacKenzie worked for the Public Defender's Office/Legal Aid Office from 1990 for five years before rising to

the position of Consultant Crown Prosecutor with the Director of Public Prosecutions over 15 years. He is also a Legal Officer in the Royal Australian Navy with many years' advocacy in Courts Martial and Defence Force Appeal Tribunals.

Brisbane Coroner - James McDougall

Magistrate McDougall holds a Master of Laws and was admitted to the Bar in 1986, and as a solicitor of the Supreme Court of Queensland and of the High Court of Australia in 1975. He was appointed to the Magistrates Court of Queensland in 2008 and served as the South Eastern Coroner from 2013. In April 2020 Magistrate McDougall moved to the position of Brisbane Coroner following Magistrate Lock's retirement.

Central Coroner – David O'Connell

In 1991 Magistrate O'Connell was admitted as a solicitor of the Supreme Court of Queensland and in 1994 to the High Court of Australia. He holds a Bachelor of Laws, Graduate Diploma in Taxation and Master of Business Administration. Magistrate O'Connell was appointed to the Magistrates Court of Queensland and to the position of Central Coroner in August 2012. Magistrate O'Connell is based in Mackay.

Northern Coroner – Nerida Wilson

Magistrate Wilson was appointed as a Magistrate in 2015, and Northern Coroner for Queensland in 2017. Magistrate Wilson is based in Cairns.

Magistrate Wilson served as an Australian Federal Police Officer from 1987 until 1995. She then practised as a solicitor and was called to the Bar in 2008 until her appointment as a Magistrate.

Magistrate Wilson was conferred the Queensland Regional Woman Lawyer of the Year award by the Women Lawyers Association of Queensland in 2013. Magistrate Wilson was one of 45 women lawyers selected from across Australia to participate in the "Trailblazing Women and the Law" oral history project now archived in the National Library of Australia.

Our Registrars

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

Coronial Registrar – Ainslie Kirkegaard

Ainslie Kirkegaard is the inaugural Coronial Registrar of the Coroners Court of Queensland. This is a unique judicial registrar role designed to triage deaths reported daily across Queensland.

Ainslie has held this role since early 2012 and previously held the positions of Counsel Assisting the Deputy State Coroner and Director, Office of the State Coroner. Ainslie became a part of the Queensland coronial system in 2008, bringing over 15 years' experience in policy and legislation development in the health, education and justice portfolios, with specialist expertise in coronial and health regulatory law and policy.

Having been appointed as an Acting Magistrate since April 2015, Ainslie now also relieves as coroner when required.

Deputy Registrar – Dr Don Buchanan

Dr Buchanan commenced with the CCQ in September 2019 as part of the Registrar Support Team as Deputy Registrar which is funded until June 2021. He has considerable experience with the coronial jurisdiction having provided clinical advice to the coronial system over many years in his role as a Forensic Medicine Officer with the Clinical Forensic Medicine Unit. Dr Buchanan holds dual qualifications in medicine and law and is an admitted legal practitioner.

Governance and Structure

The CCQ registry is part of DJAG and sits within the Magistrates Court Service. The CCQ provides registry, administrative, legal and research support to coroners and registrars across the State, is a central point of contact for bereaved families and friends and provides publicly accessible information to the community about coronial matters.

At 30 June 2020 under the leadership of Director, Ms Raelene Speers, the CCQ comprised of 51 staff members. The Court is comprised of positions ranging from the Administrative Officer (AO) level to the Senior Officer (SO) level, as well as staff in the Professional Officer (PO) stream.

Court staff are located within one of four regional offices, either in Brisbane, Southport, Mackay or Cairns and work in a team-based structure to support coronial investigations and/or the administrative functions of the Court.

Members of the CCQ are aligned to one of four streams which are each led by a senior manager (either AO8 or PO6).

Business Services:
Supports the corporate governance and operation of the Court through finance, information technology, data collation, communications, information release, human resource, burials assistance and contract management functions.

Legal Services:
Each coroner is assigned an in-house lawyer (known as counsel assisting) who assist their coroners in their investigations by reviewing case files, preparing findings and matters for inquest, as well as appearing as counsel assisting at inquests.

Operational Services:
Comprises of officers who work closely with coroners and liaise with families and other stakeholders to case manage coronial investigation. There are eight team-based coronial teams who support each of the coroners and registrars. There are three Coronial Support Coordinators who provide management support to Operational Services based on regional location and/or team.

Domestic and Family Violence Death Review Unit:
Provides specialist advice and assistance to coroners in their investigation of domestic and family violence related homicides and suicides as well as deaths of children who were known to child safety services prior to the death. The unit also provides secretariat support to the Domestic and Family Violence Death Review and Advisory Board.

The **Senior Leadership Team** consisting of a senior manager from each stream meet regularly to raise and examine any issues arising within the investigative and business functions of the Court, review court policies and procedures to ensure continued effectiveness, identify training and professional development needs of court staff, discuss workload issues and progress major projects. The Senior Leadership Team report regularly to the Director.

Delivering Coronial Services- Queensland Audit Office Report 6: 2018-19

During 2019–20 the Court continued to focus on the planning and implementation of recommendations made in the Queensland Audit Office (QAO) report[2]. The audit assessed the performance of the three key agencies involved in delivering coronial services; DJAG (through the CCQ), the QPS and QH, and the support provided by these agencies to coroners and families.

Performance Review

The audit report noted that the Queensland coronial system is complex with each agency playing a key role in the supporting coroners in investigating and helping to prevent future deaths. The coronial system was described as "under stress and is not effectively and efficiently supporting coroners or families". The report acknowledged the dedication and goodwill of its staff and partner agencies in supporting coroners and families. To improve the delivery of coronial services and the support provided to coroners and families, the QAO report made seven recommendations[3] which were accepted by all agencies.

Framework for action

Government has supported and invested in coronial services over the last few years with the allocation of six additional full-time equivalent (FTE's) for CCQ in 2017–18. In June 2019 as part of the 2019–20 budget the Palaszczuk Government provided additional funding for coronial services of $3.9 million over the next four years, including $474,000 per annum ongoing (permanent increase) as well as eleven temporary FTE positions (for DJAG, QPS and QH).

The Coronial Services Governance Board[4] (the Board) has been driving implementation of the recommendations, progressing long term solutions to current system pressures to deliver coronial services more effectively and efficiently into the future. The Board is supported by a Project Director who with members of the QPS and QH provides secretariat, policy and research assistance.

Four priority areas for action which align with the recommendations are being implemented over three financial years. This reporting period marked phase 2 or the half-way point of the reform process.

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

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

[3] Refer to Appendix 2 for the complete list of recommendations made in the QAO report.

[4] The Board consist of the State Coroner, the Deputy State Coroner, the Chief Forensic Pathologist, and other senior representatives from the QPS, Queensland Treasury and the Department of the Premier and Cabinet.

2019–20 Achievements

Enhanced triaging practices

Triaging trial

In September 2019 the CCQ commenced trialing the establishment of a temporary second coronial registrar (appointed as a deputy registrar) and support team with positions within CCQ, QH and QPS. This cross-agency team has been 'triaging' all apparent natural cause (ANC) deaths reported to police, which represent a significant percentage of deaths reported to the CCQ for investigation.

The 'triaging' approach is a multidisciplinary one that engages forensic pathologists, clinical nurses, forensic medical officers, coronial nurses and counsellors to divert non-reportable deaths from the unnecessary application of full coronial resources by reviewing medical records and liaising with families to determine if there are any concerns and authorise a cause of death certificate.

The primary objectives of the trial were designed to:

- reduce demand pressures on agencies (including reducing the number of ANC deaths reported to police, and reducing the need for deceased persons to undergo autopsy examinations unless required);
- better support families through, minimising unnecessary contact with the coronial system by ensuring these deaths do not enter the system unless they require review and investigation, use of less invasive autopsy procedures on loved ones and increase case finalisation timeframes; and
- ensure coroners have increased capacity to focus on more complex investigations.

Regular reporting to track performance measures and identify areas for future improvement has been provided to the Board by the Triage Working Group. Some of the key results from the trial following an interim review (1 September to 31 March 2020) are highlighted further in the report. A full review of the trial commences in September 2020.

Strengthen case management, legal and counselling support

Guidelines for case management – family communications – public website

To enhance internal case management processes and provide better support to families, a significant review of the internal Operational Guidelines for coronial services staff was completed. The guidelines provide consistent case management steps and highlight critical stages in an investigation when contact with families should be made. Inclusion of '*vigilance checks*' for staff was incorporated to support staff to recognise the signs and symptoms of vicarious trauma. The guidelines were supported by the roll-out of updated communications to families to make them more 'family-focused' and informative. Additional templates to complement various stages of an investigation were also drafted. A review of the public facing website to provide informative and helpful content was also completed with updates being progressed on an ongoing basis.

Aboriginal and Torres Strait Islander bereaved families – resource support

To support coroners and staff in their interactions with Aboriginal and Torres Strait Islander bereaved families and to ensure the Court engages in a culturally appropriate and respectful manner, the CCQ commissioned the development of a cultural competency resource and training package. The "*Sorry Business – A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islander people*", was specifically tailored to the coronial jurisdiction and includes content to increase CCQ members knowledge and awareness of the cultural and historical factors that impact on Aboriginal and Torres Strait Islander people and the types of concerns they may raise when a death falls within the jurisdiction of the Act.

Working with coroners resource – supplementary support guide

The Court finalised the '*Working with Coroners Resource Pack'*. The resource acknowledges the CCQ is a specialist court and is designed to orientate new coroners and staff about our jurisdiction, organisational environment, and the principles and behaviours that underpin positive and productive working relationships between coroners and staff. The resource is a supplementary guide to Resource Pack for Magistrates and Magistrates Court Service Staff Working Relationships.

Backlog project – cases greater than 24 months

Coroners are aware that delays in finalising coronial matters can cause distress for family members and strive to conclude matters expeditiously. During the reporting period the CCQ successfully reduced the backlog of cases from the previous year by undertaking a comprehensive audit of cases greater than 24 months to better understand their status and factors delaying case finalisation and by introducing timeliness indicators on matters ready for findings. Cases greater than 24 months will continue to be proactively monitored and case managed on a regular basis.

Feedback avenue for families and stakeholders

To drive continuous improvement in processes to better support families, the CCQ implemented an avenue for families and other stakeholders to provide feedback (whether it be compliments, complaints or suggestions) about the services provided by the Court. In December 2019 the CCQFeedback@justice.qld.gov.au mailbox was created. Data on feedback received is collated and measured against four key themes. Where relevant, feedback is incorporated into business practices on an ongoing basis. The CCQ Feedback facility also feeds into the Court's wider complaints management process, including any complaints made under the *Human Rights Act 2019* which commenced from 1 January 2020. The Court did not receive any Human Rights related complaints.

Legal Services Team – enhanced operating structure

An independent review of the Legal Services Team was undertaken to consider the optimal resourcing model to deliver clear and consistent services to coroners. Following the reporting period, the CCQ commenced a trial to implement the recommendations made in the report. Key recommendations in the report included establishing a Practice Manager position and the team moving towards operating as a collective unit, rather than working with dedicated coroners.

State Coroner's Guidelines – s14 of the Coroners Act

One of the State Coroner's functions is to issue guidelines[5] about the investigation of deaths and other matters under the Coroners Act. These guidelines are issued with the objective of ensuring best practice in the coronial system and the State Coroner must consult with the Chief Magistrate before issuing any guidelines or amendments to guidelines.

During the reporting period guidelines were reviewed and updated in relation to Chapter 10.2 access to coronial information, specifically in relation to documents that contain words of testamentary intention. The guidelines emphasise that coroners consider the effect of section 18 of the *Succession Act 1981* under which a broad range of communications by a deceased person such as a suicide note could be given effect as a valid will and assist in the administration of a deceased person's estate. Chapter 4.8 was updated to reflect that it is no longer necessary to approach the Supreme Court to remove gametes or reproductive tissue from a deceased person. It is still necessary however to obtain coronial consent where the death is a reportable death.

Chapter 5.2 Preliminary examinations was revised to reflect changes as a result of amendments to the Coroners Act that commenced in May 2020 (further below). Chapter 3 – in relation to the concept of "death in care" was revised to reflect amendments to the definition under the Coroners Act with the rollout of the National Disability Insurance Scheme (NDIS) on 1 July 2019. The section provides guidance on how to identify when the death of a person with a disability who is a NDIS participant triggers a mandatory report as a death in care (disability).

Enhanced structural supports

Funeral Assistance Scheme

An extensive project to review the Funeral Assistance Scheme (formerly known as the Burial Assistance Scheme) was completed in response to the QAO recommendation to *"tighten the approval process for funeral assistance applications"*. The enhancements to the Scheme were informed by an in-house project which involved consultation with Magistrates Court Service registry staff across the State as well as an independent cost-benefit analysis commissioned by the Court.

Changes to the Scheme have been designed to streamline application timeframes for applicants, reduce processing time/workloads for registrars (use of less forms that capture more relevant information), target cost-recovery actions and enhance internal reporting. The review resulted in a revised policy and operational procedures. Enhancements include centralised decision-making processes, redesigned application forms, searchable electronic policy and procedural documents and a new outgoing mailbox to communicate outcomes to applicants.

The first release of the revised Scheme was scheduled to be rolled out just following the reporting period and is expected to reduce processing times from upwards of 15 working days to 2-10 working days.

Government-contracted undertakers (GCUs)

The CCQ delivered a contract management plan for government undertakers in response to the QAO recommendation to improve the performance monitoring and management of GCUs. Some of the key works included:

- engaging an independent analyst to develop a business case to identify more efficient ways to manage transactions with GCUs and enhance internal monitoring processes;
- completing an internal review of contract management processes;

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

- developing a new contract management framework, inclusive of a trial assurance program co-designed with industry, and proactive monitoring and reporting on existing performance measures under standing offer arrangements;
- commencing site visits with GCUs; and
- delivering the first stage of a new eInvoicing portal in partnership with the Registry of Births, Deaths and Marriages and the Digital Transformation Unit to create a single login for GCUs to submit and track online invoices/claims.

In the next reporting period, the CCQ will continue to review and improve the trial assurance program, with an interim review to be conducted in March 2021.

Coronial system innovation into the future

In the final phase of the reforms the Board will work towards "sustainability for the future" by solidifying changes and recommendations implemented over the last three years. One of the key pieces of work to be undertaken will be the development of a *cross-agency service delivery framework* which will formalise service agreements amongst the partner agencies to outline how each agency with support and deliver coronial services to coroners and families into the future.

Coroners Act amendments

On 20 May 2020 the Queensland Parliament passed the *Justice and Other Legislation Amendment Bill 2019* (JOLAB) which resulted in several key changes to the Act.

Applies the Act to 'pre-commencement' deaths

For the past 16 years coroners were required to subject matters reported prior to 30 November 2003 (*"pre-commencement deaths"*) and matters reported after this date (*"post-commencement deaths"*) to different investigative regimes. Queensland was the only Australian coronial jurisdiction to make this distinction. The amendments remove application of the *Coroners Act 1958* to all future inquests despite whether a death or disappearance was reported to a coroner before this date.

Under the 1958 Act, witnesses were able to claim privilege which protected them from answering questions that would tend to incriminate them[6]. Under the current Act a coroner has powers which can be used to compel any witness to give evidence at an inquest if they are satisfied that it is in the public interest, even if that evidence may be self-incriminating[7]. The 1958 Act will continue to apply to any unfinished repealed Act inquest, unless that inquest is stopped and reopened under the current Act.

Preliminary examinations and discretion to order an autopsy

A new section, 11AA *preliminary examinations* now authorises without a coroner's formal order, a range of non-invasive procedures to be undertaken after police have reported a death. These include visual examination, CT scans, taking and testing of blood (and other samples) and reviewing a person's medical history. Coroners are no longer required to order an autopsy in every case, if they consider a death requires further coronial investigation. There is also the discretion to cease a 'natural causes' death investigation without preparing written findings once the cause of death has been determined.

The amendments allow for certain suitably qualified persons to conduct preliminary examinations, including either a doctor approved by the State Coroner, or a person qualified acting under the supervision of an approved doctor such as a coronial nurse. A range of new processes and procedures to operationalise these amendments were undertaken including updates to the State Coroners Guidelines 2013, in particular Chapter 5, the introduction of a Form 2A (preliminary investigation request) and Form 30A and Form 30B (coronial certificates) as well as the removal of the Form 20C (non-narrative findings).

Coronial Registrar

The Act now provides that more than one registrar may be appointed and that the State Coroner can delegate additional powers to the registrars. They include the power to require a person to give information, documents or any other material relevant to an investigation under section 16 of the Act and the power to consent to organ and tissue retrieval for donation.

[6] Under the 1958 Act witnesses involved in 'missing person' cases could be compelled to give evidence.

[7] Protections in section 39 of the Coroners Act provide that compelled evidence (or evidence obtained as a result) is not admissible against that witness in a criminal proceeding, other than for a perjury proceeding. It can however be used against any co-accused or others in a criminal proceeding.

COVID-19 and the CCQ

The past year has been one of significant change and development for the CCQ, not only in continuing to respond and adapt to changes as a result of QAO reforms but with the unprecedent challenges COVID-19 presented to the Court.

Pandemic planning

In early March 2020 the response to COVID-19 escalated and the Court began planning to ensure it was sufficiently resourced to continue to deliver coronial services. The Court undertook a significant review of its resources, including its *Business Continuity Plan* which considers several remote working options based on various potential scenarios.

Reportability of COVID-19 deaths

The reportability of COVID-19 related deaths was addressed with an information sheet "*When does a COVID-19 death need to be reported to the* coroner?[8]" published on the Court's website and distributed to hospitals, aged care regulators, police, funeral directors and other relevant agencies such as the NDIS Quality and Safeguard Commission and the Office of the Public Guardian.

Doctors were encouraged to issue a cause of death certificate if a person who had tested positive or was suspected to have had COVID-19 as the death was from a natural cause and the probable cause of death known. A COVID-19 death is only reportable to the Court if the death is a death in custody or in care or the person died as a result of the care they received (or did not receive), for example a missed diagnosis of failure to treat the virus.

Remote Working Arrangements

During the height of the pandemic response, the CCQ supported staff working remotely wherever possible. From the end of March to mid-June the majority of Brisbane based court staff were working remotely. A small number of staff remained in the office to ensure the main phone line for contact by families and health professionals was monitored. Plans were in place to continue this service remotely, if required. In regional CCQ offices (Southport, Mackay and Cairns), most employees continued work in the office rather than remotely. Work environments in the regional offices were considered safe with messaging around physical distancing and hygienic practices communicated.

