QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

2020-21
ANNUAL
REPORT

Acknowledgement of Country

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

The coronial system is underpinned by a shared understanding that society values and protects the life of every person. We appreciate that each death brings sadness, disruption, and trauma to the families of those who are entrusted to our care. When someone we love dies suddenly or in a way that is unexplained or unexpected, those feelings are magnified.

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

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on telephone (07) 3738 7050 and we will arrange an interpreter to effectively communicate the report to you.

22 September 2021

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 2021.

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.

During the reporting period the State Coroner's Guidelines were reviewed and updated in relation to *Chapter 4: Dealing with bodies*, specifically the management of therapeutic family viewings and organ donors post-retrieval. Minor amendments were also made to reflect that hospital records are now increasingly kept in electronic rather than paper format. 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

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 2020 to 30 June 2021. The report has been prepared in accordance with the requirements of the *Coroners Act 2003*. This report is accessible online at:

Publications | Queensland Courts

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
GPO Box 1649
Brisbane QLD 4001
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:

Coroners Court | Queensland Courts

We value your Feedback
The Coroners Court of Queensland values your feedback on this report. Any comments can be provided through the *Get Involved* website: Your say | Queensland Government (getinvolved.qld.gov.au)

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:
Resources | Queensland Courts

Contents

2020–21: IN REVIEW

Performance measures - cases

5,714
cases lodged

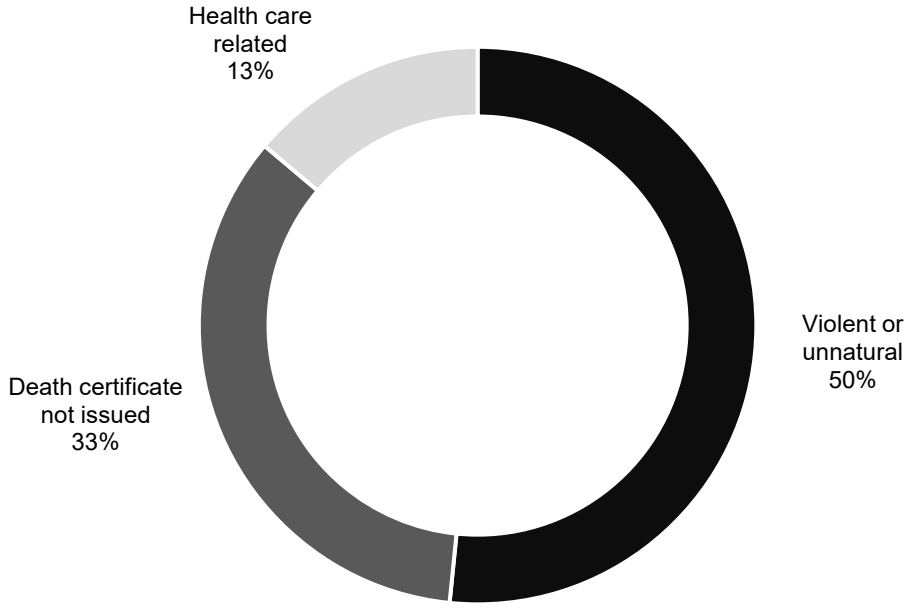
5,845
cases finalised

102.29%
clearance rate

14.18%
backlog indicator

Reportable types*

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



Timeframes

169
average days to finalise a case

81.76%
cases finalised in less than 12 months

Inquests and recommendations

26
inquests finalised

27
deaths investigated at inquest

21
recommendations made

State Coroner's Overview

I am pleased to present the Annual Report of the Coroners Court of Queensland for 2020-21.

The coronavirus pandemic continued to pose significant challenges for the wider community with ongoing lockdowns following the emergence of the Delta variant, travel restrictions and the vaccination rollout. However, the work of the Coroners Court was minimally impacted during lockdown periods. The court was increasingly able to conduct inquest hearings using audio-visual links to lawyers and witnesses. Court staff have continued to embrace remote working arrangements.

Coroners Court staff, and our colleagues in the Queensland Police Service and Queensland Health Forensic and Scientific Services, continued to capably support coroners in responding to reportable deaths over the past 12 months. The court was able to maintain a clearance rate over 100% for the third consecutive year, despite the increase in the number of deaths reported during the reporting period. The backlog of cases aged over 24 months remained at 14%.

During 2020-21 the Coronial Services Governance Board established in response to the Queensland Audit Office's 2018 *Delivering Coronial Services* Report continued to oversee the implementation of the QAO's recommendations. The work of the Board has now transitioned to a Coronial System Board chaired by the State Coroner with senior representatives from the Queensland Police Service, Queensland Health and the Department of Justice and Attorney-General, together with the Chief Forensic Pathologist. The Board will be supported by a Coronial System Coordination Group chaired by the Deputy State Coroner. These structures will help me with my role in coordinating and administering the coronial system under the *Coroners Act 2003*.