In May 2020 with the lifting of certain restrictions in Queensland, the CCQ began to prepare Brisbane staff for a graduated 'return to office'. The CCQ Leadership Team developed a return to office plan and the Building Manager facilitated an assessment on the number of staff that could safely occupy the office and courtrooms. Staff were consulted and commenced returning to the office on a rostered basis from mid-June. Consistent with other DJAG units and departments, staff working remotely commenced splitting 50/50 of their time in the office and working remotely. These arrangements commenced on mid-July 2020 and continued as the Court ended the reporting period.

Inquests

Toward the end of March 2020, the Queensland Premier gave a clear message that social distancing was crucial, and everyone must keep 1.5 metres from each other and only go out for essential reasons.

Accordingly, in response to the tightening of restrictions across the State and as part of measures implemented by Queensland Courts to limit the transmission of COVID-19, the State Coroner published a notice advising all inquest hearings that were scheduled to commence in Brisbane before 30 June 2020 would be adjourned. Scheduled inquests in other locations across the State were also adjourned to a date to be fixed after July 2020 unless the coroner was satisfied that social physical distancing practices could be achieved within a courtroom.

Apart from inquests all other coronial investigations and administrative functions of the Court continued to proceed as per normal.

From June, in line with the Practice Direction issued by the Chief Magistrate, Judge Gardiner,

[8] Information Sheet – "When does a COVID-19 death need to be reported to the coroner?"

the State Coroner published an updated notice with arrangements for inquests. Coroners across the State commenced scheduling and hearing inquests matters and operated (and continue to operate) within the Chief Health Officer's guidelines regarding physical distancing.

The Court also noted it would enforce limits on the numbers of persons in attendance in a courtroom. Coroners would also consider on a case by case basis applications for parties granted leave to appear, for witnesses and for families to participate by telephone or video conferencing facilities. These arrangements remained in place at the end of the reporting period[9].

Second wave preparations

Shortly following the reporting period in response to the "second wave" of coronavirus experienced by Victoria and New South Wales, the CCQ commenced a review to reflect on its learnings about "what worked" across the State, in particular, what could have been done better, what efficiencies were created and what changes would need to be implemented should stricter physical distancing measures be introduced.

Acknowledgments and achievements

Despite these unique events the CCQ continued to finalise findings, focused on the backlog of cases and achieved clearances rates above 100 per cent from March to June. As a result, the Court reduced the backlog indicator and exceeded its performance target at the end of the reporting period for a second year in a row.

The Court acknowledges the engagement, professionalism and efforts displayed by staff in response to the COVID-19 pandemic and managing the transition while maintaining high-quality services and focusing on delivering outcomes for families and coronial stakeholders.

The Court also wishes to acknowledge the assistance of the Magistrate Court Services Directorate and our Information Technology Service in ensuring our coroners and staff were adequately supported to work remotely.

[9] Coroners Court of Queensland – COVID-19 arrangements – coronial inquests

Coronial Performance

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 and a backlog indicator.

Clearance rates
During 2019–20, a total of **5,631 deaths were reported to the CCQ** for investigation with **5,744 cases finalised**. The Court achieved a **clearance rate of 102.02%**. This is the second consecutive year the CCQ accomplished a clearance rate above 100% meaning more cases were finalised than were lodged.

Backlog indicator and pending cases
Coroners are aware that delays in finalising coronial matters can cause distress for families. However, the finalisation of a coronial investigation can be dependent on other agencies completing their investigative processes such as the completion of autopsy, toxicology and police reports or the Court may be required to await the outcome of criminal proceedings.

A number of strategies to reduce the backlog of matters (cases more than 24 months old) were carried out during the past year. As a result, during the reporting period the CCQ significantly reduced the **backlog indicator to 14.81% down from 17.58% in 2018–19**. This is the lowest backlog percentage achieved by the Court in the previous three years. The **overall number of pending cases (2,378 down from 2,548 in the previous reporting period) also declined**.

Not reportable matters
Following a review of medical records and circumstances of death, many matters reported to the Court are found to be not reportable within the terms of the Coroners Act or reportable but not requiring autopsy or further investigation. Of the deaths finalised during 2019–20, **2,142 were found to be not reportable** within the meaning of section 8(3) of the Coroners Act. These matters are included in the Court's lodgement figures as significant work is involved in determining whether these matters are reportable or whether a death certificate can be authorised. This work can involve reviewing medical records, discussing the death with treating clinicians and family members and obtaining advice from the CFMU.

How deaths are reported
The Court receives reports of death by police (Form 1) or by medical practitioners (Form 1A). The Court also receives 'Other' reports of deaths for review and investigation, which can include phone calls from medical practitioners, funeral directors or aged care facilities, directly from family who may have concerns, missing person reports/advice, child death advice/notifications and since 1 July 2019 directly from the NDIS.

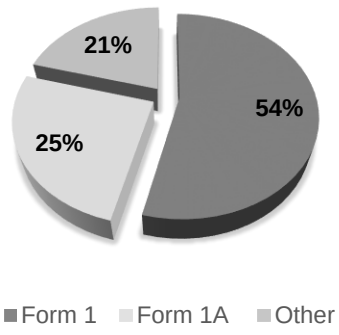


Table 1 - Performance figures from 2015–16 to 2019–20

Year	Cases reported	Percent change	Cases finalised	Clearance rate	Backlog	Inquests held
2019–20	**5,631**	**-2.86%**	**5,744**	**102.02%**	**14.81%**	**28**
2018–19	5,797	-0.26%	5,860	101.09%	17.58%	29
2017–18[10]	5,812	4.02%	5,618	96.66%	18.43%	52
2016–17	5,587	5.67%	5,014	89.7%	16.6%	30
2015–16	5,287	6.54%	5,313	100.5%	13.6%	49

Table 2: Statewide performance figures for 2019–20 [11]

Deaths reported by coronial region	Brisbane	Northern	Central	South Eastern
Number of deaths reported for investigation	3,313	792	713	813
Number of coronial cases finalised	3,289	812	721	932
Number of coronial cases pending	1,063	582	176	270
Coronial cases pending - *Less than or equal to 12 months old*	724	329	134	146
Coronial cases pending - *Greater than 12 and less than or equal to 24 months old*	192	169	22	47
Coronial cases pending - *Greater than 24 months old*	147	84	20	77

Table 3: Deaths reported statewide by type for 2019–20[12]

Category of death	TOTAL
Suspected death (missing person)	**20**
Death in custody	**19**
Death as a result of police operation	**13**
Death in care	**99**
Health care related death	**742**
Suspicious circumstances	**23**
Violent or unnatural	**2,736**
Death certificate not issued and not likely to issue	**1,973**
Unknown persons	**4**

[10] The performance data for the Coroners Court of Queensland was revised in October 2018. Any variation of figures published in previous reports is a result of the data revision.
[11] These figures represent the numbers recorded within the particular region the death was reported i.e. the State Coroner, Coronial and Deputy Registrar receive reports of deaths state-wide.
[12] The total *Reportable Type* may be different from *the total number of cases lodged*, as multiple *Reportable Types* may be selected on a case in the CCMS.

Coronial Registrar and the Registrar Support Trial

The scope and reporting catchment of the Coronial Registrar position has changed over the years due to unsustainable workloads[13]. Broadly the position uses a multidisciplinary approach to:

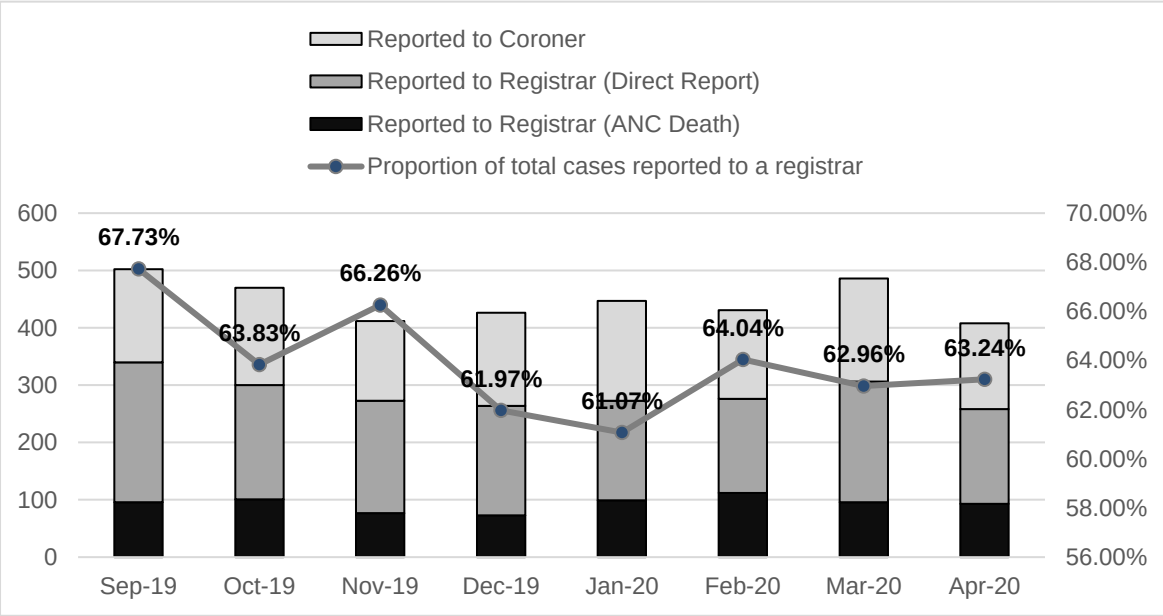
- **investigate apparent natural causes deaths reported by police** (via Form 1) because a death certificate has not been issued and is unlikely to be issued;
- **review deaths reported directly by medical practitioners** via Form 1A who seek advice about whether a death is reportable or seeking authority to issue a cause of death certificate; and
- **provide telephone advice to clinicians** who seek advice about the reportability of the death before they issue a cause of death certificate. This provides an opportunity to filter out not-reportable deaths and to triage reportable deaths where a cause of death certificate may be authorised under section 12(2)(b) of the Coroners Act

These tasks delegated by the State Coroner represent the high volume of cases referred to the Court for investigation. Since being established in 2012, the Registrar has also continued to work proactively with Queensland Health and aged care sectors in a variety of clinical forums including hospital grand rounds to help educate clinicians about their death certification and coronial reporting obligations[14].

From September 2019 with funding provided in the 2019–20 State Budget, the cross-agency Registrar Support Trial commenced. Within the CCQ this involved the establishment of a second coronial registrar and Coronial Service Officer administrative support staff. From this period all Form 1's for ANC deaths (excluding ANC child deaths) and ANC deaths in care were reported to the Registrar Support Team for management.

An interim review of the trial **from 1 September 2019 to 30 April 2020** was completed by the Triage Working Group[15]. Results from the interim review are provided below:

Figure 1 – Deaths reported to CCQ by coronial registrar/coroner and death type from 1 September to 30 April 2020

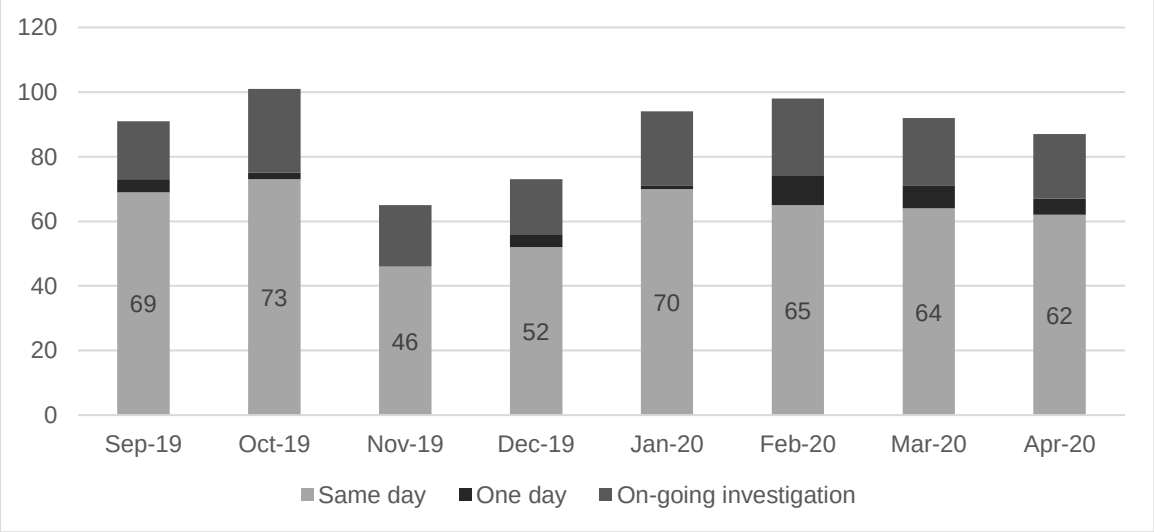


[13] The history of the establishment of the coronial registrar position is detailed in previous annual reports.
[14] Refer to Appendix 3 – Presentations by Coronial Registrar
[15] Figures provided by the Triage Working Group – Establishment of a second coronial registrar – interim review and the Coronial Services Governance Board Communique August 2020.

Table 4 – Deaths reported to CCQ by coronial registrar/coroner and death type from 1 September to 30 April 2020

Region	Reported to coronial registrar (Form 1 ANC Death)	Reported to coronial registrar (Direct Report-Form 1A/doctor calls)	Reported to coroner - statewide	TOTAL
Greater Brisbane	18.26% (383)	49.33% (1,035)	32.41% (680)	58.59% (2,098)
Southern	23.80% (129)	32.84% (178)	43.36% (235)	15.14% (542)
Central	21.64% (95)	36.90% (162)	41.46% (182)	12.26% (439)
Northern	25.10% (126)	32.27% (162)	42.36% (214)	14.02% (502)
TOTAL	**20.47% (733)**	**42.92% (1,537)**	**36.61% (1,311)**	**3,582**

Figure 2 – Timeframes for finalisation of ANC deaths reported to a coronial registrar from 1 September to 30 April 2020



The trial is producing demonstratable outcomes with some of the key highlights from the 1 September 2019 to 31 March 2020 period showing:

- **91.32% (or 652 ANC deaths) reported by the police to the CCQ were reported directly to a coronial registrar.** Without the deputy registrar these deaths would have been reported to and managed by a coroner. In the 2018–19 reporting period, 1,550 ANC deaths were reported to the CCQ for investigation.
- **33.87% (or 148 fewer ANC deaths) proceeded to autopsy, compared to the same time period in the previous year.** The cross-agency team has been working to strengthen actions to obtain a cause of death certificate, where possible, to reduce the number of ANC deaths requiring an autopsy.
- **86.61% (or 533 ANC deaths) managed by the registrars were finalised within one day of the death being reported to the CCQ[16].** This is an increase from the 2018–19 period where only 60.08% of ANC deaths were finalised within one day.

[16] These figures refer to dates between 1 September 2019 and 30 April 2020, not 30 March 2020.

Deaths in care of people with a disability

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

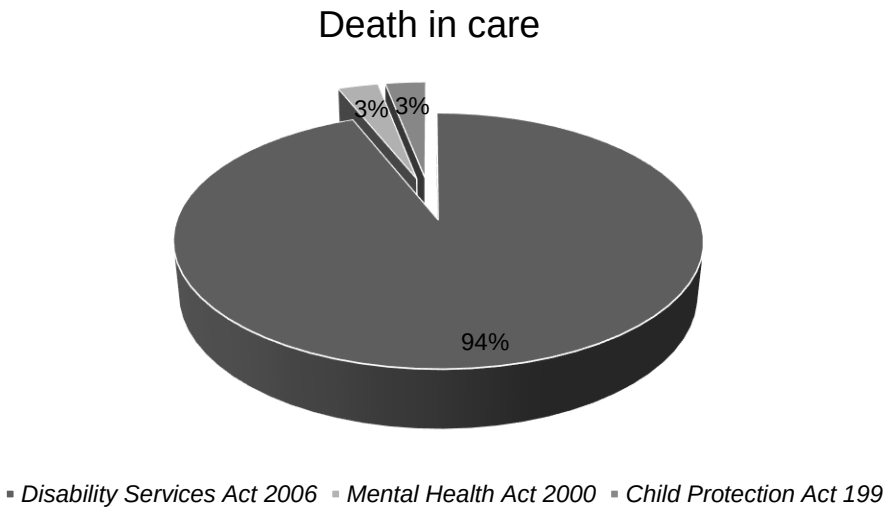
A 'death in care' is defined in section 9[17] of the Coroners Act and makes reportable the death of certain vulnerable people in the community, that is those with a disability or mental illness and children who are in certain types of care facilities or under certain types of care arrangements. These deaths are reportable irrespective of the cause of death or where the death occurred to reflect the underlying policy objective of ensuring there is scrutiny of the care provided to these people given their particular vulnerabilities.

On 17 June 2019 the *Disability Services and Other Legislation (NDIS) Amendment Act 2019* was assented to after passage by the Queensland Parliament. Sections 50 and 51 of that Act amended the Coroners Act to ensure a relevant service provider has a 'duty to report' a death in care and revised the definition of a 'death in care. In addition, on 1 July 2020 the National Disability Insurance Disability Scheme commenced in Queensland.

Since the 2016–17 Coroners Court of Queensland Annual Report, the State Coroner has reported on data in relation to deaths in care. This was done in response to the Office of the Public Advocate (QLD) report *Upholding the right to life and health: a review of the deaths in care of people with a disability in Queensland*, which made a recommendation in this regard.

During 2019–20, 99 'death in care' matters were reported to the Court for investigation. Of these**, the majority related to deaths in care of people with a disability.** Further details on the categories of death in care that were reported to the Court for investigation are depicted below.

Figure 3 – Death in care matters reported during 2019–20



[17] Refer to the *Coroners Act 2003* s9 for the full definition and categories a death in care.

Forensic pathology services

Autopsies can be an important aspect of coronial investigations. However, they are invasive, can be distressing to bereaved families and costly. In line with the State Coroner's Guidelines, coroners are encouraged to order the least invasive autopsy examination necessary to inform their investigation[18].

Coronial autopsies are performed by QHFSS-employed forensic pathologists in Brisbane, Gold Coast, and Cairns only. Some coronial autopsies are undertaken in Toowoomba and Townsville (and some at the Gold Coast and occasionally Cairns) by fee-for-service forensic pathologists approved under the Coroners Act. The CCQ manages the expenditure of fee-for-service autopsy examinations[19].

The sustainability of forensic pathology services continues to be a focus of the Court in conjunction with QHFSS to ensure Queensland has access to timely and quality forensic pathology services. The 'triaging' process and the introduction of the preliminary examination procedures are intended to divert cases from unnecessary autopsy. Accordingly, during 2019–20, there continued to be a further reduction in the percentage of autopsies ordered (2,353)[20] relative to the number of reported deaths overall. Towards the end of the reporting period, the CCQ also implemented a new facility within the Coroners Case Management System to easily capture preliminary investigation and examinations ordered as a result of the JOLAB amendments.

2,353
Autopsy examinations ordered

$286,385
Autopsy expenditure (includes related travel and mortuary costs)

Table 5 – Percentage of orders for examination issued in relation to reportable deaths

	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20
Deaths reported	4,962	5,287	5,587	5,812	5,797	**5,631**
Examinations ordered	2,542	2,550	2,730	2,629	2,476	**2,353**
Percentage	51.2%	48.2%	48.9%	45.23%	42.71%	**41.78%**

Table 6 – Number and type of examination ordered 2014-15 to 2019-20

	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20
External	679	769	856	967	1,049	**1,008**
Partial internal	597	533	583	630	614	**498**
Full internal	1,266	1,248	1,291	1,032	765	**800**

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

[19] A fee structure for the performance of fee-for-service autopsies is prescribed by regulation under the Coroners Act - Coroners Regulation 2015 - https://www.legislation.qld.gov.au/

[20] This figure includes total ordered, including cases where multiple orders were made.

Funeral Assistance

DJAG can arrange for a simple funeral where someone has died in Queensland and have no known relatives or friends who able to pay for a funeral or where the deceased's person assets cannot cover the costs. This is called 'Funeral Assistance'.

As noted earlier in this Report during 2019–20 the CCQ delivered an enhanced Funeral Assistance Scheme (the Scheme). The Scheme is governed by the *Burials Assistance Act 1965* and is intended to afford dignity to a deceased person, their family and friends and preserve public health in circumstances where families are unable or unwilling to meet the costs of a funeral. Funeral Assistance is not a monetary grant and eligibility is based on a set list of criteria which must be met by applicants.

Applications are made through Registrars across Queensland in the Magistrates Court Service or by staff in Regional Services Outlets[21]. Applications can be made by individuals or agencies like police where there are no known or willing next of kin.

For approved applications, the CCQ arrange for a simple funeral (burial or cremation) to be conducted by the applicable GCU in the boundary where the person died[22]. Under the Act the funeral director is not permitted to provide extra services for additional fees such as flowers, a church or religious service, viewings, or headstones or plaques.

For Aboriginal and Torres Strait Islander persons who have passed away, they may be returned to their traditional homelands or Country for burial, however this must be at the cost of the applicant, as this type of transfer is not covered or funded by the Scheme.

Funeral costs can be recovered subject to conditions of section 4A of the Act. This can include recovery of monies from bank accounts and superannuation funds from the estate of a deceased. The CCQ is responsible for the administration of the Scheme, the budget, cost recovery activities, policy, procedure, strategic oversight and management and reporting. Appeals on applications also sit with the CCQ and are reviewed by the Director of the CCQ.

During 2019–20, 382 applications were approved (in comparison to 317 in 2018-19) under the Scheme at a total state-wide cost of $566,663. This figure is based on the total expenditure minus the expenditure recovered. The Court continued to improve on its cost recovery functions with 37.17% recovered (in comparison to 36.37% in 2018–19)[23]. Revenue from recovery can include funds received from applications approved in previous financial years as applicants may discover funds at any time.

Funeral Assistance Scheme figures for 2019–20:

382	**$901,845**	**$335,182**	**37.17%**
applications approved	state-wide expenditure	expenditure recovered	of expenditure recovered

[21] Regional Service Outlet – court locations that transferred to the Department of Transport and Main Roads.

[22] Map of regional coronial boundaries - https://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/resources-and-legislation

[23] The cost recovery figures include outstanding costs for approved applications recovered in 2019-20 from previous financial years.

Government-contracted undertakers

Government-contracted undertakers (GCUs) are the funeral directors engaged when a deceased person is required to be transferred from the place of death to the place where the coronial autopsy will be conducted[24]. They are also appointed to perform funeral services approved under the Funeral Assistance Scheme. For this purpose, the State is divided into 77 local government area boundaries.

The contracts known as standing offer arrangements (SOA) have been in effect with 33 funeral directors across Queensland since February 2018. SOA are in relation to, Service A – the conveyance of human remains and Service B – the burial or cremation of deceased persons. In the lead up to the end of the 2019–20 reporting period the CCQ was engaging with each provider to gauge their interest in extending the contract for a two-year period from 1 February 2021.

The management of these contracts' rests with the CCQ and is overseen by a dedicated position within the Court, the Finance and Contracts Coordinator. This position was created with temporary funding from the 2019–20 Queensland Budget in response to the QAO recommendation to improve the performance monitoring and management of GCUs.

As noted earlier the CCQ delivered a contract management plan for GCUs which sets out their responsibilities in managing existing standing offer arrangements, including administering a voluntary trial quality assurance program, proactive monitoring and reporting on performance measures and more effective management of complaints about services delivered by GCUs.

GCU conveyancing figures for 2019–20:

4,509
conveyances by GCU

$2,513,548
state-wide expenditure of conveyances

[24] The government-contracted undertaker returns the body to the mortuary nearest to the place of death (unless specified) or to the government undertaker's premises.

Inquests

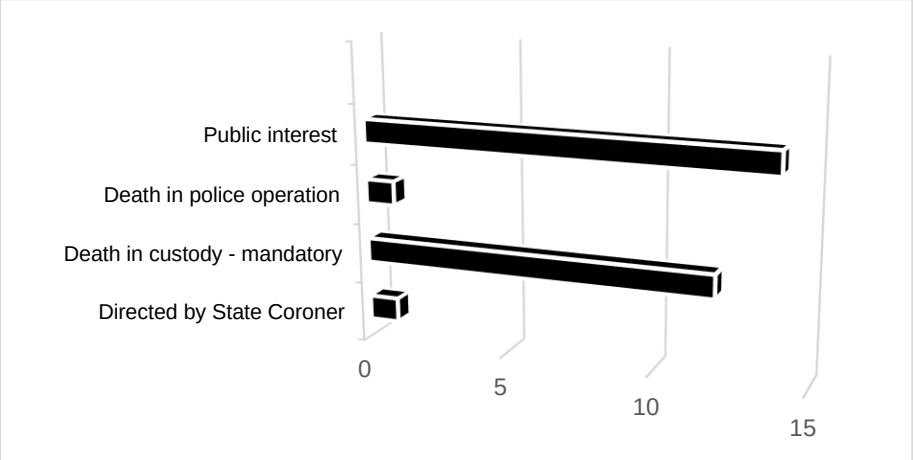
An inquest is the 'public face' of the coronial process; an open proceeding that scrutinises the events leading up to the death. While an inquest can help families understand the circumstances of their loved one's death, and provides the public with transparency about a death, it also provides the legislative authority for coroners to make comments and recommendations that aim to prevent or reduce deaths from similar circumstances in future.

Finalised inquests

Each year only a small percentage (< 1%) of matters proceed to inquest. Findings of inquest into the deaths of **48 persons were finalised** during the reporting period, **with 28 inquests completed** (several joint or clusters of similar deaths were finalised during the year). It is important to note that this figure does not account for the number of inquests that were opened by coroners during the reporting period.

Pursuant to the Coroners Act it is mandatory that certain deaths be investigated at inquest, including for example, those that are in custody, those in care, where there are issues about the care or those directed by the Attorney-General or District Court. The breakdown of the category of inquests finalised during the reporting period is depicted below.

Figure 4 – Inquests finalised by type during 2019–20



Responses to coronial recommendations

All responses to recommendations directed at the Queensland Government are published on the Queensland Courts website adjacent to the relevant inquest finding. The response indicates if a recommendation is under consideration, if and how it will be implemented or the reason a recommendation is not supported.

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

Of particular note during this reporting period was the Queensland Government's response to the recommendations made by Deputy State Coroner, Magistrate Jane Bentley regarding the child death of Mason Jett Lee. The response to Magistrate Bentley's recommendations were tabled in Parliament on 17 June 2020 and were noted as all being 'accepted'[25].

[25] Queensland Government response to Mason Jet Lee coronial inquiry recommendations - https://www.parliament.qld.gov.au/documents/tableOffice/TabledPapers/2020/5620T911.pdf

Table 7 – Finalised inquests during 2019–20

Name of inquest/deceased	Coroner	Key catchwords
Stephen VINER	Lock	Workplace death, undetermined cause of death, electrocution or natural causes
FV Cassandra and FV Dianne	O'Connell	Loss of life arising from capsize of two fishing vessels, cause of loss, recommendations as to safety improvements in fishing industry
Talieha NEBAUER, William FOWELL, Caitlin WHITICKER	Lock	Closure of Barrett Adolescent Centre, Commission of Inquiry, transition arrangements for adolescents to adult mental health services
Kerri PIKE, Peter DAWSON, Tobias TURNER	Wilson	Skydiving multiple fatality, Mission Beach, mid-air, back to earth solo sports jump under tandem
Colin BLAIR	Ryan	Death in custody, Indigenous prisoner, risk assessment, hanging
Neil BANJO	Ryan	Death in police operation, remote community, use of force
Thomas HUNT and Youngeun KIM	Wilson	Josephine Falls, Ngadjon-ji traditional owners, warning signs, rising water levels, drowning deaths
Ashley GAVENOR	Ryan	Death in custody, Indigenous prisoner, chronic disease, acute cardiac event following physical altercation
Robert SKILTON	Ryan	Death in custody, natural causes
Frank BURROWS	Ryan	Death in custody, natural causes
Steven HARRISON	Ryan	Death in custody, natural causes
Rodney PASCOE	Ryan	Death in custody, Indigenous prisoner, natural causes
Brendon LAHRS	Ryan	Death in custody, natural causes
Darren TAYLOR	Ryan	Death in custody, natural causes
Terence BURGESS	Ryan	Death in custody, natural causes
Maria WILLERSDORF	McDougall	Radiological procedure performed, location of injection(s), loss of consciousness, adequacy of response and care provided
Lee Edward PARKER	Lock	Fire, suspicious circumstances, Mobile Home Park, smoke alarms
Dreamworld Inquest	McDougall	Amusement device, Theme Park, safety management systems, ride maintenance, training, external safety audits, amusement device modification
Paige JONES	Lock	Motorcycle crash, identity of rider and passenger, recommendations, referrals
March 2014 plane crash Caboolture	Ryan	Aircraft accident, tandem parachuting, regulatory oversight of commercial parachuting operations
Matthew RUSSO	Wilson	Bilateral bronchopneumonia, lower lung crackles, community acquired pneumonia, general practitioner failure to record vital sign, misdiagnosis

Paul MCGUIRE	O'Connell	Fatality in underground mining, asphyxiation via exposure to depleted-oxygen atmosphere, misdirected to incorrect location
Mark NEWSTEAD	Ryan	Death in custody, natural causes
Lawrence SMITH	Ryan	Death in custody, natural causes
Mason LEE	Bentley	Child death, child protection, Department of Child Safety, Youth and Women, information sharing, adoption, permanency orders
Christopher BETTS	Ryan	Death in Iraq, Australian Embassy, close personal protection officer, security contract, alcohol and drug consumption, weapons handling and storage.
Ravenshoe café explosion	Wilson	Ravenshoe Café Explosion, obligations of Driver Licence holder to report relevant medical conditions to Department of Transport and Main Roads, medical fitness to drive, obligations of medical and general practitioners, recommendations to review fitness to drive protocols and education
Taare RANGI	Wilson	Hospital Health Service Officer vascular restraint, mental health unit involuntary patient, prone position, cardiac arrhythmia during a restraint

John Lock

During the reporting period, Magistrate John Lock announced his resignation from the position of Deputy State Coroner and retirement from the general magistracy.

After receiving a Bachelor of Arts and Bachler of Laws from the University of Queensland Mr Lock was admitted as a solicitor in 1976. He practiced as a private solicitor (firstly as an employee and later partner) doing a wide range of general legal work but specialising in Family Law. In 1998 he was appointed as the Senior Solicitor of Legal Aid Queensland, Ipswich and engaged in high court crime and as a Child Representative in Family Court.

Mr Lock was appointed as a magistrate in 2002 to work in Far North Queensland which included coronial work. In 2006 he was appointed to the Brisbane Court, including six months of full-time coronial work. On 1 January 2008, Mr Lock was appointed as a full-time Brisbane Coroner and to the position of Deputy State Coroner in December 2013 in which he remained until his resignation.

During his time with the Court, Mr Lock investigated over 6,000 deaths with over 100 inquest and non-inquest findings published, including over 140 recommendations being made to prevent future deaths in similar circumstances from occurring.

One of Mr Lock's first inquest findings handed down in the Mossman Magistrates Court was into the death of a young woman who took part in an underwater resort drive and resulting in three recommendations being made. In September 2008, Mr Lock made 13 recommendations where a doctor failed in his duty of care to a child after she fell from a bunk bed which did not comply with Australian standards. The joint inquest into the nine deaths caused by quad bike accidents between 2012 and 2014 received significant media and community attention and resulted in 15 recommendations being made about use of helmets and mechanical maintenance, training and introduction of legislation to mandate the completion of accredited training and prohibiting children from riding adult sized quad bikes.

Mr Lock's contribution, dedication, and commitment to the coronial jurisdiction after more than a decade's service will be greatly missed by his colleagues and court staff.

Public interest inquests and non-inquest findings

During 2019–20 interest in the coronial jurisdiction continued with the handing down of high-profile inquest matters, notably the Dreamworld deaths which received world-wide media attention, the tragic deaths from the Ravenshoe Café explosion, the multiple fatality tandem parachute deaths at the Caboolture airfield, the joint inquest into the capsize of two fishing vessels which resulted in the loss of eight lives, the child death of Mason Lee which received considerable community and media attention and the non-inquest findings into the Home Hill backpacker double fatality. The following is a summary of 'public interests' matters that received a significant amount of media attention.

Capsizing of Fishing Vessels Dianne and Cassandra

Central Coroner, David O'Connell – 29 August 2019

Circumstances of the deaths

On 4 April 2016 the FV Cassandra was lost at sea, on board was David Barry Chivers and Matthew Neil Roberts who were never located. On 16 October 2017 the FV Dianne was lost at sea, on board the FV Dianne was Adam Jeffrey Bidner, Zachary John Feeney, Adam Ross Hoffman, Benjamin Patrick Leahy, Christopher David Sammut and Eli Davey Tonks. The two sinkings were directed to be held as a joint inquest due to the similarity of circumstances.

The *FV Cassandra* was approximately 17 metres in length, 5 metres in breath. It had been modified from a single boom trawler to a two boom, outrigger-style, trawler.

The vessel was fitted with a Vessel Monitoring System (VMS) which 'polls' (emits a radio signal) at hourly intervals in the area they were then operating. They departed Bundaberg on 31 March 2016 and headed south to an area north-east of Waddy Point, Fraser Island.

On the morning of 4 April 2016 at 2.28am the VMS polled the last known or recorded position of the Cassandra. The vessel was then observed by a nearby trawler fisherman who saw its' boom lights at 3.05am, and then saw that they appeared to be 'switched off'. It is likely that at around this time the boat capsized. It was first located after dawn floating upside down and partially sunken at approximately 6:30am by the owner and master of another fishing vessel which had also been working nearby. The master of that vessel, alerted authorities and a Search and Rescue (SAR) mission was commenced.

The *FV Cassandra* was located in forty-seven metres of water on 7 and 8 April 2016 in the vicinity of the last known co-ordinates of the vessel. It was. The vessel was on the sandy seafloor in an upright position with damage sustained to the bow, rigging and nets. There was no hole in the hull.

The *FV Dianne* was a vessel of approximately 18 metres in length, and there were seven crewmembers on board when it departed from Bundaberg on 16 October 2017. At around 7.15pm the vessel was about five nautical miles due east off the coast from the Town of 1770. The Town of 1770 boasts a Volunteer Marine Rescue (VMR) Squad. No radio communications were received.

At about this time, whilst the vessel was steaming north, the vessel did its usual roll to port, but on this occasion, it did not commence to 'come back' to starboard but instead continued rolling to port. The vessel completely rolled over, causing the wheelhouse to fill with water. Over the period from 7.15pm until about 11.15pm the vessel slowly sank lower in the water, stern first, before it slipped under the surface at about 11.15pm.

One member of the crew, Mr McDornan, escaped the vessel and swam towards the shore. At about 6.30am the following morning members of the VMR Squad happened to be sailing past and rescued him, and a mayday call was made advising of the six missing crew. Nearly 12 hours had passed since the time of the capsize, to the time the mayday call was made.

The *FV Dianne* was found upturned resting on the bottom. There was no external damage to the hull. The vessel had forward gear engaged, and a drogue rope was observed to be tightly wrapped around the propeller. Rescue authorities found two deceased crew members' bodies in the upturned hull of the vessel, but the other four bodies were not found.

Findings and comments

The Central Coroner found that each search and rescue was carried out diligently, promptly and extensively. What is of note was that in each search and rescue there was a delay between the time the capsize occurred and authorities first being alerted by a mayday distress call issued from a passing vessel. In the case of the *FV Cassandra* it was a delay of a little over four hours, in the case of the *FV Dianne* it was more than twelve hours.

In respect of the *FV Cassandra*, the vessel sunk because of the actions of the crew following a hook-up of a trawl net on the ocean floor. The Central Coroner found that it is very likely that modifications to

the trawler had a detrimental effect on stability but could not determine whether it affected its overall stability such as to make the vessel dangerous as opposed to simply more prone to capsize.

It appears that the safety and emergency devices on board did not deploy nor operate as expected, in that the life raft did not release to the surface. There was no time to reach and activate the manual Emergency Position Indicating Radio Beacon, nor get lifejackets or deploy the life raft. It cannot be said whether the presence of a life raft would have saved the lives of those on board.

The *FV Dianne* vessel sunk when it was overcome by the heavy seas on that particular evening. The Central Coroner was unable to determine whether the drogue rope fouled the propeller before the vessel rolled over, or after but the Central Coroner did find that a rope from the drogue had fouled the propeller whilst the vessel was still at the surface.

The Central Coroner found the vessel appeared to be compliant with all stability requirements when built and the modifications made would not have overly affected its general stability, although the modifications would have reduced to a slight degree. The safety and emergency devices on board did not operate as intended, in particular the life raft did not deploy at all.

Recommendations

The Central Coroner made a total of nine recommendations as to safety improvements in the fishing industry.

The Department of Agriculture and Fisheries was responsible for responding to Recommendation 9 being:

The Department of Agriculture & Fisheries immediately implement the sharing of the 'failure to poll' function of the Vessel Monitoring System (VMS) system to allow the QPS to be immediately notified by text (SMS) and email of any failure to poll by a vessel.

On 25 March 2020 the Minister for Agricultural Industry Development and Fisheries agreed with the intent of the recommendation but would implement the recommendation in a different way to achieve the same result. Since the making of the recommendation the department and the QPS have entered into a memorandum of understanding (MOU) which allows the department to provide QPS with a live feed of vessel tracking data from its VMS.