The Board's priorities for the next year include developing strategies to reduce the backlog of cases over 24 months, and to reduce the number of deaths (38%) that are reported to the Court but are found to be not reportable, including natural causes deaths reported only because a death certificate has not been issued by a medical practitioner (33%).

Emphasising the fact that coronial services are delivered in partnership, agencies involved in the system worked together in developing the Coronial Services System Delivery Framework 2021-2025. This Framework signifies the commitment of agencies to a system that works together through shared principles and responsibilities.

The 2021-22 Queensland Budget provided additional funding of $2.776M for the coronial system, including $1.011M recurrent funding and seven permanent staff for the Court to maintain reform improvements, to enhance triaging practices and case management practices to continue to strengthen Queensland's coronial system. Importantly, funding was provided to develop material for staff in relation to building resilience and managing vicarious trauma.

December 2020 saw the departure of Deputy Registrar Dr Don Buchanan, and July 2021 saw the retirement of Magistrate James McDougall. I acknowledge their invaluable contribution to the Queensland justice system. I thank Dr Buchanan and Mr McDougall for their valuable contributions to the coronial system over many years.

Our Coroners

Queensland has seven specialist coroners located across the State in Southport, Brisbane, Mackay, and Cairns. During 2020-21, the Chief Magistrate also allocated Magistrate Christine Roney to work in the coronial jurisdiction on a part-time basis.

State Coroner – Terry Ryan
State Coroner Terry Ryan was appointed as a magistrate and as 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 commenced his career in 1984 as a social worker in the fields of child protection and youth justice. Magistrate Ryan holds a Bachelor of Social Work, Bachelor of Laws (Hons), 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 Assistant Director-General, Strategic Policy, Legal and Executive Services in the Department of Justice and Attorney-General (DJAG). From 2010 up until his commencement with the Coroners Court, Magistrate Ryan was the Deputy Director-General of 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 more than 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.

Acting Deputy Registrar – Alana Martens

Alana Martens has been Counsel Assisting at CCQ for more than seven years. Alana has considerable advocacy experience having appeared as Counsel Assisting for a number of high profile health care related inquests. Alana has worked in a variety of roles in health law including at the Office of the Health Ombudsman, acting on behalf of medical and nursing staff in inquests and disciplinary proceedings and acting on behalf of families in medical negligence claims and inquests.

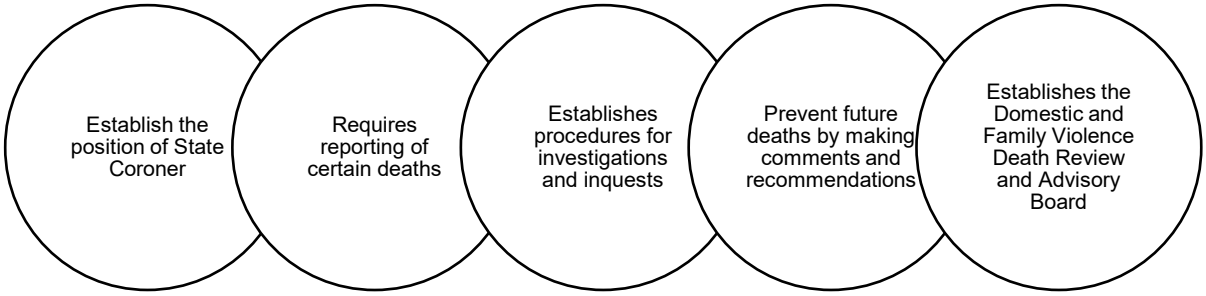
Queensland's Coronial System

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) and Queensland Health (QH).

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

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

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.

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.

Governance and Structure

The CCQ registry is part of DJAG and sits within the Magistrates Courts Service (MCS). 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 2021 under the leadership of Director, Ms Raelene Speers, the CCQ comprised 58 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 resources, burials assistance and contract management functions.

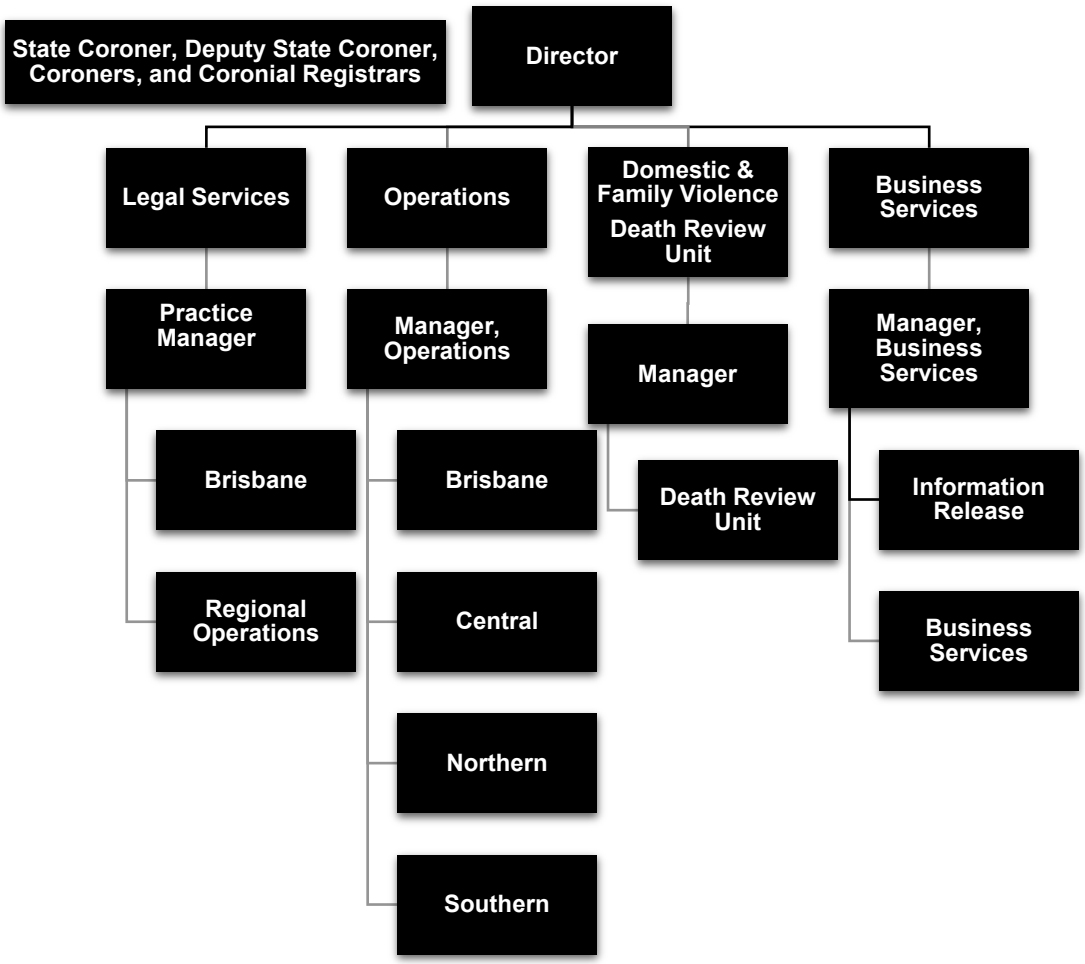
Legal Services:
In-house lawyers (known as counsel assisting) assist coroners in their investigations by providing legal advice on case files, preparing matters for inquest, as well as appearing as counsel assisting at inquests.

Operational Services:
Comprises officers who work closely with coroners and liaise with families and other stakeholders to case manage coronial investigations. 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.

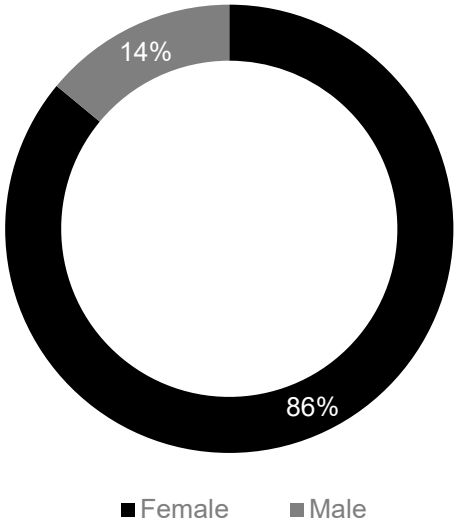
Domestic and Family Violence Death Review Unit:
Provides specialist advice and assistance to coroners in their investigation of domestic and family violence related homicides and suicides as well as deaths of children who were known to the child protection system prior to the death. The unit also provides 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, meets regularly to raise and examine any issues arising within the investigative and business functions of the Court; reviews court policies and procedures to ensure continued effectiveness; identifies training and professional development needs of court staff; discusses workload issues and progresses major projects. The Senior Leadership Team reports regularly to the Director.

Senior Management Organisational Structure



Workplace Profile



Reforming our coronial system

During 2020–21 the Court continued to focus on the planning and implementation of recommendations made in the (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 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 (FTEs) for CCQ in 2017–18. In June 2019 as part of the 2019–20 budget the 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 11 temporary FTE positions (for DJAG, QPS and QH). A further $0.963 million was allocated in the 2020-21 budget to continue implementation of reforms through to 30 June 2021.

As part of the 2021-22 Budget, the Department of Justice and Attorney-General (DJAG) was allocated recurrent funding from 2021-22 and permanent FTE for seven positions in the Coroners Court of Queensland.

These positions and funding will ensure long-term sustainability of critical reforms implemented over several years to strengthen Queensland's coronial system.

In addition, a further $1.422 million was allocated to DJAG in 2021-22 to support the coronial investigation and inquest into the deaths of Hannah Clarke and her three children Aaliyah, Laianah and Trey Baxter.

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 3 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-resources/delivering-coronial-services

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

[4] The Board consists 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.