As of 1 January 2019, vessel tracking has been required on all commercial fishing vessels operating in the trawl, net, line and crab commercial Fisheries. Previously, vessel tracking had only been required in the trawl commercial fisheries. Whilst the requirement in the trawl commercial fisheries is for polling at 15 minute intervals, the requirement in the net, line and crab commercial fisheries is for polling at five minute intervals.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0008/624176/cif-fvdianneandfvcassandra-20190829.pdf.

Deaths following closure of the Barrett Adolescent Centre

Deputy State Coroner, John Lock – 30 August 2019

Circumstances of the deaths

Talieha Nebauer, William Fowell and Caitlin Whiticker were all aged 18 at the time of their deaths. They were all patients at the Barrett Adolescent Centre (BAC) with varying levels of service requirements. They were all part of the transition process following the announcement in August 2013 of the closure of the BAC, and all were provided with, and took up an option for further care post-BAC closure. All three of these young people took their own lives subsequent to the closure of the BAC. Talia died on 1 April 2014, William on 10 June 2014, and Caitlin on 5 August 2014. The official closure date for the BAC was 31 January 2014.

The BAC was a 15-bed inpatient service operated by the West Moreton Hospital and Health Service (WMHHS) at Wacol, on the same campus as The Park Centre for Mental Health. The BAC provided extended treatment and rehabilitation programs for adolescents across Queensland presenting with complex mental health diagnoses including eating disorders, anxiety and mood disorders, severe self-harm and suicidal behaviour. In addition to the inpatient service, the BAC offered a day program service involving a school and structured group activities

Talieha had been a long term patient at the BAC. When it closed Talieha became a resident at an adult mental health facility at Pine Rivers, which was staffed 24 hours a day. Talieha had very complex mental health problems considered to be post-traumatic stress disorder, emotionally unstable personality disorder and problems with life cycle adjustment.

William had been an inpatient of the BAC at the time of its closure in January 2014. He was living in temporary accommodation funded by Disability Services supported by a high level of supervision by carers and case management by Disability Services Queensland (DSQ). William had a complex mix of conditions including intellectual impairment, physical disability and a generalised anxiety disorder.

Caitlin was a day patient at the BAC and was transitioning towards independent living at the time the BAC closed. Her mental health condition was complex, longstanding and evolving as she moved from adolescence into adulthood. Her living arrangements broke down and for a number of months she was living with her mother whilst other alternatives were being sourced.

Investigation and inquest

On 16 July 2015, The Barrett Adolescent Centre Commission of Inquiry (the Commission) was established and considered the basis of the closure decision; the adequacy of the transition arrangements for BAC clients; the adequacy of the care, support and services provided to BAC clients and their families; and the consideration of any alternatives to the closure. The Commission's report was delivered in June 2016. The causes of the deaths of Talieha, William and Caitlin were considered to be not within the remit of the Commission.

During the joint inquest the Deputy State Coroner heard evidence of the circumstances of the deaths of each young person in separate hearings, heard from a limited number of witnesses focusing on events more proximate to the deaths and then considered evidence from those who were of relevance to more than one of the three young persons. The Deputy State Coroner considered whether any recommendations should be made, particularly relating to the prevention of self-harm and suicide in adolescents and young people.

Findings and comments

The Deputy State Coroner made detailed findings about the circumstances of each young person's death, their mental health conditions and how they were managed, and the care afforded to them after their discharge from BAC. In respect of the transition planning for each individual, the Deputy State Coroner accepted evidence given that each transition plan was individualised and bespoke in nature and *"without exception, were thorough and comprehensive".*

The transition plans for each of them were largely carried out. The Deputy State Coroner found that Caitlin was already in the process of transition and Talieha and William were turning 18 and this process would have occurred at some point in time in the near future. The imminent closure of BAC meant plans had to be developed quickly and their transition/transfer to alternative accommodation had to occur in circumstances that were quicker than had been the case if BAC was still open. As Professor Kotze noted in her report *"the process of transition occurred in an atmosphere of crisis"* but this did not *"appear to have detrimentally affected the process of transitional planning for the patients."*

Recommendations and referrals

DSQ engaged the Centre of Excellence for Clinical Innovation and Behaviour Support (CECIBS) to conduct a process review. The review was subsequently reviewed and endorsed by Professor Karen Nankervis who gave evidence in respect of the nine recommendations made in the process review report and the department's responses to those recommendations.

Professor Nankervis noted the recommendations were accepted and actioned immediately after the Process Review report was received and prior to the Commission of Inquiry. The Commission of Inquiry also endorsed the recommendations of the Process Review report.

The Deputy State Coroner heard evidence at the inquest as to the six recommendations which had been made at the Barrett Centre Commission of Inquiry, and the response to these recommendations at the time of the inquest.

Dr John Allan, Executive Director, Mental Health Alcohol and Other Drugs Branch (MHAODB), Queensland Health Independent gave evidence that reviews and reports addressing the six recommendations were delivered and noted at the final meeting of the Implementation Steering Committee on 19 July 2017. It was noted there was need for ongoing work arising from each of the reports and an ongoing commitment to strong governance and transparency was expressed.

Dr Allen also gave evidence about recommendations made by The Child and Youth Panel, an expert panel convened to examine the deaths by suspected suicide of children and young people with a recent contact with a health service. This was one panel amongst other panels for other cohorts where a similar analysis was performed, and relevantly for the purposes of this inquest considered the suicide deaths of children and young people aged 17 years and under, during the calendar years of 2015 and 2016. The deaths of Caitlin, Talieha and William were not considered as their deaths occurred in 2014.

The Panel identified 34 initial recommendations associated with the nine themes, which recommendations were prioritised and further refined into 17 final recommendations addressing each of the nine identified themes.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/624237/cif-bac-20190830-web-version.pdf.

Skydiving multiple fatality Mission Beach- mid-air back to earth solo sports jump under tandem pair

Northern Coroner, Nerida Wilson – 30 August 2019

Circumstances of the deaths

Peter Dawson and Tobias (Toby) Turner were friends and colleagues at Skydive Cairns, an arm of Skydive Australia Pty Ltd, owned and operated by Experience Co Limited, a commercial operation facilitating jumps out of Mission Beach.

Peter was a Tandem Master Skydiver, having completed 7,731 solo jumps and completed approximately 5,000 tandem jumps. He was 'C' Class instructor and a Packer 'A'. Toby had completed approximately 8,000 solo jumps and approximately 5,000 tandem jumps. He had previously been a Chief Instructor at a different drop zone. He held the highest instructor rating 'A' and was a Packer 'B'. Both Peter and Toby were highly qualified and experienced skydivers.

On 13 October 2017, Kerri Pike was undertaking a tandem jump as a fee-paying customer (student). Kerri was strapped to her tandem instructor, Peter, for the jump.

Kerri and Peter were the fourth group of skydivers to exit the plane on the last flight (load) of the day and utilised equipment maintained by the company. They were closely followed by Toby who had received permission to undertake a solo sports jump on the same load. Toby packed and maintained his own sports parachute rig.

At 7500 feet / 2286 metres Toby flew back to earth under the tandem pair (the Northern Coroner found this position to be accidental and inadvertent – the possible result of 'zooming' whilst below the tandem pair) and his parachute then deployed in an out of sequence event due to the impact of the wind on his pack in that position. The main canopy was undersize for the container, and outside manufacturers recommendations.

The descending pair (Kerry and Peter) collided with Toby mid air and all three died instantly as a result. The cause of death for all three persons was multiple injuries consistent with a parachuting mid-air collision.

The investigation

The QPS investigated the accident in consultation with the Australian Parachuting Federation (APF), and both agencies provided a report to the Coroner. Witnesses from each agency were called to provide oral evidence at the inquest. A representative from the United Kingdom Civil Aviation Authority (CAA) was retained by the Coroner to provide a peer review of the APF investigation and gave evidence at inquest.

The inquest

The inquest was conducted over five days in November 2018 with seventeen witnesses called to give evidence. Three witnesses sought to object to answer questions on the grounds of self-incrimination. Pursuant to section 39 *Coroners Act 2003*, the Northern Coroner was satisfied that it was in the public interest to require the three witnesses to give evidence that would tend to incriminate them. The Australian Parachuting Federation (APF), Skydive Australia and The Civil Aviation Safety Authority (CASA) each had leave to appear and were represented, as were the Pike and Turner family.

Findings and comments

The Northern Coroner found that, Kerri and Peter, collided with Toby mid-air and all three persons died instantly as a result of non-survivable multiple injuries sustained. The Northern Coroner made a further ten (10) findings about the positioning of the skydivers, their qualifications, and the equipment they used.

The APF made a number of recommendations which had in essence been implemented by the time of the inquest, with further processes envisaged to be completed by March 2019. The Northern Coroner acknowledged Skydive Australia implemented two new policies following the accident.

Recommendations

The Northern Coroner made recommendations directed to each of the relevant stakeholders and regulatory bodies with the overarching intent of ensuring airworthiness and compliance of relevant equipment by implementing certification processes, ongoing inspection and review, and buddy checks at the drop zone of all relevant equipment.

The Northern Coroner noted that many of the recommendations and proposals had already been adopted or considered by the relevant stakeholders.

CASA have since committed to the effective implementation of relevant recommendations arising from the Inquest, to be included within the provisions of Part 105 of the *Civil Aviation Safety Regulations* 1998 (Cth) (CASR) and by way of a review of Part 149 CASR relating to the obligations of self-administering sport aviation bodies.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0003/624234/cif-skydiveinquest-20190830.pdf.

Dreamworld Tragedy

Southeastern Coroner, James McDougall – 24 February 2020

Circumstances of the deaths

At around 2:00pm on 25 October 2016, Cindy Low and her son Kieran, Kate Goodchild and her daughter Ebony Turner, along with Kate's brother, Luke Dorsett and his partner Roozbeh Araghi, boarded Raft 5 of the Thunder River Rapids Ride (TRRR) at Dreamworld Theme Park.

The TRRR, which is no longer in commission, was an aquatic based family orientated 'moderate thrill ride', which was suitable for patrons over the age of two. It was designed to simulate white water rafting for six patrons, with the option of having three children seated on an adult's lap, within a circular raft.

Raft 5 travelled through the water course without incident before being picked up by the conveyor at the end of the ride and moved towards the elevated unloading area. At this time, Raft 6, which was dispatched in front of Raft 5, became stranded on the steel support rails situated at the end of the conveyor near the unloading area. Raft 5 continued to travel on the conveyor where it collided with Raft 6 before being lifted and pulled vertically into the conveyor mechanism. Ebony and Kieran, who were seated at the top of Raft 5, were able to free themselves and escape to safety. Ms Goodchild, Ms Low, Mr Dorsett and Mr Araghi were caught in the mechanism of the ride and were either trapped in the raft or ejected into the water beneath the conveyor.

The Ride Operators and some patrons immediately responded, attempting to assist those trapped in the raft and in the watercourse. Emergency services were contacted, and various Dreamworld staff responded to the incident. Unfortunately, all attempts to provide medical assistance to Ms Goodchild, Mr Dorsett, Ms Low and Mr Araghi were unsuccessful, and they were declared deceased at the scene.

The investigation

A major investigation was commenced by QPS, which included support from various internal specialty units. The scope of the QPS investigation was to determine whether there was any criminal negligence or criminal responsibility, and also assist the South Eastern Coroner in his investigation of the incident to make the requisite findings and identify any possible preventative recommendations.

In addition to undertaking an expert forensic examination and search of the incident scene, a multitude of witnesses were interviewed, including eyewitnesses, Ride Operators, Dreamworld management staff, maintenance workers, current and former Dreamworld employees, Queensland Ambulance Service (QAS) officers, and Dreamworld patrons. Relevant evidence from the scene was seized, extensive photographs of the incident site taken, and various external and internal subject matter experts were engaged in order to comprehensively canvas all of the pertinent issues associated with the tragedy.

The Office of Industrial Relations (OIR), whilst undertaking their own separate statutory investigation, assisted QPS in examining the incident. Various interviews and evidence was obtained pursuant to s.171 of the *Work Health and Safety Act 2011,* for an array of potential witnesses, who refused to provide voluntary statements to QPS, however, were highly relevant to provide context, evidence, information regarding training, maintenance, safety and the history of the TRRR.

Extensive documentary evidence was also sought from Ardent Leisure, as well as other external parties, by way of numerous coronial directions. As a result, voluminous records pertaining to a myriad of issues, including the TRRR, modifications made, training, maintenance, job descriptions, operations at Dreamworld, certifications, workplace health and safety related issues, meeting minutes, safety decisions, policies and procedures, directions and complaints, were obtained.

The inquest

The inquest was convened over a six-week period at various dates in June, October, November and December 2018. The primary issues for the inquest were to examine the circumstances of the incident, as well as the construction, maintenance, safety measures, staffing and modifications to the TRRR, the

sufficiency of training provided, whether changes need to be made to the regulatory environment and applicable standards and what measures could be introduced to prevent a similar incident in future. Oral evidence was taken from 59 witnesses, with an expert engineering conclave convened to provide evidence concurrently.

Findings and comments

The primary cause of this tragic incident was found to be the failure of the south pump, leading to a sudden drop in water level, following which the conveyor was not stopped. Dreamworld were aware that when one pump failed on the TRRR, the ride was no longer able to operate, with the water level dropping dramatically stranding the rafts on the steel support railings around the trough. Despite the significance of the water level to the safe operation of the ride, there was no automated safety system in place to monitor the water level or provide any audible or visual alert should it fall below a safe level.

A second major contributing factor of the incident was that the conveyor continued to operate in the event of a pump failure. Whilst it appears the initial design of the TRRR was approved by the Chief Inspector of Machinery in 1987, there were multiple significant modifications made to the ride prior to the incident in 2016. The records available with respect to these modifications were scant and ad hoc, and established that for the duration of the rides commission, it was modified essentially without a 'designer'. The modifications made to the ride, despite being significant, were also never reported to the Regulator.

It was concluded beyond doubt that in the 30 years prior to this tragedy, Dreamworld failed to undertake, either internally or via an external auditor, a holistic examination of the TRRR by a suitably qualified engineer, so as to ensure its safe operation through the identification of the high and low probability risks and hazards present.

Recommendations

Coroner McDougall made a number of recommendations, in brief:

OIR

- Changes be made to the current regulatory framework in Queensland with respect to the inspection and licensing of Major Amusement Park devices to ensure that a more structured and compliance focused regime is implemented.
- Regular auditing and oversight of such devices, as well as the associated inspections and required safety systems in place at the Major Amusement Park, must be conducted by the Regulator. Such auditing should be undertaken by suitably qualified and trained OIR Inspectors. That OIR continue to develop a Code of Practice for the amusement device industry in Queensland, which will establish a minimum standard for the operation of amusement devices, in consultation with the requisite industry stakeholders, including the Amusement Device Working Group.
- That efforts to harmonise the requirements of the relevant design standards, particularly the critical safety requirements on amusement devices in Australia, Europe and America continue in consultation with relevant industry stakeholders.
- Steps be taken to rectify the lack of detailed knowledge of Safety Related Control Circuits held by the majority of OIR Inspectors.

Other agencies

- The Board of Engineers, in consultation with OIR and other industry groups, to continue efforts to address the shortfall in suitably qualified and experienced RPEQ's with respect to the inspection of amusement devices.
- That a reassessment of the Australian Standards applicable to waterborne rides (including raft rides) be undertaken to include some of the types of safety requirements associated with roller coasters, including more thorough considerations for lifts/elevators, collisions and passenger

loading/unloading.

- Consideration as to whether the requirement for hazard identification and risk assessment in AS 3533.2 section 5.1 should be made mandatory. Furthermore, whether any modification or alteration to the ride should require hazard identification and risk assessment to ensure that changes made do not affect safe operation and use.

Pursuant to s.48 of the Act, the Coroner referred Ardent Leisure Limited to the OIR as it was reasonably suspected an offence may have been committed under Workplace Law. RPEQ Mr. Tom Polley was also referred to the Board of Professional Engineers Queensland for his conduct in issuing an annual renewal certificate for the TRRR without any documentation pertaining to the ride and his failure to properly inspect the ride.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0004/641830/10545784-final-dreamworld-draft-6-for-upload.pdf.

March 2014 plane crash at Caboolture Airfield

State Coroner, Terry Ryan – 10 March 2020

Circumstances of the deaths

On 22 March 2014, Cessna aircraft VH-FRT took off from Caboolture Airfield for a commercial tandem parachute operation conducted by Skydive Bribie Island. It was the third flight of the morning. There were five people on board: Andrew Aitken (pilot), Glenn Norman and Juraj Glesk (parachuting instructors), and Joseph King and Rahuia Hohua (tandem parachutists).

After take-off, the Cessna climbed to about 200 feet with a nose up tail low attitude and commenced to bank to the left. The aircraft suddenly declined nose down and impacted with the ground in an almost vertical, left wing low attitude. The plane was destroyed by a fuel fed fire which began almost immediately upon impact, killing all those on board and destroying the aircraft.

The investigation

The crash was investigated by the QPS Forensic Crash Unit (FCU) and the Australian Transport Safety Bureau (ATSB). The ATSB made a number of safety recommendations directed to Civil Aviation Safety Authority (CASA) and the Australian Parachute Federation (APF).

The investigations revealed that the pilot's seat was missing a 'rear seat stop' safety mechanism and there could have been uncommanded rearward movement of the seat. The aircraft was inspected a month before the crash and the engineer found it to be safe despite knowing the safety mechanism was missing.

The investigations concluded that neither the engine nor the propeller of the Cessna contributed to the crash. However, given the extensive fire damage, an unidentified mechanical defect could not be ruled out as a possible contributing factor. It could also not be determined whether the left turn was a deliberate manoeuvre by the pilot, the result of the developing aerodynamic stall or movement for some other reason.

An autopsy report in relation to Mr Aitken indicated there was no medical evidence of any incapacity that may have contributed to or caused loss of control of the aircraft.

The families of the deceased expressed a range of concerns about the operations of Skydive Bribie Island and the way aircraft maintenance was overseen in the skydiving industry.

The inquest

The inquest conducted over six days in September 2018 and December 2018, with oral evidence heard from 11 witnesses. On the first day of inquest, a view of a Cessna U206G was conducted at the Redcliffe

Aero Club. The inquest investigated six primary issues with a further issue emerging during the course of the hearing.

Findings and comments

The State Coroner found that the aircraft modified for parachuting operations aerodynamically stalled at a height from which the pilot was unable to regain control. The reasons for the aerodynamic stall could not be established as extensive fire damage prevented examination and testing of most of the aircraft components.