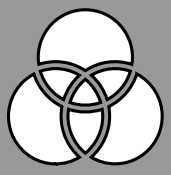
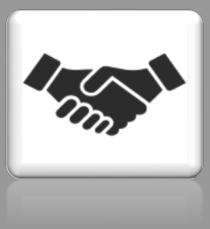
Coronial Services Governance Board

The Coronial Services Governance Board (the Board) was established in late 2018 in response to the to the Queensland Audit Office (QAO) in *Delivering Coronial Services* (Report 6: 2018-19) (the Audit Report). The QAO report identified a stressed coronial system unable to effectively respond to current and future demand and made seven recommendations to: improve systems and legislation underpinning coronial services; improve processes and practices across the responsible agencies; and establish effective governance arrangements.

To ensure the recommendations were addressed in a coordinated manner, and improve overall coronial system governance, in late 2018 the responsible agencies established the Board.

The Board is chaired by the Deputy Director-General, Justice Services, DJAG. Membership includes the State Coroner, Deputy State Coroner, Chief Forensic Pathologist, and senior officer representatives from the DJAG, QH, QPS, the Department of the Premier and Cabinet (DPC), and Queensland Treasury (QT).

The Board has directed implementation of the QAO recommendations targeting **four priority areas for action** phased over three financial years until 30 June 2021:

Enhanced triaging practices	**Strengthened case management, legal and counselling supports**	**Enhanced structural supports**	**Driving system innovation**
			
Phase 1 (2018 - 19)	**Planning our approach**		
Phase 2 (2019 - 20)	**Designing a responsive system**		
Phase 3 (2020 - 21)	**Sustainability for the future**		

Sustainability for the future 2020-21

This period has involved consolidation of reforms implemented over the last three years, and planning for longer-term strategies to ensure the continued strengthening of Queensland's coronial system. Steps taken remain informed by the matters identified in the QAO report, particularly the need for system-wise cohesion with strong governance mechanisms to support leadership, accountability, planning and reporting across the system.

With the QAO clear criteria, the Board has committed to a more integrated approach to managing and operating the coronial system in the following significant ways:

New permanent governance arrangements

The Board is transitioning from its QAO report focus to long term governance arrangements with responsibility for supporting the State Coroner's statutory functions in coordinating the coronial system and monitoring and managing system performance. As such, the Board's existing governance structure needs to alter to accommodate the new period.

The Board acknowledges the achievements delivered since the QAO report and the need for continued oversight to maintain and build upon system improvements. The Board recognises that the efficient and effective delivery of coronial services requires whole-of-system thinking, management and integration.

In May 2021, the Board endorsed terms of reference underpinning a new way forward to meet this change in focus. The new arrangements are:

Coronial System Board - chaired by the State Coroner. The new Coronial System Board will commence in July 2021. Membership will consist of senior leaders from the DJAG, QH, and the QPS. The Board will provide strategic direction, enhance partner collaboration, and oversight end to end system performance.

Coronial System Coordination Group - chaired by the Deputy State Coroner, will operationalise the Board's priorities to deliver improved services to families and the community. Membership is from senior departmental officers from partner agencies.

Both entities support the State Coroner's functions regarding co-ordination, administration, and efficient operation of the coronial system.

Coronial Services System Delivery Framework 2021-2025

A key sustainability action has been the development of the Coronial Services System Delivery Framework 2021- 2025[5] (the Framework). The Framework provides the overarching strategic charter for agencies delivering coronial services with its aim of facilitating a co-ordinated system putting families at its centre.

Designed in early 2021, through a series of strategic conversations and cross-agency workshops, the Framework explains the partnership approach that underpins the coronial system and sets out its vision, purpose, and partnership principles.

Vision
Coronial services that partner to deliver independent, family-centred, and timely investigations.

Purpose
Independent death investigation providing answers to families and informing the community about death prevention to advance public health and safety.

Shared approach
Coronial services operate as an interconnected and interdependent system. Each partner has specialist skills and expertise applying at different stages in the coronial process. Together we:

- Commit to operating as a single coronial system using our shared principles.
- Pursue Commit to operating as a single coronial system using our shared principles.

[5] Coronial Services System Delivery Framework 2021- 2025 Coronial Service System Delivery Framework 2021-2025 (courts.qld.gov.au)

- Optimise available resources with integration, innovation, and continual improvement.
  Collaborate with openness and integrity; working to remove organisational barriers.
- Recognise the strength and resilience of families from all social and cultural backgrounds and their diverse service needs.
- Communicate with families in a sensitive, aware, and empathetic way – respectful of loss and trauma.

Partnership principles

The coronial system multidisciplinary approach is underpinned by five shared commitments (partnership principles):

- **Family Centred** – Families are the focus of the Queensland coronial system. Families contact with the system follows tremendous loss. The system engages with families, seeking answers, at a significantly vulnerable time. Our system directly affects them, and any decisions and actions taken, are to have families as the first consideration.

- **Collaboration** – All partners work together in the best interests of the coronial system. This collective approach is underpinned by collegial consultation and communication between all partners and acknowledges the effectiveness of the Queensland coronial system is a shared responsibility.

- **Respect** – The Queensland coronial system provides respectful and compassionate services. Delivered services acknowledge the diversity of the Queensland community, and the inherent trauma connected with loss of a family member.

- **Excellence** – The Queensland coronial system delivers timely, expert, independent and professional coronial services to families and the Queensland community.

- **Innovation –** Through continuous improvement the Queensland coronial system will deliver contemporary and responsive coronial services.

This is an important system planning document, providing a strategic framework for multidisciplinary coronial services delivery to ensure family focus, sustainability, and performance.

The Framework was endorsed by the Board at its April 2021 meeting, noting the new governance entities will use it to guide the direction of the coronial system over the next five years.

QAO Report – Key reform achievements

Over the last three years, significant reform to Queensland's coronial system has resulted in a system with enhanced coordination and a transformation agenda.

Key achievements include:

- Stronger governance arrangements to support leadership, accountability, planning, reporting, and resourcing across the coronial system;

- Development of the Coronial Services System Delivery Framework 2021-2025 (the Framework), which creates a uniform sense of partnership purpose and high-level system strategic direction;
- Development of the QH led Regional Coronial Services Plan, which aims include improving forensic pathology services for regional areas;
- Establishment of a second coronial registrar cross-agency team to triage apparent natural causes deaths, with permanent funding secured for DJAG triage team staff**;**
- Additional coronial counsellors appointed to support families in the critical initial stages of a death investigation;
- Legislative amendments to enable preliminary examinations to reduce unnecessary contact with the coronial system;
- CCQ internal enhancements to its case management practices and leadership structure, with permanent funding secured for key staffing roles;
- Improved monitoring and management of government undertakers and the funerals assistance scheme; and
- Reduction in case backlogs (investigations older than 24 months) in the last three years.

Significant progress has been made, with four of the seven QAO recommendations fully completed. However, parts of three recommendations are still open. While a range of actions have been taken over the three-year cycle to address the remaining open recommendations, ongoing actions and strategies need to be enacted to fully realise the intent of the QAO recommendations.

The open recommendations are also central to considerations about modern coronial services delivery – relating to demand and case management, support for families and identifying funding and resourcing needs. These recommendations and considerations carry over for progression under the guidance and oversight of the newly constituted Coronial System Board.

Achievements 2020-21

Second Coronial Registrar
In the June 2021-22 State Budget, Department of Justice and Attorney-General (DJAG) received recurrent funding for case and demand management initiatives commenced in response to the QAO report. Significantly, funding was allocated to DJAG, to make permanent its temporary second coronial registrar and support team triaging all adult apparent natural causes deaths (which represents a significant percentage of deaths reported to the court each year).

The trial commenced in September 2019 and assists with reducing service demands and importantly, ensures bereaved families avoid unnecessary contact with the coronial system.

CCQ For You
In March 2021 staff members in the CCQ For You working group commenced monthly meetings to facilitate training and professional development sessions for CCQ. All staff were provided with the opportunity to complete an online survey designed to gain insight on what they would like to see occur as future training. During the reporting period The CCQ For You working group has successfully implemented several information, training, and development sessions for CCQ staff.

Centre of Excellence (CoE)
In May 2021 the Centre of Excellence was launched for the Brisbane Magistrates Court (BMC) and CCQ. Five registries from across Queensland have been selected to take part in the project which includes BMC, CCQ, Cairns Magistrates Court, Maroochydore Magistrates Court, and Ipswich Magistrates Court. The CoE is about working with intention on the way that registry operates by utilising the High Performing Team (HPT) Model with the goal of ultimately showing what excellence in registry practice looks like. The focus is on leadership, relationships, and practices.

DJAG Divisional Awards
The Justice Services Divisional Awards were held on 6 May 2021 and recognised the innovative work of both individuals and teams. The CCQ received three nominations, including an individual staff nomination and nominations for the Funeral Assistance Scheme and Registrar Support Team.

The Registrar Support Team was nominated for their project work to deliver a new version of the Coroners Case Management System (CCMS) working collaboratively with key stakeholders in CCQ and Information Technology Services (ITS). The teamwork and successful deployment of the project was highly recognised within DJAG and via the CCQ Feedback email address from families, funeral directors, and coronial nurses.

COVID-19 and CCQ
Despite the continuation of these unique events the CCQ continued to finalise findings, focused on the backlog of cases, and achieved clearances rates above 100 per cent. As a result, the Court reduced the backlog indicator and exceeded its performance target at the end of the reporting period for a third year in a row.

The pandemic disrupted regular clinical education forums that the Coronial Registrar and Acting Deputy Registrar present to a variety of stakeholders. Although the disruptions were ongoing, 13 presentations were completed within the reporting period.

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

State Coroner's Guidelines – s14 of the Coroners Act

One of the State Coroner's functions is to issue guidelines[6] 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 4: Dealing with bodies*, specifically the management of therapeutic family viewings, and organ donors post-retrieval.

The revised section of the guideline reinforced the underlying principle that therapeutic family viewings are to be facilitated as compassionately as possible and without requiring coronial authorisation or a police presence, except where the death is suspicious or where there is a family dispute. It also clarified that police attendance is not necessary following donor organ retrieval.