The State Coroner made a number of comments addressing the:

- Regulatory oversight of parachuting operations
- Jump pilot maintenance
- Secondary seat stop issue
- CASA / APF responses to ATSB recommendations

The State Coroner commented that the issues raised in the ATSB report highlighted the need for CASA to maintain an active role in relation to airworthiness control and the oversight of aircraft maintenance that involves modifications to a range of aircraft structures and systems, including aircraft configured for use in parachuting operations, which may occasionally be used for other purposes.

Recommendations

The State Coroner made four recommendations for the Australian Parachuting Federation and the CASA's management of skydiving companies, in particular to the safety, review and maintenance of aircrafts, pilots and parachutists, specifically that:

1. The APF revise its policies and procedures for the assessment of whether candidates for and holders of the position of Chief Instructor and others in control of parachuting organisations are 'fit and proper persons' and of 'good repute'.

2. The APF require club members using Cessna 206 type aircraft or any similar aircraft with pilot seats that slide on rails to only use such aircraft as jump aircraft for tandem parachute activities where the aircraft has a secondary seat stop mechanism installed.

3. A thorough review of the requirements of the CASA-approved APF Jump Pilot Manual, and its suitability for providing appropriate risk-based standards for all air operations conducted by APF club members.

4. That CASA and the APF review the implications for public safety of low-time or part-time jump pilots flying sorties in aircraft owned by APF club members and organisations not controlled by persons with the background and experience of an AOC operator. Four issues that should receive particular attention were identified.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0005/642551/cif-march2014cabooltureplanecrash-20200310.pdf.

Paul Thomas McGuire – fatality in underground mining, asphyxiation via exposure to depleted-oxygen atmosphere

Central Coroner, David O'Connell – 22 May 2020

Circumstances of the death

Mr McGuire was a 34 year old mine electrician who was employed at Grasstree Underground Mine at Middlemount. On 6 May 2014 Mr McGuire had been tasked to calibrate gas sensors in an area of the mine detailed on his job card. His job card incorrectly directed him to an area of the mine known as a GOAF, which is an area which has previously been mined for coal but has since been sealed off and

filled with methane to prevent spontaneous combustion. Mr McGuire entered this area through a door which was bolted closed but not locked and was unable to breathe in the oxygen depleted atmosphere. He lost consciousness and died of asphyxiation.

Investigation

The Department of Natural Resources, Mines and Energy (DNRME) concluded that there were certain breaches of required procedures. DNRME commenced prosecutions against the mine operator and the SSE, Mr Garde. The prosecutions were handled by the Commissioner for Mine Health and Safety. Prosecutions were commenced for four charges.

In September 2016 the solicitors on behalf of the mine operator and Mr Garde wrote correspondence to the Commissioner which highlighted deficiencies or uncertainties with those prosecutions and submitted that the Department should accept a plea of guilty from the mine operator to one of the charges, but that the other three charges be discontinued. The Commissioner reviewed the strength of their evidence, sought further advice on the likelihood of success, and ultimately determined to accept the submission.

The inquest

The focus of the inquest was how Mr McGuire came to be tasked the job that he was doing and whether any of the following factors caused or contributed to Mr McGuire's death:-

a) training in tasks to be performed by Mr McGuire on the 06 May 2014;
b) supervision of Mr McGuire while undertaking duties on the 06 May 2014;
c) practice of the employer governing the sealing of mined (goaf) areas;
d) the keeping of records pertaining to Mr McGuire's duties on 06 May 2014;

The inquest also examined whether the actions of employees following the "high high methane" alarm were in accordance with best practice, whether changes should be made to the systems of work applicable to the performance of Mr McGuire's duties and whether the discretion to discontinue a prosecution in respect of a mining safety offence involving a death should remain with the Commissioner for Mine Safety and Health, or whether such discretion should fall under the jurisdiction of the WHS prosecutor.

Findings and comments

The Central Coroner found that the actions of the employees following the "high high methane" alarm were adequate, if not in accordance with best practice. The Central Coroner considered it appropriate that changes should be made to the system of work applicable to the performance of Mr McGuire's duty to prevent further deaths in the mining industry and made recommendations to that end (see below).

The Central Coroner found what was deficient was the practice of Mr McGuire's employer in failing to adequately prevent ingress by a person through a hatch seal, and in failing to warn that a particular metal door was a hatch seal and that dangerous GOAF gases were behind it. Most significantly, the failure to keep adequate, accurate and up-to-date records pertaining to the duties Mr McGuire was to perform on 6 May 2014 was the most significant contributing factor. The Central Coroner found that the mine's record keeping, particularly the updating or acting upon received information which required change, was grossly deficient.

The Central Coroner found that outcome of the prosecution by the Commissioner suggested that there are benefits in having a specialist prosecutor deal with the Court aspects of the prosecution, with input from the Mines Commissioner as to mining practices. The Coroner noted that during the inquest he was informed that this Inquest Issue was addressed by legislation being passed by the Queensland Parliament.

Recommendations and referrals

The Central Coroner made recommendations aimed at reducing the identified risks in relation to GOAFs. In addition, the Central Coroner determined, on the basis of the evidence and his findings, that

Mr Anthony Johns may have committed an offence made a referral to the Chief Executive of DNRME for further investigation of Mr Johns' actions (or inaction).

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0003/650532/cif-mcguire-pt-20200522.pdf.

Mason Jet Lee – child death

Deputy State Coroner, Jane Bentley – 2 June 2020

Mason Jet Lee was 22 months old when he died. He was the fifth child of Anne-Maree Lee. Just over a year before Mason's death, Ms Lee commenced a relationship with William O'Sullivan but they did not live together. In the period before Mason's death, Mr O'Sullivan kept Mason at his residence.

Circumstances of the death

In the midnight hours of 11 June 2016 police and ambulance were called to Mr O'Sullivan's residence. Mason was obviously deceased and had been for some time.

An autopsy revealed, Mason had suffered displacement of his large bowel and rectum, displaced fracture of his coccyx, a fracture of his tibia, 46 bruises to his body, mouth and ear ulcers, scalp haemorrhages consistent with head trauma and hair pulling and severe bowel injuries which led to infection of the peritoneum and sepsis. Mason's injuries were caused by multiple blunt force traumas.

Mr O'Sullivan was charged with Mason's manslaughter and cruelty. He was sentenced to 9 years imprisonment for the manslaughter with a concurrent term of 12 months imprisonment for the cruelty offence. The Crown appealed that sentence on the basis that it was manifestly inadequate. The Court of Appeal allowed the appeal and substituted a sentence of 12 years imprisonment for the manslaughter. Ms Lee was sentenced to 9 years imprisonment for Mason's manslaughter and a concurrent sentence of 3 and a half years for the cruelty offence.

The inquest

The fundamental task for the inquest was to identify whether the entities involved in protecting children can be better assisted to render the *whole* picture of a child in need. As a result of the COVID-19 restrictions, oral evidence was completed on Day 2 of the inquest and the remainder of the inquest proceeded by way of written cross-examination and submissions.

Findings and comments

The Deputy State Coroner found that the relevant employees of the Department failed in nearly every possible way to comply with their statutory obligations, their manual, their policies and procedures. Two of the most significant failures by the department, was the lack of sighting Mason since his discharge from hospital until his death; and the lack of oversight at the Caboolture Child Safety Service Centre which contributed to Mason falling through the cracks.

The Deputy State Coroner acknowledged the Department and the State Government had taken comprehensive steps to investigate Mason's death and that many reforms had been made. Queensland Health was found to have treated and managed Mason appropriately, and no adverse findings were made against the QPS.

The Deputy State Coroner made a total of six recommendations, including broadly:

1. The Suspected Child Abuse and Neglect (SCAN) manual and relevant legislation, policies and procedures mandate that when a family is engaged with an external support service, the external support worker be included at all meetings and information share with the external support worker;

2. Queensland Department of Health implement formal policies and procedures for the escalation of a case where medical officers disagree with a decision made by the Department;

3. The sharing of information between the department and QPS be reviewed and monitored;

4. The SCAN manual and policies be amended to require that cases remain open until appropriate feedback has been provided and it has been agreed that recommendations have been fulfilled or no longer appropriate;

5. The SCAN manual and relevant legislation, policies and procedures mandate case planning and discussion take place even when a meeting is inquorate; and

6. The Department review its policies and procedures to ensure that adoption is routinely and genuinely considered as a suitable permanency option for children in out-of-home care.

On 17 June 2020, the Queensland Government formally adopted every recommendation of the Deputy State Coroner.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0009/651636/cif-lee-mj-20200602.pdf.

Ravenshoe Café Explosion – Nicole Nyholt and Margaret Clark – obligations of Driver Licence holder to report relevant medical conditions to Department of Transport and Main Roads, medical fitness to drive, obligations of medical and general practitioners, recommendations to review fitness to drive protocols and education

Northern Coroner, Nerida Wilson – 26 June 2020

Circumstances of the deaths

On 9 June 2015 Brian Scutt, whilst driving his Toyota Landcruiser experienced an epileptic seizure, temporarily losing consciousness and control of his vehicle, and veered off the main road travelling approximately 170 metres before colliding with a 180kg LPG gas cylinder positioned at the rear of the Serves You Right Café, Ravenshoe. Nineteen people were present inside the café at the time, including the deceased Nicole Nyholt and Margaret Clark. Both succumbed to their injuries in the days following the explosion. The police investigation established that Mr Scutt had a known medical history of seizures which was relevant to his fitness to drive and therefore directly relevant to the events.

Investigation

The QPS Forensic Crash Unit examined the Landcruiser, interviewed witnesses to determine the route Mr Scutt had taken that morning and how the crash had occurred, and examined the café building and appliances to determine how the gas ignited.

The vehicle was found in satisfactory mechanical condition and there were no defects. The mechanical inspection confirmed the Landcruiser was likely to have been in fourth gear. The inspection also showed the accelerator cable was in the half-applied position, pulled down and had seized approximately 35mm from the rest position. It was determined that the impact of the collision caused the gas cylinder to rupture and forced it through the wall of the café, the contents mixed with the surrounding oxygen and ignited upon contact with a heat source in the kitchen of the café, causing the explosion.

Mr Scutt was subsequently charged with offences under the Criminal Code relating to the dangerous operation of a motor vehicle causing death or grievous bodily harm. All charges were referred to the Mental Health Court which determined that Mr Scutt:

- was not suffering from unsoundness of mind at the time of the alleged offences; but
- was not fit for trial and that such unfitness was of a permanent nature.

On 28 November 2018 all criminal charges against Mr Scutt were discontinued.

The inquest

Two key witnesses, Mr Scutt, and his general practitioner Dr Kenneth Connolly, died prior to the commencement of the inquest. The Coroner determined that an inquest could proceed given that Dr Connolly had provided a statement upon which the Inquest could rely, prior to his death. Dr Connolly and Mr Scutt were each represented at the inquest.

The inquest took place over 6 days split between two sittings, the first at the Atherton Courthouse to accommodate local witnesses, and for the community affected by the explosion to attend proceedings should they wish to do so, and the second in Cairns where the expert and professional witness gave evidence. A total of 31 witnesses gave evidence.

The inquest examined the circumstances surrounding the collision, the medical management provided by the Atherton Hospital and by general practitioner Dr Connolly in relation to Mr Scutt's presentations for seizures, and further explored the obligations of Mr Scutt, and the medical and general practitioners to notify the Department of Transport and Main Roads (DTMR) of his seizure history.

Findings and comments

The Northern Coroner found Brian Scutt, experienced an epileptic seizure and temporarily lost consciousness and control of his vehicle and veered off the main road before colliding with a 180kg LPG gas cylinder, thereby triggering an explosion in the Serves You Right Café

The Northern Coroner found that the medical care given to Mr Scutt at the Atherton Hospital and by his GP was adequate and appropriate. Although not mandated by law the Northern Coroner commented that Dr Connolly had a discretion to advise DTMR of a medical condition.

With respect to Mr Scutt's own obligations, the Northern Coroner found that Mr Scutt disregarded all requests by family, and by doctors at the Atherton Hospital, on separate occasions over a period of years, not to drive. The Northern Coroner found that Mr Scutt was not medically fit to drive at the time of the accident and should not then have held an unconditional drivers licence.

Recommendations

The Northern Coroner recommended that the Department of Transport and Main Roads take the role as lead agency in the formation of an inter-agency working group to:

Recommendation 1

Develop an ongoing education and awareness campaign directed to all medical practitioners in the State of Queensland, including hospital based doctors (including rural and remote hospitals) and general practitioners, (including rural and remote general practitioners) and that such campaign be specifically developed to educate medical practitioners about the pathways that already exist, for medical practitioners to report patients directly to the State driver licencing authority in circumstances that are consistent with the Medical Standards provided for in the Austroad assessing fitness to drive guidelines.

Recommendation 2

Review the current standards and guidelines in respect of continuity of care, discharge, and handovers relevant as between doctors and patients, and doctors and doctors, and hospitals and General practitioners.

Recommendation 3

Consider a community campaign targeted at licence holders reminding them of their obligations to immediately report to TMR any medical events (including seizures and epilepsy) which may impact on their fitness to drive.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0004/653242/cif-nyholtandclark-ravenshoe-20200626.pdf.

Non-inquest findings into the deaths of Mia Ayliffe-Chung and Thomas Jackson - stabbing death, multiple fatality, Home Hill Queensland, backpacker deaths, backpacker accommodation, fruit picking, drug induced psychosis (cannabis), paranoid schizophrenia, foreign nationals, Mental Health Court (Queensland), criminal charges discontinued, gender violence

Northern Coroner, Nerida Wilson – 30 June 2020

Circumstances of the deaths

Home Hill is located approximately 98 kilometres south-east of Townsville and is a predominantly agricultural economy that draws labour from foreign nationals travelling through Australia on working visas. Both Mia and Thomas were UK nationals, unknown to each other, travelling through Australia on working holiday visas accommodated at the same backpacker hostel and engaged in farm work at the time of their deaths.

Mia Mishka Annie Ayliffe-Chung died on 23 August 2016 aged 20 years. Thomas Leslie Jackson died on 29 August 2016 aged 30 years.

Both Mia and Thomas died as a result of fatal stab wounds inflicted during a shocking and unforeseen attack at a backpacker hostel, by Smail Ayad a 29-year-old French national from Marseille, in Australia on a working holiday visa, during a drug induced psychosis.

Findings and comments

In determining that an inquest was not required, the Northern Coroner took into account the Criminal and Mental Health Court proceedings which concluded that Mr Ayad was of unsound mind at the time of the fatal stabbing and all charges were discontinued. Mr Ayad is currently the subject of a Forensic Order awaiting deportation.

The Northern Coroner also took into account the concerns raised by Mia's family regarding circumstances in which Mia found herself accommodated in the same room with Mr Ayad (who was not known to her prior) at the backpacker hostel and referred to the Harvest Trail Inquiry, conducted by the Commonwealth Fair Work Ombudsman, commencing in August 2013. That Inquiry examined various workplace arrangements amongst people working in the agriculture sector including those people on working holiday visas and considered the role of accommodation providers. The Northern Coroner concluded that an inquest would not yield further meaningful information.

The findings of investigation are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0004/653494/nif-homehilldeaths-20200630.pdf.

Access to coronial information

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

Generally, researchers may only access coronial documents once the investigation is finalised. However, the State Coroner may give access to documents on open files if the State Coroner considers it appropriate having regard to the importance of the research and the public interest in allowing access before the investigation has finished. The Coroners Act requires the names of persons given access to documents as genuine researchers to be noted in the annual report.

The following genuine researchers were approved under s. 53 of the Coroners Act during the reporting period:

Freya McLaughlan, Dr Bridget Harris and Dr Claire Ferguson – School of Justice – Queensland University of Technology

Project into intimate partner homicide and understanding the offenders involved. The research project is titled: *Predicting intimate partner homicide: Key risk factors and the heterogeneity of male offenders*

The project aims to examine the role and impact of criminal history and individual-level risk factors in predicting intimate partner homicide.

Professor Douglas, Dr Fitzgerald and Dr Sharman - The University of Queensland

Research project into the non-fatal strangulation offences as a response to domestic violence.

The CCQ also manages and maintains a register of reported deaths and supports the State's involvement in the National Coronial Information System (NCIS). The NCIS is the national database or mortality data on deaths reported to a coroner in Australia and New Zealand. Data provided to the NCIS is used to inform death and injury prevention activities for a wide range of stakeholders, including coroners (for their own investigations), government agencies and researchers.

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

Information requests in 2019–20:

2
Genuine Researchers approved

1,739
Coronial files processed for 8 general research requests

1,404
Individual requests for documents on finalised maters

Domestic and Family Violence

Domestic and Family Violence Death Review Unit (DFVDRU)

The DFVDRU based within the CCQ, provides specialist advice and assistance to coroners in their investigation of domestic and family violence related homicides and suicides and the deaths of children who were known to the child protection system. Through analysing demographic characteristics and static and dynamic risk indicators, the DFVDRU analyses trends and patterns regarding domestic and family violence related homicides and suicides.

The DFVDRU further provides advice on national and state policy and practice initiatives as they relate to domestic and family violence and the coronial system more broadly. Data held by the DFVDRU is shared with government and non-government sectors to inform policy and practice reforms.

The DFVDRU is also a founding member of the Australian Domestic and Family Violence Death Review Network (the Network) and continues to work closely with other death review mechanisms in Australia. The Unit also present on the domestic and family violence death review process[26].

The DFVDRU maintain two comprehensive statistical databases:

- the Queensland Domestic and Family Homicide Database; and
- the Queensland Domestic and Family Suicide Database.

In the 2019–20 financial year, the DFVDRU completed 67 comprehensive case reviews to assist coroners in their investigations of domestic and family violence-related deaths, and deaths of children known to the child protection system. Case reviews, and the supporting research summaries provided by the DFVDRU, have been referenced in numerous coronial findings, including multiple published findings. Of particular note are the non-inquest findings into the death of Mrs B, the death of Mr M and the deaths of Nyobi Jade Hinder, River Jamie Hinder and Charlie Hinder.

The value of a dedicated domestic and family violence resource for coroners was recently recognised in an academic article, *Facts seen and unseen: Improving justice responses by using a social entrapment lens for cases involving abused women (as offenders or victims)*[27]

The authors examined Coroner Nerida Wilson's non-inquest findings in the death of Rinabel Blackmore and explored the way that Her Honour examined the facts of this case in comparison to the relevant sentencing remarks. The authors concluded that Her Honour investigated the domestic and family violence context using a social entrapment lens, recognising that intimate partner violence is characterised by tactics of coercive control (both physical and non-physical violence) used by the predominant aggressor toward the victim to undermine the victim's autonomy. The authors suggested that Her Honour's investigation this death was "*a model approach to analysing facts involving [intimate partner violence] through a social entrapment lens*".