These two issues had been problematic at some hospital sites. Minor amendments were also made to reflect that hospital records are now increasingly kept in electronic rather than paper format.

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 extensive consultation with stakeholder groups 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 also resulted in formalised policy and operational procedures, with a number of enhancements including centralised decision-making processes to increase fairness and consistency.

Following a successful year since release, the second version of the renewed Funeral Assistance Scheme is currently being drafted and is scheduled to be rolled out following the reporting period.

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;
- developing a new contract management framework, inclusive of a new complaints management framework, a voluntary 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.

In the next reporting period, the CCQ will continue to review and improve the trial assurance program, with a review of the program to be completed prior to the end of 2021.

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

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 2020–21, a total of **5,714 deaths were reported to the CCQ** for investigation with **5,845 cases finalised**. The Court achieved a **clearance rate of 102.29%**. This is the third 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.

Numerous 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 continued to maintain the **backlog indicator at 14.18%.** This is the lowest backlog percentage achieved by the Court in the previous four years. The **overall number of pending cases (2,348 down from 2,378 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 2020–21, **2,171 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.

Figure 1 – Reports of death 2020-2021

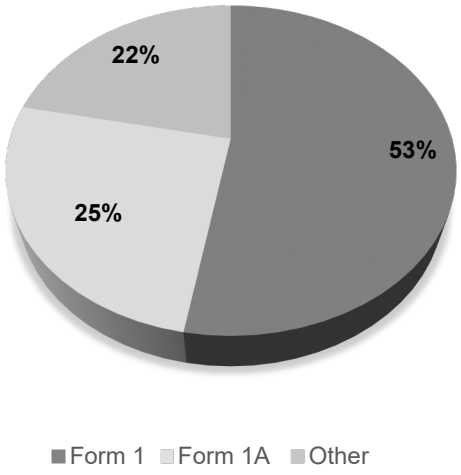


Table 1 - Performance figures from 2015–21

Year	Cases reported	Percent change	Cases finalised	Clearance rate	Backlog	Inquests held
2020–21	**5,714**	**1.47%**	**5,845**	**102.29%**	**14.18%**	**26**
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[7]	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 2020–21 [8]

Deaths reported by coronial region	Brisbane	Northern	Central	South Eastern
Number of deaths reported for investigation	3,476	685	692	861
Number of coronial cases finalised	3,343	905	656	941
Number of coronial cases pending	1,348	469	280	251
Coronial cases pending - *Less than or equal to 12 months old*	886	260	219	141
Coronial cases pending - *Greater than 12 and less than or equal to 24 months old*	276	145	33	55
Coronial cases pending - *Greater than 24 months old*	186	64	28	55

[7] 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.
[8] These figures represent the numbers recorded within the particular region the death was reported ie. the State Coroner, Coronial and Deputy Registrar receive reports of deaths state-wide.

Table 3: Deaths reported statewide by type for 2020–21[9]

Category of death	TOTAL
Suspected death (missing person)	**12**
Death in custody	**14**
Death as a result of police operation	**16**
Death in care	**117**
Health care related death	**764**
Suspicious circumstances	**17**
Violent or unnatural	**2,848**
Death certificate not issued and not likely to issue	**1,907**
Unknown persons	**10**

[9] 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

The position of the Coronial Registrar 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.

While the Form 1A process is primarily a triage mechanism aimed at diverting reportable deaths from unnecessary autopsy, it too is driven by the underlying general prevention object of the Coroners Act. The Coronial Registrars manage this reporting pathway with an eye to proactively identifying opportunities to improve patient safety and inform quality improvement in the health care sector.

In practice, most of the deaths reported by Form 1A resolve with the Coronial Registrar authorising the issue of a cause of death certificate under section 12(2)(b) of the Act without further coronial investigation. This is because there is sufficient clinical information to support the treating doctor's cause of death diagnosis without a coronial autopsy, and the Coronial Registrar is satisfied there were no significant outcome changing issues requiring a full coronial investigation.

Not infrequently the Coronial Registrar's investigation will identify clinical management issues that, while not significantly outcome changing for an individual deceased person, are issues the Coronial Registrar considers may benefit from clinical review by the care provider with a view to improving patient safety and health care quality. It has been the Coronial Registrars' routine practice to refer these matters formally to the relevant care provider with a recommendation for formal internal clinical review for this purpose. Where relevant, the Coronial Registrars have also notified agencies including the Aged Care Quality & Safety Commission and the National Disability Insurance Scheme Quality & Standards Commission of issues warranting regulatory review rather than coronial investigation.

This is done with the family's knowledge and the care provider is encouraged to engage directly with the family as part of any subsequent local clinical review process. While the coronial investigation is finalised once the Coronial Registrar authorises the issue of the cause of death certificate in these cases and care providers are under no legal obligation to share internal review outcomes with the Coronial Registrar, it has been our experience that most care providers are very responsive to these notifications and keen to share the outcomes of their internal reviews with both families and the Coronial Registrars.

It has been heartening to see many positive changes made in response to issues identified by the Coronial Registrars through the Form 1A triage process which, while not meeting the threshold for a full coronial investigation, have been examined and acted on by care providers across the health, aged care, and disability sectors to make timely changes to improve patient and client outcomes.

The Coronial Registrar's experience to date also shows how meaningful these responses are to bereaved families who often express relief and gratitude that their concerns have been heard and acted on quickly.

Recent examples of care provider responses to Coronial Registrar referrals for internal review include the following outcomes:

- a major metropolitan hospital reviewed its relationship with NDIS participants with a view to implementing an internal NDIS navigator role to improve communication between the patient, the patient's carers, and the treating team to ensure those involved in the patient's care are properly informed about the patient's ongoing care needs, for example in relation to positioning for feeding
- a major metropolitan public hospital developed and delivered targeted education for clinicians about the importance of closely monitoring renal function for patients on Acyclovir and to develop a local administration and fluid monitoring guideline for these patients
- a secure mental health facility took steps to improve monitoring of clients' bowel habits (regularity, consistency, and size) to enable early identification of faecal impaction, given the recognised effect of clozapine on bowel motility
- a regional public hospital reviewed its pleural drain insertion and management policy to ensure its clear application to general medical patients
- a disability service provider delivered education to its care workers about recognising and responding to signs and symptoms of stroke
- a regional public health service reviewed its processes for reviewing and endorsing medical imaging to reduce the risk of clinicians missing abnormal radiological findings
- a metropolitan public hospital standardised its complex discharge planning processes to ensure patients are appropriately assessed prior to discharge and the proposed discharge destination is suitable for their care requirements and the treating team provides comprehensive verbal and written handover before a patient is discharged to a nursing home for either respite or permanent placement
- a regional public health service developed and implemented a 'discharge safety checklist' to mandate family involvement in discharge planning, highlight identified 'at risk' patients for allied health assessment before discharge; and a discharge process including a risk matrix to ensure consideration of time of discharge, patient's mode of transport, patient's age/capability and multidisciplinary discharge planning and accountability for ensuring all teams involved in the patient's care (medical/surgical, allied health, social work, pharmacy) deem the patient safe for discharge
- a regional tertiary public hospital recognised risks associated with the design of falls management in the ieMR (integrated electronic medical record) and its local fall risk management processes not only as an organisational priority, but also escalated the issue to the Department of Health Statewide Falls Prevention Reference Group to optimise functionality within the ieMR
- a regional tertiary hospital identified improvements to be made to the functionality of the ieMR with respect to prescribing anti-coagulant medications to support clinician decision making maximising medication safety
- a rural public health service identified inconsistencies within the Statewide *Total Knee Arthoplasty Clinical Pathway* regarding whether chest x-rays are required to be performed as part of the orthopaedic preoperative assessment
- a regional public hospital developed mandatory patient escort criteria identifying the appropriate level of clinical escort and observation equipment required prior to transfer between units and a work instruction to ensure a two-person check of oxygen cylinder levels prior to transfer (with recommended minimum remaining percentage of 50% full for patient transfer)

- a tertiary public hospital developed a new process to ensure follow up plans for patients being managed through a specialist outpatient clinic are actioned and to enhance the visibility of unendorsed or potentially not-actioned laboratory results
- a regional public hospital undertook a review of its antenatal high-risk clinics and developed revised antenatal schedules and a flow diagram to assist clinicians to develop a comprehensive care plan for high-risk patients (to be supported by a workplace instruction and clinical education)
- a residential aged care facility made significant changes to their wound care policies and practices including providing additional training to registered and enrolled nursing staff, ensuring that wounds are appropriately documented with suitable management plans and developing a practice for nursing staff to escalate wounds that are not responding to treatment
- the Queensland Health Statewide Cardiac Clinical Network updated the coronary angioplasty and stent procedural consent form to provide more details about the specific risks of this procedure including gastrointestinal bleeding
- a tertiary public hospital undertook a review of practices and procedures regarding removal of a peripheral intravenous cannular when it was not in use (to reduce the infection risk) and provided additional training to staff about appropriate infection management
- a regional private hospital undertook an audit of renal dialysis patients and identified issues regarding appropriate documentation of patients' observations and management plans which resulted in additional training for staff with a repeat audit planned in the future
- a metropolitan public hospital provided additional training to staff regarding recognition, clinical escalation, and communication of acute airway obstruction, upgraded the patient call system in the relevant ward and reviewed workflows to ensure nursing staff meal breaks were not occurring at the same time as patient's meals
- a regional hospital provided training to staff regarding the assessment of capacity for mental health and non-mental health patients in the context of presentations of patients with eating disorders and developed a new pathway for referral to specialised allied health practitioners (including mental health practitioners) for these patients.

Deaths in care

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[10] 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.