The Domestic and Family Violence Death Review and Advisory Board

The DFVDRU provides secretariat support to the Domestic and Family Violence Death Review and Advisory Board (the Board) to support its systemic review function. The Board is an independent body established by the *Coroners Act 2003* to undertake systemic reviews of domestic and family violence deaths in Queensland. The Board make recommendations to the Queensland Government to improve

[26] Refer to Appendix 4 – Presentations by the Domestic and Family Violence Death Review Unit

[27] Heather Douglas, Hannah McGlade, Stella Tarrant & Julia Tolmie (2020) Facts seen and unseen: improving justice responses by using a social entrapment lens for cases involving abused women (as offenders or victims), Current Issues in Criminal Justice, DOI: 10.1080/10345329.2020.1829779].

legislation, policy and practice to prevent or reduce the likelihood of domestic and family violence deaths.

The first term of the Board commenced in 2016 and expired in 2019. On 10 February 2020 the Attorney-General re-appointed State Coroner, Terry Ryan to chair the second term of the Board, alongside 10 government and non-government members. During 2019–20 the Board reflected on issues identified during its first term and undertook to examine particular types of domestic and family violence deaths as it moves into its second term.

Further information about the Board can be found in the Board's annual reports available on the Queensland Courts website[28].

[28] Reviews of deaths from domestic and family violence - https://www.courts.qld.gov.au/courts/coroners-court/review-of-deaths-from-domestic-and-family-violence

Deaths in custody: case summaries

The term '*death in custody'* is defined in s10 of the Act to include those who at the time of their death, are in custody, trying to escape from custody or trying to avoid being placed into custody. '*Custody'* is defined to mean detention under arrest or the authority of a court order or an act by a police officer or corrective services officer, court officers or other law enforcement personnel. An inquest is mandatory in these circumstances.

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

COLIN WAYNE BLAIR

State Coroner, Terry Ryan – 6 September 2019

Mr Blair was a 44 year old indigenous man who died in the High Dependency Unit (HDU) of the Brisbane Correctional Centre (BCC). At the time of his death, Mr Blair was being held in a 'suicide resistant' cell. He had been placed in that cell upon his return to custody following breaches of his parole because of his history of suicide attempts while in prison.

Circumstances of the death

On 1 October 2015, Mr Blair was remanded in custody at the Arthur Gorrie Correctional Centre (AGCC). Though he was assessed as a low risk of self-harm when first admitted, over the next two days Mr Blair made two attempts to hang himself. He was assessed by the Prison Mental Health Service (PMHS) and deemed a high risk of suicide and placed on continuous observations. On 9 October 2015, Mr Blair was sentenced to six months imprisonment, with a parole release date of 23 October 2015. On 12 October 2015, a Risk Assessment Team (RAT) at AGCC determined that Mr Blair's behaviour was stabilising and reduced his observations to intervals of 15 minutes.

On 15 October 2015, Mr Blair was transferred to BCC and housed in unit S3 which catered for vulnerable and at-risk inmates. He was assessed by a senior psychologist and remained on 15 minute observations. While he was still on a 15-minute observations regime Mr Blair was released on parole on 23 October 2015. His release late on a Friday afternoon limited the immediate capacity of QCS to supervise his successful transition into the community. As he was subject to court ordered parole, there was no capacity to delay his release, or to release him at an earlier date. Mr Blair was referred to the Homeless Health Outreach Team (HHOT) and placed in an inner city hostel, by the PMHS Indigenous Mental Health Worker.

Mr Blair was returned to custody on 29 October 2015. On reception at BCC on 5 November 2015, Mr Blair was assessed by Anna Howlett, a QCS psychologist, for the purpose of an Immediate Risk Needs Assessment (IRNA). Ms Howlett assessed Mr Blair as being at moderate risk of suicide. Mr Blair was placed on 60 minute observations which reflected a moderate risk level in accordance with the Risk Level Observation Guidelines.

<u>Events of 13 November 2015</u>

Mr Blair was seen by Natasha McLennan, a Sentence Planning Advisor with Sentence Management, which was a separate unit within BCC. Mr Blair told her that he wanted to be transferred to Wolston Correctional Centre to be close to family and because it also had a protection unit. Ms McLennan told Mr Blair that she would be recommending that he be transferred to Wolston and he said that he had no issues with that. She did not discuss a timeframe for the transfer with him. After her interview with Mr Blair had finished, Ms McLennan advised an officer in S3 that Mr Blair wanted to be moved to Wolston and that would be her recommendation. After this conversation, Mr Blair told a prison Cultural Liaison Officer that he was concerned about going to Wolston.

After these interactions, the CCTV footage from the camera in the top corner of Mr Blair's cells showed that Mr Blair was given lunch in his cell by correctional officers at 12:53pm. He started to eat that meal, but at 12:59pm he started to make a noose out of the electrical cord attached to the television. At 1:02pm he got under the desk in his cell, and from then on, only his legs could be seen. After 1:07pm, he was not seen to move again.

Although the correctional officers on duty conducted a muster at 1:30pm, and a 2:00pm observation (by looking through the glass pane in the cell door), it was not until 2:48pm that a correctional officer entered Mr Blair's cell and found that he had hanged himself using the noose under the desk. The correctional officer called a code blue, and Mr Blair was cut down. Medical staff and QAS paramedics attended, but Mr Blair was unable to be resuscitated and was pronounced deceased.

Investigation

The QPS CSIU and the Office of the Chief Inspector (OCI), Queensland Corrective Services (QCS) investigated the death. The OCI investigators submitted a report which identified a number of root causes for Mr Blair's death and contained recommendations to QCS.

An external autopsy examination with associated CT scanning and toxicology testing concluded the cause of death was consistent with hanging.

The inquest

The inquest heard evidence from 18 witnesses and over 250 exhibits were tendered. The focus of the inquest was the adequacy of the care, treatment and observations of Mr Blair prior to his death, specifically, his mental health treatment and referral to the PMHS, the decisions made by the RAT on 12 November 2015 and the observations regime of Mr Blair in his cell on 13 November 2015. The inquest also examined the communication between Sentence Management and the RAT over 12 – 13 November 2015 and the response by AGCC and the BCC to the recommendations made by the OCI.

Findings and comments

The State Coroner found that Mr Blair was dealt with appropriately by the PMHS during his final period of imprisonment and that earlier psychiatric intervention is unlikely to have prevented Mr Blair's death.

The State Coroner considered that Mr Blair would have benefited from a more immediate response within BCC to his concerns about his move from unit S3, and his perception of increasing estrangement from his family. The fact that Mr Blair reached out to the cultural liaison officer rather than a CCO after being told of his transfer to Wolston highlights the importance of having culturally competent staff within prisons who can respond to the specific concerns of Indigenous prisoners.

The State Coroner found it is likely that a higher level of observations would have been implemented if the RAT were aware that Mr Blair was facing an imminent transfer from BCC and had they been aware of Mr Bond's communication with Mr Blair about the fact that he could not live with his mother, which appears to have coincided with the RAT meeting.

In respect of the observation's regime, the State Coroner found that it was adequate, but that the 2:00pm observations were not. However, medical evidence given at the inquest suggested that it is highly unlikely that Mr Blair could have been medically retrieved if he had been found at either observation.

The State Coroner found that the lack of communication between the RAT and Sentence Management was the most significant issue identified in this matter. Mr Blair's death soon after he met with Ms McLennan was not coincidental. The State Coroner was satisfied that Mr Blair determined to end his life after information was given to him about his transfer to Wolston. That information was given to Mr Blair without any regard to the conclusions and recommendations of the RAT from 12 November 2015. Earlier that day he had been given an assurance that he would be kept in unit S3 for at least seven days. Ms McLennan's evidence was that if she had known the RAT recommendation was that Mr Blair not be moved from unit S3, she would not have conducted her assessment on 13 November 2015. Finally, the State Coroner found that the AGCC responses to the OIC recommendations were adequate. The State Coroner made no recommendations or referrals in this matter.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0007/624850/cif-blair-cw-20190906.pdf.

ASHLEY GLENFIELD GAVENOR

State Coroner, Terry Ryan – 21 November 2019

Ashley Glenfield Gavenor was 48 years of age when he died in the exercise yard of the secure unit at the Townsville Correctional Centre (TCC) on 19 September 2017. Mr Gavenor was an Indigenous man

from Mornington Island who was regarded as an elder by fellow Indigenous prisoners and a man with knowledge of traditional healing practices.

Circumstances of the death

Mr Gavenor suffered from a number of significant comorbidities, which included coronary artery disease, hypertension and Type 2 diabetes. He was prescribed several medications for these conditions while in custody. The evidence suggested he took no medication while living in the community.

Up until 9 April 207, Mr Gavenor was largely compliant with his medications. However, after that date he almost continuously refused to take any medication or was absent at medication rounds. Although Mr Gavenor was advised by medical staff about the potentially detrimental consequences of failing to take his medication, he continued to refuse, indicating that he was relying on "spiritual healing".

There was a notable decline in Mr Gavenor's behaviour from July 2017, perceived as unusual by others. He was referred to the Prison Mental Health Service (PMHS), after appearing *'psychotic'* in the unit.

On 11 August 2017, Mr Gavenor was seen by PMHS and referred to Assessment Services. He refused to engage with the service and asked to be removed from the Mental Health Unit, claiming that the psychologists did not understand 'black magic' in his culture. In the following days, Mr Gavenor was highly agitated and threatening, and he was placed on a Safety Order. He underwent a psychiatric review which concluded that he had a relapse of bipolar affective disorder.

A multidisciplinary meeting discussing Mr Gavenor's condition and recent behaviour, concluded that he would be continued to be monitored with Indigenous support. Mr Gavenor continued to refuse medications and medical appointments in favour of 'spiritual healing'. Correctional staff were not formally advised that Mr Gavenor frequently refused medication.

On 19 September 2017, Mr Gavenor was involved in two relatively minor altercations with another prisoner, Michael McKinley. Mr Gavenor was the aggressor in both incidents. On the second occasion punches were exchanged by both prisoners for about one minute. Mr Gavenor collapsed soon after. Assistance was rendered by fellow prisoners who placed him into the recovery position and was then continued by Custodial Correctional Officers (CCO). He was initially responsive but semi-conscious. Mr Gavenor deteriorated after medical staff arrived and he was unable to be revived.

The investigation

The Corrective Services Investigation Unit (CSIU) obtained correctional files and medical records, together with statements from the relevant prisoners, custodial correctional officers and medical staff.

Mr Gavenor's family identified specific queries and concerns about the incident at the time of his death. The CSIU investigation encompassed these as well as, the management of Mr Gavenor while in custody, criminal responsibility of Mr McKinley, and the incident response, which included the medical treatment he was provided while in custody.

An autopsy opined the cause of death was coronary atherosclerosis and minor trauma. It was noted that Mr Gavenor's collapse was consistent with a sudden cardiac problem, precipitated by fairly rigorous exercise in an overweight male, subsequently found to have substantial coronary artery narrowing.

The State Coroner was further assisted by a report from the Clinical Forensic Medicine Unit. The report concluded that there was no issue with the delivery of health services to Mr Gavenor, commenting that his sudden collapse from an acute cardiac event could not have been foreseen, and the outcome for individuals who suffer a sudden cardiac arrest remains extremely poor.

The Office of the Chief Inspector (OCI), Queensland Corrective Services appointed investigators to examine Mr Gavenor's death. The OCI Report noted that it was well known by correctional staff that Mr Gavenor was non-compliant with his medication as he was suspicious of 'white man's medicine'. The TCC Cultural Liaison Officer told investigators that he wondered whether Mr Gavenor's erratic behaviour shortly before his death may have been because he was 'spiritually troubled'.

Three primary issues were identified as a result of the OCI investigation, which may have contributed to the occurrence of the incident; lack of shared health information, cultural liaison issues and suitability and training of McKinley in his role. The OCI Report made a number of recommendations, five of those fell within the scope of the inquest focusing on:

- Information sharing with Queensland Health – ensuring QCS staff are provided with sufficient information about prisoners' medical conditions; and proper documentation of multidisciplinary meetings
- Prisoners who refuse medications – QCS and TCC to consider what further action can be taken when prisoners with known life-threatening conditions refuse to take medication
- Cultural issues – TCC should consider the development and implementation of centre-specific strategies for cultural responsiveness and safety in the management of Aboriginal and Torres Strait Islander prisoners
- Case noting

QCS adopted the above recommendations and are continuing to liaise with the relevant stakeholders about the review and development of new strategies and potential policies to assist in these areas.

The inquest

The inquest was held at Townsville and heard evidence from six witnesses were called to give evidence at the inquest. At the conclusion of the evidence, written submissions were provided by Counsel Assisting which were largely adopted by the other parties.

Findings and comments

The State Coroner accepted that the medical (mental and physical) care and treatment provided to Mr Gavenor while at the TCC was appropriate in the circumstances, as was the response by CCOs and medical staff following Mr Gavenor's collapse. The State Coroner found that the further measures being implemented and considered by the TCC, and QCS Statewide Operations in response to the OCI report were appropriate.

The State Coroner commented that such measures would have been unlikely to have changed the outcome of Mr Gavenor's case, given he suffered an unforeseeable acute cardiac event.

Having regard to the QCS response to the OCI recommendations and ongoing work on information sharing between QCS and Queensland Health, the State Coroner accepted that there were no comments or recommendations to be made that would assist in preventing similar deaths in the future.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0004/633415/cif-gavenor-ag-20191121.pdf.

ROBERT DOUGLAS SKILTON

State Coroner, Terry Ryan – 5 December 2019

Robert Douglas Skilton was 73 years of age when he died in the Wolston Correctional Centre (WCC) on 29 April 2018. Mr Skilton was sentenced to life imprisonment on 3 October 1975.

Circumstances of the death

Mr Skilton had a 59 year smoking habit ending when tobacco was banned in correctional centres in 2015. Mr Skilton's history displayed extensive avoidance of medical treatment since his incarceration of over 43 years began. The only record of self-referring to a doctor was an appointment on 10 April 2018 with the WCC medical officer. Mr Skilton was observed as emaciated in appearance and with a wheeze on the left side of his chest.

On 19 April 2018, Mr Skilton was transferred to the Princess Alexandra Hospital (PAH) Emergency Department for imaging. A CT scan confirmed a large right lung mass compressing vital structures. The likely diagnosis of advanced pulmonary malignancy was discussed with Mr Skilton and he understood that it was likely to be incurable.

On 24 April 2018, a bronchoscopy was performed, providing a tissue diagnosis of squamous cell carcinoma (non-small cell lung cancer) with advanced staging. During the recovery period of the biopsy, Mr Skilton incurred complications including tachyarrhythmia, tachypnea and hypoxemia. Mr Skilton was scheduled to commence palliative radiotherapy for comfort/symptom control the following week.

On 28 April 2018 at approximately 8.20pm, a rapid response call was made due to the onset of acute respiratory distress with tachycardia and tachypnea. Comfort measures were taken in accordance with Mr Skilton's Acute Resuscitation Plan. He was declared deceased at 12.30am.

The investigation

The QPS Corrective Services Investigation Unit (CSIU) investigated. An external autopsy examination and CT were conducted which found the cause of death as lung cancer.

The State Coroner also sought an expert medical opinion on the cause of death from the Clinical Forensic Medicine Unit which noted that the medical examination conducted on 10 April 2018 was comprehensive and of a high standard. Mr Skilton had died 18 days after his first appointment with the WCC medical officer. The report commented that while Mr Skilton's x-ray request were not processed in a timely way, it did not cause significant or outcome-changing delays in his management as his lung disease was incurable and rapid deterioration was expected.

The inquest

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

Findings and comments

The State Coroner accepted that the death was from natural causes with no suspicious circumstances. The State Coroner was satisfied that the treatment provided by the PAH was appropriate. The circumstances of Mr Skilton's death did not call for any comments or recommendations.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0008/635372/cif-skilton-rd-20191205.pdf.

FRANK LESLIE BURROWS

State Coroner, Terry Ryan – 5 December 2019

Frank Burrows was 58 years of age when he died on 23 November 2016. He had been imprisoned for over 28 years for two counts of murder. He was in custody at the Townsville Correctional Centre (TCC). Mr Burrows had an extensive medical history including morbid obesity, minor lymphadenopathy of the neck and chest, severe microcytic anaemia, rectal bleeding, dyslipidaemia and internal haemorrhoids. He had been largely wheelchair bound for several years prior to his death.

Circumstances of the death

On 6 October 2016, Dr Kault saw Mr Burrows at the TCC medical unit where Mr Burrows presented with nausea, intermittent fevers and excessive thirst. Blood tests were ordered. On 20 October 2016, he was recalled to the TCC medical unit due to very high inflammatory markers detected on his blood analysis and referred to the General Medical/Rheumatology Clinic at the Townsville Hospital. He was put on the waiting list for a specialist review and advice. On 7 November 2016, Mr Burrows presented to the TCC medical unit with diarrhoea, chills, sweats and vomiting. Mr Burrows declined hospitalisation.

Three days later, a nurse spoke to Mr Burrows about the need to investigate his symptoms. Mr Burrows agreed to be transferred to the Townsville Hospital for assessment and was noted to have had a febrile illness for two weeks with fevers, sweats, shaking and diarrhoea. His vital signs were normal he was returned to TCC the next day with his discharge summary reading "possible post-viral autoimmune phenomenon" and a recommendation to expedite the rheumatology review.

On 12 November 2016, nursing staff noted that Mr Burrows was 'grey' and struggling for breath. The Queensland Ambulance Service was called, and he was transferred back to Townsville Hospital. A medical review on 13 November 2016 noted low blood counts on all three lines and raised CRP (non-specific inflammatory marker). A multidisciplinary medical review was arranged including haematology, infectious diseases, gastroenterology and cardiology. Cardiology reviewed Mr Burrows on the same day and arranged an echocardiogram which revealed normal cardiac function. The gastroenterology registrar reviewed Mr Burrows on 15 November 2016 and opined that the underlying cause may be infectious, with a differential diagnosis of lymphoma. Several infectious disease tests and iron studies were ordered.

On 14 November 2016, Dr Kault sent an email to the Senior Staff specialist expressing his concern about Mr Burrows discharge on 10 November and re-admittance on 12 November. Dr Brown replied on 16 November 2016, stating that the assessment undertaken was reasonable. At approximately 7:30pm on that day Dr Yu, the haematology registrar, attended Mr Burrows for review. At this time, Mr Burrows was acutely unwell with drowsiness, dyspnoea (shortness of breath), mild fever, worsening liver function and very high ferritin count (iron protein). Dr Yu noted in the medical records that Mr Burrows possibly had lymphoma, with a differential diagnosis including infective, rheumatological or solid organ malignancy with metastases. At 9:48pm, a MET call was made for hypotension. Mr Burrows was transferred to the ICU where he was intubated and ventilated. From the medical records, it appears the hypotension was secondary to sepsis; however, his microbiology was negative.

On 17 November 2019, Dr Yu had discussions with the consultant physician and haematologist (Dr Cowtan and Dr Morris respectively) and HLH was suggested as a possible diagnosis with a possibility of underlying lymphoma. A bone marrow trephine biopsy was arranged for tissue diagnosis on 18 November 2016, which confirmed the diagnosis of HLH. His condition worsened; he was ventilator dependent, on dialysis and failed to wake off sedation. His liver function was continuing to deteriorate and there was concern for coagulopathy and disseminated intravascular dysfunction. On 21 November 2016, he was found in multi-organ failure with a poor prognosis. He died on 23 November 2016.

Investigation

The QPS Corrective Services Investigation Unit (CSIU) investigated Mr Burrows death. An external and full internal examination of the body, toxicology, microbiology and histology investigations revealed the cause of death was given as Haemophagocytic lymphohistiocytosis, due to or as a consequence of T-cell lymphoma (nasal type).

The CFMU conducted a review of Mr Burgess' care and considered whether there may have been an opportunity to intervene to prevent Mr Burrows' death on three occasions:

- ENT Outpatients 17 July 2013 - that the enlarged hilar and mediastinal nodes may well have indicated the presence of lymphoma. However, to diagnose the condition would require a high-risk operation to access the nodes, located close to major chest vessels.
- Failure to admit to hospital on 10 November 2016 - Mr Burrows did not present as constitutionally unwell and his discharge back to prison by Dr Brown was not unreasonable at the time.
- Haematological intervention earlier than 16 November 2016 - reiterated that the treating team had recommended reviews from several specialist teams on 13 November 2016, gastroenterology on 15 November and haematology on 16 November. It was the haematology review that had made the possible diagnosis of HLH through the ferratin test. While a ferratin test is a matter of routine in iron studies, had a haematology review been conducted, and the ferratin test ordered earlier, it is arguable that HLH may have been diagnosed earlier.

The inquest

All of the statements, medical records and material gathered during the investigation were tendered. Counsel Assisting proceeded immediately to make submissions in lieu of any oral testimony. The focus of the inquest was the appropriateness the medical treatment provided to Mr Burrows in the 12 months prior to his death at the TCC and the Townsville Hospital.

Findings and comments

The State Coroner found that Mr Burrows died from a very rare and rapidly progressing syndrome known as HLH that develops from excessive immune activation which is triggered by infection or malignancy (commonly blood cancers).

The State Coroner accepted that the comprehensive examination and consideration of Mr Burrows' history by the medical teams at the Townsville Hospital was impressive, and noted that they were thorough, timely and appropriate.

The State Coroner noted that there were only 11 days between his admission to the Emergency Department and his death, and found that, while there may have been opportunities to diagnose Mr Burrows marginally sooner than 17 November 2016, the decisions made did not affect the outcome. The State Coroner made no recommendations or referrals in this matter.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0005/635369/cif-burrows-fl-20191205.pdf.

STEVEN LESLIE HARRISON

State Coroner, Terry Ryan – 5 December 2019

Steven Leslie Harrison was 61 years of age when he died in the Wolston Correctional Centre (WCC). Mr Harrison had a medical history of hepatitis C infection, Type 2 Diabetes, Parkinson's disease/restless leg syndrome and chronic lower back pain. He had advised doctors that he was a heavy smoker and used speed and heroin intravenously.

Circumstances of the death

In July 2016, Mr Harrison was arrested remanded at the Brisbane Correctional Centre (BCC). He advised that he was taking medications for diabetes and back pain, as well as a daily dose of Valium. He advised that he was in withdrawal from heroin use, having injected it daily for the previous eight months.

On 16 August 2016, Mr Harrison was transferred to the WCC. During his orientation to WCC medical services with a nurse, he asked for pain medication for his back. The nurse explained that pain medication had not been prescribed at BCC, so Mr Harrison would need to see the VMO at WCC and have his medical records available for the VMO to see.

On 30 August 2016, Mr Harrison attended an appointment with the VMO. A range of blood and urine tests were ordered as well as an x-tray of his lumbar spine. On 8 September 2016, Mr Harrison had the x-ray which reported changes to his spine and various discs, revealed "age advanced atherosclerotic calcifications of the abdominal aorta, for correlation with vascular risk factors".

On 7 October 2016, Mr Harrison was convicted for the offences he was on remand for and sentenced to 2 years 6 months imprisonment. On 9 October 2016, Mr Harrison sent a letter to the person in charge of the medical clinic asking to see a different doctor because he was not happy with the doctor's attitude towards "supplying S8 medications for inmates". He subsequently saw a different doctor on 26 October 2016.

On 10 November 2016 at 8.52am, Mr Harrison used the emergency intercom in his cell to advise corrective services staff that he "can't breathe properly". A *Code Blue* was called, and nurses responded immediately. Mr Harrison was placed on a trolley and taken to the health centre. He was pale, sweating

heavily, and saying “I can’t breathe”. On arrival at the health centre, Mr Harrison’s heartrate was 108bpm and he appeared to be in atrial fibrillation, and he was placed on oxygen. At 9.08am the Queensland Ambulance Service (QAS) was called.

Nurses tried to insert an IV line but was unsuccessful due to the poor state of Mr Harrison’s veins from his history of intravenous drug use. QAS officers arrived at 9:20am, and also unsuccessfully tried to insert an IV line. At 9:25am, Mr Harrison’s heart stopped beating and he became unresponsive. The QAS officers commenced CPR with a Laryngeal Mask Airway Device (LMA) and attempted to use a defibrillator, but no shockable rhythm was detected.

At 9:55am a QAS Critical Care Paramedic (CCP) arrived and intubated Mr Harrison so ventilation could be performed more effectively than with the LMA, and CPR continued for the next 40 minutes. At that point, the decision was made to discontinue first aid, as Mr Harrison was not responsive. Mr Harrison was declared to have died at 10:10am.

The investigation

The QPS Corrective Services Investigation Unit (CSIU) investigated. A full internal autopsy examination revealed that Mr Harrison had severe narrowing of his coronary arteries and extensive areas of scarring or fibrosis in his heart. The cause of death was opined as coronary atherosclerosis.

An expert medical opinion from the Clinical Forensic Medicine Unit saw no reason to be critical of the care provided to Mr Harrison on the day of his death. However, Dr Home considered that Mr Harrison should have been assessed and offered medication to reduce his risk of cardiovascular complications earlier during his incarceration; given his age and risk factors, particularly poorly controlled diabetes it could be presupposed that Mr Harrison had cardiovascular disease that likely exceeded the level normally seen in individuals of his age.

In respect of the Prison Health Service’s (PHS) management of prisoners with diabetes, The Clinical Director advised of two initiatives, both of which commenced after Mr Harrison died:

a. The development and implementation of a standardised way of prescribing insulin across the service using a short stay-based insulin form specifically adapted for use in prisons; and

b. the appointment of a Nurse Practitioner (NP) ‘Nurse Navigator for Chronic Disease Management’: the NP’s works with patients with other chronic disease, but much of her work has been with diabetic patients, and involves developing care plans, diabetic medication management, ensuring they have relevant checks for complications of diabetes and implementing the insulin order form

West Moreton Health Service advised that Mr Harrison would have been managed more vigorously today considering the following changes implemented since his death, namely:

i. Appointment of the Nurse Practitioner / Nurse Navigator model for Chronic Disease Management

ii. A new reception and Medical Request Triage system

iii. Updating rebooking system

At present, correctional facilities do not operate using an electronic record system. It was acknowledged that this would assist with information sharing of consumers health issues across all prison health services, prison mental health service, GP and other health service providers. Currently, there is no definite date for the implementation of the Corrections electronic Medical Record system.

The inquest

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

Findings and comments

The State Coroner accepted that the death was from natural causes with no suspicious circumstances. The State Coroner was also satisfied with the measures implemented by West Moreton Health since Mr Harrison's death, including more thorough management of prisoners with chronic diseases, sufficiently address the concerns about the lack of assessment and provision of medication to reduce the risk of cardiovascular complications earlier in Mr Harrison's incarceration.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/635370/cif-harrison-sl-20191205.pdf.

RODNEY DICK PASCOE

State Coroner, Terry Ryan – 5 December 2019

Rodney Dick Pascoe was a 53 year old Indigenous man who had a number of conditions: alcoholic liver disease, hepatic encephalopathy, ischaemic heart disease, hypertension, non-insulin dependent diabetes mellitus, recurrent urinary tract infections, and was a smoker. In the 12 months prior to his death, Mr Pascoe was incarcerated twice.

Circumstances of the death

During a period of remand at LGCC in July 2017, he was deemed to be palliative for end of stage liver disease and received regular medical treatment and follow up while on remand at LGCC through the Mareeba Hospital. After being released from LGCC on 20 November 2017, Mr Pascoe was admitted to the Mareeba Hospital for nursing care, his function gradually declined to the point he needed full-time nursing care.

On 5 January 2018, Mr Pascoe was once again remanded at LGCC for sentencing in relation to a number of offences. He was scheduled to be sentenced in the Cairns Magistrates Court on 9 March 2018. On 8 January 2018, Mr Pascoe was taken to the Cairns Hospital for treatment of suspected hyperglycaemia, however he was deemed fit for custody. Mr Pascoe was not administered or prescribed any medication. His condition was monitored until he was collected by Correctional Officers from LGCC on 9 January 2018

Mr Pascoe was admitted to Mareeba Hospital a further four times, the final admission occurring on 14 February 2018. His care needs were reportedly beyond that which could be provided to him at LGCC, and he subsequently received full time nursing care at the Mareeba Hospital.

On 18 February 2018, a CT scan established Mr Pascoe had severe hepatic encephalopathy. On 20 February 2018, in consultation with the Adult Guardian, all interventions provided to Mr Pascoe were ceased. The following day, the Mareeba Hospital staff enquired whether Mr Pascoe could be granted bail or parole as his death appeared imminent. Unfortunately, as a remand prisoner Mr Pascoe was not eligible for parole nor was a bail application lodged on his behalf. On 22 February 2018, Mr Pascoe stopped breathing and was declared life extinct at 1.40am.

The investigation

A targeted investigation by the Corrective Services Investigation Unit (CSIU) obtained correctional files and medical records from the LGCC and Mareeba Hospital, together with statements from the relevant custodial correctional officers and medical staff. Mr Pascoe's family did not express any concern about the care he had received in prison or at the hospital. An autopsy found evidence of pleural adhesions, cirrhosis, chronic pancreatitis and bilateral pneumonia. The cause of death was opined as pneumonia due to hepatic encephalopathy, which was due to cirrhosis.

The State Coroner was further assisted by a report from the Clinical Forensic Medicine Unit which noted that there was no reason to be critical of the care provided to Mr Pascoe by Offender Health Services, Cairns Hospital and the Mareeba Hospital, particularly during the two months prior to his death.

The inquest

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

Findings and comments

The State Coroner accepted that the death was from natural causes with no suspicious circumstances. The circumstances of Mr Pascoe's death did not call for any comment relating to issues of public health and safety or the administration of justice or ways to prevent deaths from happening in similar circumstances.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0007/635371/cif-pascoe-rd-20191205.pdf.

BRENDON JOHN LAHRS

State Coroner, Terry Ryan – 6 December 2019

Brendon John Lahrs was 27 years old when he died. He had been in custody at the Southern Queensland Correctional Centre (SQCC) for over six years. On 2 September 2013, he was sentenced to 10 years imprisonment for manslaughter.

Circumstances of the death

In May 2016, Mr Lahrs was diagnosed with a rare terminal cancer, referred to as Ewing's sarcoma. He immediately commenced chemotherapy which involved being transported to the Princess Alexandra Hospital Secure Unit (PAHSU) for review and treatment at least twice a month.

Further scans in November 2016 revealed the cancer was refractory to treatment, chemotherapy was ceased, and treatment instead was changed to palliative radiotherapy.

In March 2017, Mr Lahrs was admitted to the PAHSU with worsening shortness of breath, increasing lower limb fluid retention, abdominal distension and lower back pain. The following day he was moved from the PAHSU to the Oncology Unit for palliative care.

On 12 March 2017, Mr Lahrs' family attended the Oncology Unit to celebrate his 27th birthday with him, which was on 13 March. Shortly before midnight nursing staff were called to Mr Lahrs' room as he appeared to be nearing the end of his life. Mr Lahrs was declared deceased at 12.14am

The investigation

A targeted investigation into the circumstances surrounding Mr Lahrs' death was conducted by the Corrective Services Investigation Unit (CSIU). Correctional files and medical records from the SQCC and PAH were obtained, together with statements from the relevant custodial correctional officers and medical staff.

Mr Lahrs' family did not express any concern about the circumstances of his death. An external autopsy examination, which included a CT scan revealed a large tumour mass within the right side of the chest with metastatic deposits within the lungs and liver, and fluid within the left chest cavity. The cause of death was opined as metastatic sarcoma.

The State Coroner was further assisted by a report from the Queensland Health Clinical Forensic Medicine Unit (CFMU), who noted that there was no reason to be critical of the care provided to Mr Lahrs by Offender Health Services or the PAH, nor did his treatment raise any areas of concern.

The inquest

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

Findings and comments

The State Coroner accepted that the death was from natural causes with no suspicious circumstances. The circumstances of Mr Lahr's death did not call for any comments or recommendations to prevent deaths from happening in similar circumstances.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0007/635920/cif-lahrs-bj-20191206.pdf.

DARREN RODNEY TAYLOR

State Coroner, Terry Ryan – 6 December 2019

Darren Rodney Taylor was an Indigenous man aged 52 years when he died in the Princess Alexandra Hospital Secure Unit (PAHSU). Prior to his admission to hospital he was an inmate at the Wolston Correctional Centre (WCC) since 13 December 2012.

Circumstances of the death

On 2 March 2017, Mr Taylor first presented to the WCC medical centre with pain in his stomach and chest. Mr Taylor presented a further three times before he was transported to the PAHSU with severe abdominal pain and hypertension.

On 24 March 2017, Mr Taylor was diagnosed with high grade neuroendocrine cell carcinoma with metastasis to the liver, abdomen and lymph nodes. His condition was not amenable to surgery and Mr Taylor completed an Acute Resuscitation Plan (ARP) indicating he wanted comfort cares along with antibiotics.

On 12 July 2017, Mr Taylor was found in a confused state with low oxygen saturations and a non-recordable blood pressure. He was transferred to the PAHSU where he was diagnosed with multi-organ failure due to recurrent biliary sepsis that was likely terminal. The following day Mr Taylor was in clear distress due to abdominal pain and a decision was made to cease active treatment and transition to comfort cares. His condition deteriorated and he was subsequently declared deceased at 7:16am on 14 July 2017.

The investigation

The QPS Corrective Services Investigation Unit (CSIU) investigated the death. An external autopsy examination with associated CT scans and toxicology testing was conducted and found the cause of death to be metastatic neuroendocrine carcinoma.

The State Coroner also sought an expert medical opinion from the Clinical Forensic Medicine Unit which found no reason to be critical of the care provided to Mr Taylor by Offender Health Services or the PAH, nor did he find any areas of concern.

The inquest

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

Findings and comments

The State Coroner accepted that the death was from natural causes with no suspicious circumstances and was satisfied that he received adequate and appropriate medical care while in prison and at the PAH. The circumstances of Mr Taylor's death did not call for any comment relating to issues of public health and safety or the administration of justice or ways to prevent deaths from happening in similar circumstances.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0008/635921/cif-taylor-dr-20191206.pdf.

TERENCE NEIL BURGESS

State Coroner, Terry Ryan – 6 December 2019

Terence Burgess was a 50-year-old man who was incarcerated at the Southern Queensland Correctional Centre (SQCC). Mr Burgess had a significant medical history which included hardening and narrowing of the heart valve, mitral regurgitation, and ischaemic cardiomyopathy.

Circumstances of the death

On 25 July 2017, Mr Burgess was transferred to the PAH having experienced acute exacerbation of shortness of breath. After he was advised surgery for his worsening heart condition would be optimal, Mr Burgess declined any further investigations or surgery and asked to return to SQCC the same day.

Mr Burgess was re-admitted on 28 July 2017 with worsening symptoms and advised that he had stopped taking his prescription medications. He declined surgery but agreed to recommence his medications and take anticoagulation medication.

On 7 August 2017, he suffered a further myocardial infarction. On 9 August 2017, the PAH palliative care team reviewed Mr Burgess and he completed an Acute Resuscitation Plan (ARP). The ARP reflected Mr Burgess' request for comfort cares and he expressly declined the provision of intervention/treatment of all resuscitation efforts. There was agreement amongst the treating practitioners that Mr Burgess had capacity to refuse medical treatment.

On the morning of 11 August 2017, Mr Burgess was reviewed, provided with his medications and was monitored hourly during his admission on CCTV footage and face to face.

At 10:30am Mr Burgess made a telephone call and spoke with family members. At 1:40pm, Mr Burgess was provided with afternoon tea and his regular medications. At 2:40pm he notified staff his constipation had resolved. The supervising medical practitioner confirmed Mr Burgess could be discharged back to the SQCC.

At approximately 3:30pm, Dr Balasubranamiam attended on Mr Burgess and found him unresponsive on the floor. Mr Burgess had no pulse, was breathing but then ceased, and his pupils were fixed and dilated. After considering his wish not to be resuscitated, Dr Balasubranamiam alerted staff for assistance and Mr Burgess was moved from the floor to his bed and declared him deceased at 3:40pm.

Investigation

The QPS Corrective Services Investigation Unit (CSIU) investigated the circumstances leading to Mr Burgess' death.

The cause of death, based on a review of the medical records, external post-mortem examination and associated testing including CT scanning, was identified as ischaemic and valvular heart disease (severe aortic stenosis). The degree of Mr Burgess' heart disease was of such severity that sudden collapse and death could have occurred at any time.

The Clinical Forensic Medicine Unit conducted a review of Mr Burgess' care which noted, Mr Burgess "was adamant he did not want any invasive treatment including aortic valve replacement surgery or

further angioplasty, despite numerous discussions with doctors advising him his condition was treatable. As a result, his management was restricted to pharmacological therapies".

The inquest

All the statements, medical records and material gathered during the investigation were tendered. Counsel Assisting proceeded immediately to make submissions in lieu of any oral testimony. The focus of the inquest was the appropriateness the medical treatment provided to Mr Burgess in the 12 months prior to his death and while at the PAH from 25 July 2017 to 11 August 2017.

Findings and comments

The State Coroner found that Mr Burgess' death was from natural causes with no suspicious circumstances associated with it. The State Coroner was satisfied that Mr Burgess was given appropriate medical care by staff at SQCC and the PAH while he was admitted there. His death could not have reasonably been prevented. The State Coroner made no recommendations or referrals in this matter.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0005/635918/cif-burgess-tn-20191206.pdf.

MARK GRAHAM NEWSTEAD

State Coroner, Terry Ryan – 25 May 2020

Mark Graham Newstead was 51 years of age when he died at the Princess Alexandra Hospital (PAH) Secure Unit. He was placed at the Brisbane Correctional Centre (BCC) on 4 January 2018 for charges including fraud, stealing and drug possession.

Mr Newstead had a lengthy history of engagement with mental health services and a number of medical conditions, including intravenous drug use; untreated hepatitis C with associated liver cirrhosis, splenomegaly and portal hypertension; intellectual impairment; type 2 diabetes; hypertension; gastro-oesophageal reflux; and lower back pain.

In late 2017 the Queensland Civil and Administrative Tribunal (QCAT) appointed the Public Guardian as Mr Newstead's guardian for the provision of services, including decisions around legal matters as well as personal matters relating to accommodation, and health care.

Circumstances of the death

During his last period on remand at BCC, Mr Newstead was assessed on three occasions primarily for treatment of injuries, including fractured ribs and clavicles, which he had sustained before being incarcerated in 2017.

On two occasions in mid to late January, Mr Newstead reported groin pain and some difficulty passing urine. On the second occasion, he also reported the onset of lower limb weakness, and he was transported to the emergency department of the PAH for treatment. An urgent MRI showed evidence of an epidural abscess causing severe spinal cord stenosis with an associated pathological fracture of the third thoracic vertebrae. Also seen were lesions in the twelfth thoracic and first lumbar vertebrae that were thought to be abscesses or less likely metastases.

Mr Newstead underwent urgent surgery to relieve the pressure on his spinal cord. However, Mr Newstead's symptoms did not improve, and he became progressively weaker leading to a complete loss of muscle function. On 1 February 2018 the results of further investigations showed that Mr Newstead was suffering from malignant small round cell tumour, likely Ewing's Sarcoma (a bone or soft tissue cancer). On 5 February 2018, Mr Newstead was commenced on a course of radiotherapy to his thoracic spine.

On 8 February 2018, a scan confirmed that Mr Newstead had widespread advanced metastatic Ewing's Sarcoma which was untreatable and terminal. The following day he commenced palliative care and was then transferred to the Palliative Care Team at the PAH on 12 February 2018.

A letter was sent from the Palliative Care Team to BCC on 22 February 2018 seeking compassionate release to a palliative care unit for end of life care. However, Mr Newstead's condition deteriorated before a formal decision could be made and he died on 4 March 2018.

Investigation

The QPS Corrective Services Investigation Unit (CSIU) investigated the circumstances leading to Mr Newstead's death. On 7 March 2018 an autopsy consisting of an external examination of the body, a CT scan and toxicology testing concluded that the cause of death was metastatic small round cell tumour. Other significant conditions found to have contributed to his death were liver cirrhosis, diabetes, hypertension and schizophrenia.

The Clinical Forensic Medical Unit conducted a review of Mr Newstead's care in custody with an opinion, Mr Newstead was managed appropriately by the PAH and Offender Health Services with input from the Public Guardian.

The inquest

All of the statements, medical records and material gathered during the investigation were tendered. Counsel Assisting proceeded immediately to make submissions in lieu of any oral testimony.

Findings and comments

The State Coroner found that Mr Newstead's death was from natural causes and that there were no suspicious circumstances associated with it. The State Coroner was satisfied that Mr Newstead was given appropriate medical care by staff at BCC and at the PAH, and that his death could not reasonably have been prevented.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0003/650784/cif-newstead-mg-20200525.pdf.

LAWRENCE SYLVESTER SMITH

State Coroner, Terry Ryan – 25 May 2020

Lawrence Sylvester Smith was 81 years of age at the time of his death. He was a remand prisoner at the Capricornia Correctional Centre (CCC) and detained under the *Dangerous Prisoners (Sexual Offenders) Act* 2003. Mr Smith suffered from multiple co-morbidities at the time of his reception at the CCC in late 2015.

Circumstances of the death

After his release from custody for multiple counts of incest and indecent (and attempted indecent) treatment of a child, Mr Smith was subject to a supervision order under the *Dangerous Prisoners (Sexual Offenders) Act 2003*. The remainder of his criminal history related to breaches of this order.

On 2 November 2017, in the absence of suitable community-based nursing accommodation, the Supreme Court of Queensland rescinded the supervision order. The Court ordered that Mr Smith be detained in custody for an indefinite term for control, care and treatment. The expert evidence given to the Court was that Mr Smith was an elderly man (80 years old) suffering advancing dementia and various cognitive impairments, and his overall condition was expected to deteriorate over time. He suffered from multiple co-morbidities including Type 2 Diabetes, eye disease, cardiovascular disease, hypercholesterolemia, angina, chronic kidney disease and congestive heart failure.

On 7 December 2017 during routine observations, Mr Smith was found with acute onset left side paralysis and dysphonia, having suffered a stroke. He was admitted to the Rockhampton Hospital where his condition rapidly declined, and by 18 December 2017, he could no longer move or speak, but could still open his eyes. Mr Smith died on 19 December 2017at 4:47am.

Investigation

The QPS Corrective Services Investigation Unit investigated the death. An external and internal examination of the body, a CT scan and toxicology testing was undertaken with the cause of death to be a massive right cerebral haemorrhage as a result of hypertensive heart disease. Contributing to death was severe calcific coronary artery atherosclerosis, a terminal right lower lobe bronchopneumonia and type 2 Diabetes Mellitus. Given Mr Smith's extensive medical history and his death from apparent natural causes, an independent medical review was not requested in relation to his care at the CCC or the Rockhampton Hospital.

The inquest

All of the statements, medical records and material gathered during the investigation were tendered. Counsel Assisting proceeded immediately to make submissions in lieu of any oral testimony.

Findings and comments

The State Coroner found that Mr Smith died from natural causes and that his death could not have reasonably been prevented. The State Coroner noted that is a recognised principle that the health care provided to prisoners should not be of a lesser standard than that provided to other members of the community. The evidence tendered at the inquest established the adequacy of the medical care provided to Mr Smith when measured against this benchmark.

The findings of inquest are available here or on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0009/650799/cif-smith-ls-20200525.pdf.

Higher courts decisions relating to the coronial jurisdiction

Where a person is dissatisfied with inquest findings or a decision by a coroner not to hold an inquest, they may apply to the State Coroner or the District Court. If the State Coroner declines the application, the person may apply to the District Court for an order that an inquest be held. The following section contains a summary of the decisions pursuant to the *Judicial Review Act 1991* handed down during the reporting period.

***Davis v Ryan, State Coroner* [2019] QCA 282 – 3 December 2019**

This decision involved an application to the District Court for an order to hold an inquest into the death of Mr Davis' wife. The District Court judge was not satisfied under s30(8) of the *Coroners Act* 2003 that holding an inquest would be in the public interest and dismissed the application. The applicant then sought leave to appeal from the District Court judge's decision. Ultimately, the Court of Appeal refused his application.

Mr Davis' wife took her own life in 2013. She had in the past been treated for a generalised anxiety disorder, and over the 3 months before her death had been under the care of a psychiatrist for that condition and for depression. The investigating coroner declined to hold an inquest into her death or into the management of the medical treatment she received prior to her death.

Mr Davis then applied to the State Coroner for an order than an inquest be held into her death. The State Coroner declined to order an inquest, considering that all relevant material was obtained in order to make the required findings into the all the necessary matters, and determined that it was not in the public interest to hold an inquest.

Mr Davis applied to the District Court for an order than an inquest be held into the death of his wife. In considering whether to exercise a discretion to order that an inquest be held, s30(8) of the *Coroners Act* 2003 required that a District Court judge be satisfied that it would be in the public interest to hold an inquest. Mr Davis' application was dismissed.

An extension of time was initially sought with respect to Mr Davis' appeal of the District Court decision. This application was granted by the Court of Appeal. His proposed grounds of appeal fell into three categories, corresponding to categories of error identified in *House v The King* (1936) 55 CLR 499:

i) The District Court judge had misconstrued the term "public interest", and consequently took into account irrelevant considerations by: looking to resourcing matters in deciding whether an inquest should be ordered; considering that applications refused by the State Coroner should not be granted lightly; and by considering that the recommendations arising from an inquest in this case would not be binding on the profession and unlikely to be supported by the medical profession;

ii) Mr Davis contended that the primary judge had wrongly taken into account peer professional opinion in considering whether Mrs Davis' doctors had breached their duty of care owed to her; and

iii) The primary judge failed to take into account a relevant consideration – namely, evidence of a widespread practice of dangerous prescribing.

The Court of Appeal, Holmes CJ, Gotterson JA and Flanagan J, acknowledged that Mr Davis' motives in making his application were worthy. However, the Court of Appeal held that Mr Davis had no prospect in demonstrating any *House v The King* error in the primary judge's exercise of discretion. Further, the matters alleged to be irrelevant considerations, were all relevant; the provisions said to be binding on the primary judge were not tenable here; and that primary judge did not err in his treatment of what was said to be evidence of dangerous prescribing practices.

***Jones v State Coroner & Anor* [2019] QSC 175 – 24 July 2019**

This matter involved a direction from the Attorney General for the State of Queensland to the State Coroner to reopen the initial inquest into the death of Mr Anthony Jones, after his disappearance, under the *Coroners Act* 1958. An application was made by Mr Anthony Jones' brother seeking declarations that the decision to reopen the inquest was unlawful; orders quashing the reopening and setting them aside; and an order referring the matter to the State Coroner with directions that he consider holding a new inquest under the *Coroners Act* 2003.

Mr Anthony Jones disappeared on about 3 November 1982. His body has never been found. An inquiry into a missing person commenced under s10 of the *Coroners Act 1958* ("the 1958 Act") between 1998 and 2002. Coroner Fisher found that Mr Anthony Jones is deceased, having died on or around the date of his disappearance at the hands of a person or persons unknown ("the initial inquest").

On 17 September 2010, the Attorney General directed the then State Coroner to reopen the initial inquest, which occurred on a date between 17 September 2010 and 2013 ("the reopened inquest"). The inquest was reopened under the 1958 Act. Proceedings commenced in August 2016, with evidence concluding in July 2017, and adjourned to a date to be fixed for the delivery of findings. On 29 March 2018, the State Coroner adjourned the reopened inquest pending the result of the Supreme Court judicial review decision.

This application was instituted on 3 April 2018. The applicant was Mr Anthony Jones' brother, Mark Jones, who was present during both inquests. However, another brother was the primary contact throughout all proceedings since Anthony's disappearance was reported. The Jones family were legally represented during the reopened inquest. The applicant argued that both the direction to consider reopening the inquiry and the decision to reopen the inquest were unlawful as those decisions were made pursuant to the 1958 Act, which had been superseded at the time of the reopened proceedings.

Justice Wilson dismissed the application on the grounds that the application was not made within a reasonable time after the decisions were made (some 6 to 7 years after the fact), and therefore refused to consider the application made by the applicant.

This application raised an interesting statutory construction issue in relation to the meaning of section 100 of the 2003 Act. Even though Justice Wilson refused to consider the application, Her Honour was of the view that the application would have failed in any event as the 1958 Act applied to these circumstances. Her Honour provided detailed discussions and reasons for this, in order to provide some finality to the Jones family as to this issue.

***Neumann v Hutton and Anor* [2020] QSC 17 – 2 March 2020**

This decision involved an application for judicial review of a Coroner's comments and referral of a Detective Senior Constable to the Queensland Police Commissioner arising out of the Detective Senior Constable's criminal investigations of the death. At the hearing, Mr Neumann's case was confined to seeking declarations that:

i) the Coroner's adverse comments were made in breach of the rules of natural justice;
ii) the conduct referral was made in breach of the rules of natural justice; and
iii) the conduct referral was made contrary to s46(3) of the *Coroners Act* 2003.

The application was dismissed on all three grounds by Justice Martin on 2 March 2020.

At about 7.40 pm on 22 August 2012, Shui Ki Chan was cycling home along the Warrego Highway after finishing his shift at the College View McDonalds. He was about one kilometre away from his home when, it appears, he was struck by a passing vehicle. His injured body came to rest in a ditch on the side of the road and he died, not from the injuries caused by the collision, but from hypothermia after lying in the ditch for the remainder of that cold winter evening.

The death was investigated by police and an inquest was held by Coroner Hutton. Detective Senior Constable Neumann had led the criminal investigation into the death. The inquest proceeded across 21 days sporadically between February and April 2016. Coroner Hutton delivered his findings on 2 November 2017, and included in his findings that [8]:

a) the criminal investigation conducted by Detective Senior Constable Neumann was inadequate; and

b) the assistance provided to me by Detective Senior Constable Neumann, during my investigation, was inadequate.

The Coroner went on further to refer Mr Neumann [10]:

"*Due to the inadequacies I have found with Detective Senior Constable David Neumann's criminal investigation, and with the assistance he provided to me during my coronial investigation, I refer his conduct to the Commissioner of the Queensland Police Service, for consideration as to whether any disciplinary action should be taken."*

The Supreme Court discussed the rules of natural justice to be flexible, and the content of the rule required consideration of the relevant legislation, nature and purpose of a coronial inquest, the circumstances being considered in the inquest, and the particular statements or actions being impugned.

Mr Neumann identified a series of nine events in the history of the inquest to support his contention that he was not afforded natural justice. These broadly revolved around:

i) Mr Neumann's conduct was not identified to the Court or the parties as an issue to be considered in the inquest at the pre-inquest conference, during the inquest, or at the conclusion of the evidence;

ii) Mr Neumann was not present for any hearing of the evidence, and the Coroner excused him from giving evidence;

iii) Significant information was not put before the Coroner with respect to contentions that Mr Neumann had attempted to obtain statements from many of the people proposed be called as witnesses by Counsel Assisting;

iv) Emails between Mr Neumann and Counsel Assisting were shown to the Coroner. Some of them were relevant to a consideration of Mr Neumann's conduct, but were not tendered in evidence nor were parties advised the Coroner had been shown the correspondence; and

v) Mr Neumann was first notified that his conduct was in issue on 13 October 2017 when he received Counsel Assisting's submissions, and he was allowed until 30 October 2017 to provide his response.

At the application, Mr Neumann accepted that he could have asked for the inquest to be reopened to deal with the matters raised in his submissions. One of the unusual elements in this case is that the coroner was obliged to conclude the inquest because his retirement date was fast approaching. This restricted the time available to Mr Neumann to make his submissions, but it was not contended that a request to reopen could not have been granted in the circumstances.

Mr Neumann submitted that there was no probative evidence that could reasonably support the Coroner's findings concerning him; the onus to prove such argument lies on the applicant. Given that the Coroner's Court is not bound by the rules of evidence, the Supreme Court concluded that the Coroner was entitled to rely upon material tendered during the inquest, oral testimony and the other documentary material generated by the applicant during the investigation. The Supreme Court therefore considered that was sufficient material to demonstrate that the applicant did not discharge the onus under this aspect of his case.

The heart of the applicant's argument was that a referral for disciplinary sanction was akin to civil liability. The Supreme Court rejected that argument, concluding that factual findings of a Coroner cannot be said to be findings of criminal or civil liability. Further, section 46(3) of the Coroners Act is not concerned with a reference to a disciplinary body which may result in a disciplinary proceeding.

The Supreme Court dismissed the application on the grounds that the applicant had not demonstrated any reason to make the declarations sought.

APPENDIX 1

Reportable death types within Queensland

Unknown identity

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

Suspicious circumstances

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

Violent or unnatural

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

Death in custody

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

Death as a result of a police operation

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

Death in care

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

Cause of death certificate is unlikely to be issued

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

Health care related

Broadly, this refers to a health procedure (i.e. dental, medical, surgical, diagnostic or health-related such as anaesthetic or drug), or any care, treatment, advice, provided for the benefit of human health. These deaths include those due to a failure to treat or diagnose, and clinical or medication incidents and errors. A death is health care-related if both:

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

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APPENDIX 2

Recommendations made in the Queensland Audit Office report

RECOMMENDATION 1:

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

- creating a governance board with adequate authority to be accountable for coordinating the agencies responsible for delivering coronial services and monitoring and managing the system's performance. This board could be directly accountable to a minister and could include the State Coroner and Chief Forensic Pathologist;
- more clearly defining agency responsibilities across the coronial process and ensuring each agency is adequately funded and resourced to deliver its services; and
- establishing terms of reference for the interdepartmental working group to drive interagency collaboration and projects, with consideration of its reporting and accountability. This should include its accountability to the State Coroner and/or a governance board if established.

RECOMMENDATION 2:

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

RECOMMENDATION 3:

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

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

RECOMMENDATION 4:

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

- ensuring the CCQ appoints appropriately experienced, trained and supported case managers to proactively manage entire investigations and be the central point of information for families. This should include formal agreement from all agencies of the central role and authority of these investigators;
- ensuring there is a coordinated, statewide approach to triaging all deaths reported to coroners to help advise the coroner on the need for autopsy;

- establishing processes to ensure families receive adequate and timely information throughout the coronial process. This should include notifying families at key stages of the process and periodically for investigations that are delayed at a stage in the process; and
- ensuring sufficient counselling services are available and coordinated across agencies to support families and inquest witnesses.

RECOMMENDATION 5:

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

RECOMMENDATION 6:

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

RECOMMENDATION 7:

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

APPENDIX 3

Presentations by Coronial Registrar, Ainslie Kirkegaard

10 July 2019:	Patient Safety & Clinical Improvement Service, Royal Brisbane and Women's Hospital – *Coronial management matters!*
22 August 2019:	Rockhampton Base Hospital Grand Rounds –*When to make THAT phone call….*
11 October 2019:	Queensland Children's Hospital Emergency Department – 11 October 2019
23 October 2019:	Townsville Hospital Intern Education – *When to make THAT phone call….*
6 November 2019:	Gladstone Hospital Grand Rounds – 6 November 2019 - *When to make THAT phone call….*
24 January 2020:	Greenslopes Private Hospital junior medical officer education – *When to make THAT phone call….*
19 February 2020:	Townsville Hospital Grand Rounds – *When to make THAT phone call….*
11 June 2020:	Royal Brisbane and Women's Hospital – interns - *When to make THAT phone call….*[29]

APPENDIX 4

Presentations by the Domestic and Family Violence Death Review Unit

19 July 2019:	Brisbane Central Community Corrections
4 October 2019:	Queensland Corrective Services Domestic and Family Violence Working Group Presentation
21 November 2019:	South Coast Community Corrections
5 December 2019:	Roundtable discussion with Dr Shilan Caman, member of the Swedish DFV Death Review Team
28 April 2020:	Child Death Review Board establishment working group

[29] Presentation by Alana Martens, A/Deputy Registrar