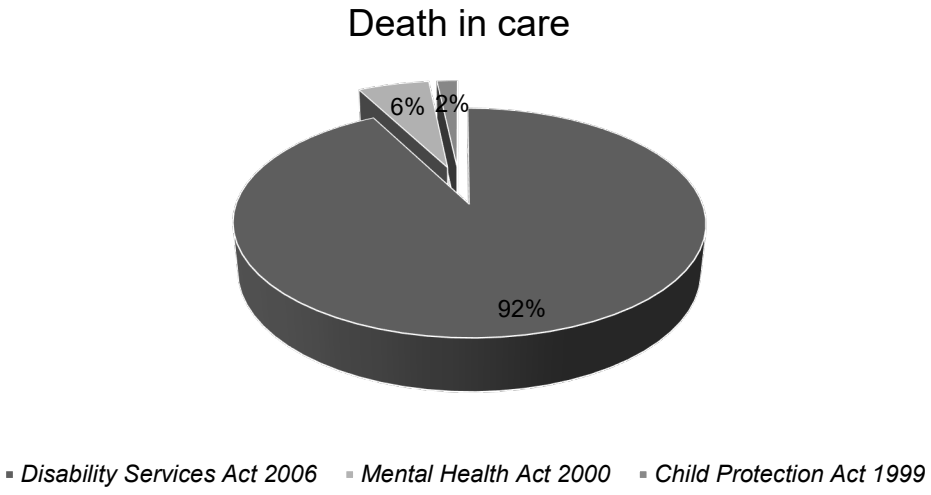
On 17 June 2019 the *Disability Services and Other Legislation (NDIS) Amendment Act 2019* received assent after passage through the Queensland Parliament. Sections 50 and 51 of that Act amended the Coroners Act to ensure a relevant service provider has a 'duty to report' a death in care and revised the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

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

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 2020–21, 117 '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 2 – Death in care matters reported during 2020–2021



Forensic pathology services

Autopsies can be an important aspect of coronial investigations. However, they are invasive, costly, and can be distressing to bereaved families. In line with the State Coroner's Guidelines, coroners are encouraged to order the least invasive autopsy examination necessary to inform their investigation[11].

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[12].

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 2020–21, there continued to be a further reduction in the percentage of autopsies ordered (2,095)[13] 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.

[11] Refer to State Coroner's Guidelines – Chapter 5 'Preliminary investigations, autopsies and retained tissue' https://www.courts.qld.gov.au/__data/assets/pdf_file/0015/206124/osc-state-coroners-guidelines-chapter-5.pdf
[12] 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/
[13] This figure includes total ordered, including cases where multiple orders were made.

2,095
Autopsy examinations ordered

$192,900
Autopsy expenditure (includes related travel and mortuary costs)

Table 4 – Percentage of orders for examination issued in relation to reportable deaths

	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
Deaths reported	4,962	5,287	5,587	5,812	5,797	5,631	**5,714**
Examinations ordered	2,542	2,550	2,730	2,629	2,476	2,353	**2,095**
Percentage	51.2%	48.2%	48.9%	45.23%	42.71%	41.78%	**36.66%**

Table 5 – Number and type of examination ordered 2014-15 to 2020-21

	2014–15	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21
External	679	769	856	967	1,049	**1,008**	**319**
Partial internal	597	533	583	630	614	**498**	**762**
Full internal	1,266	1,248	1,291	1,032	765	**800**	**520**

Funeral Assistance

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

As noted earlier in this Report during 2020–21 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[14]. 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[15]. 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

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

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

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 2020–21, 308 applications were approved (in comparison to 382 in 2019-20) under the Scheme at a total state-wide cost of $379,767.39. This figure is based on the total expenditure minus the total costs recovered under the Scheme. The Court has continued to improve its cost recovery functions, with 44.02% recovered (in comparison to 37.17% in 2019–20)[16]. Revenue from recovery can include funds received from applications approved in previous financial years, as applicants may later come into funds.

Funeral Assistance Scheme figures for 2020–21:

308	**$678,385.08**	**$298,617.69**	**44.02%**
applications approved	state-wide expenditure	expenditure recovered	of expenditure recovered

[16] The cost recovery figures include outstanding costs for approved applications recovered in 2020-21 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[17]. 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 current contracts, known as standing offer arrangements (SOA), have been in effect since February 2018, with 33 funeral directors providing coronial services across Queensland. The services comprise of 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. All contracts were successfully extended through this process and will remain in place until 31 January 2023.

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 temporary position was originally established with funding from the 2019–20 Queensland Budget, in response to the QAO recommendation to improve the performance monitoring and management of GCUs. It is currently funded through to the end of the 2021-22 financial year to continue to implement this important work for the Court.

Achievements in the last year have included the roll-out of a voluntary trial assurance program, more proactive monitoring and reporting on performance measures, the development and go-live of an innovative new invoice and claim processing portal for GCUs, and a new complaints management framework.

GCU conveyancing figures for 2020–21:

4,648
conveyances by GCU

$2,690,725.47
state-wide expenditure of conveyances

[17] 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 provide 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 **27 persons were finalised** during the reporting period, **with 26 inquests completed.** 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.

Figure 3 – Inquests finalised by type during 2020–21

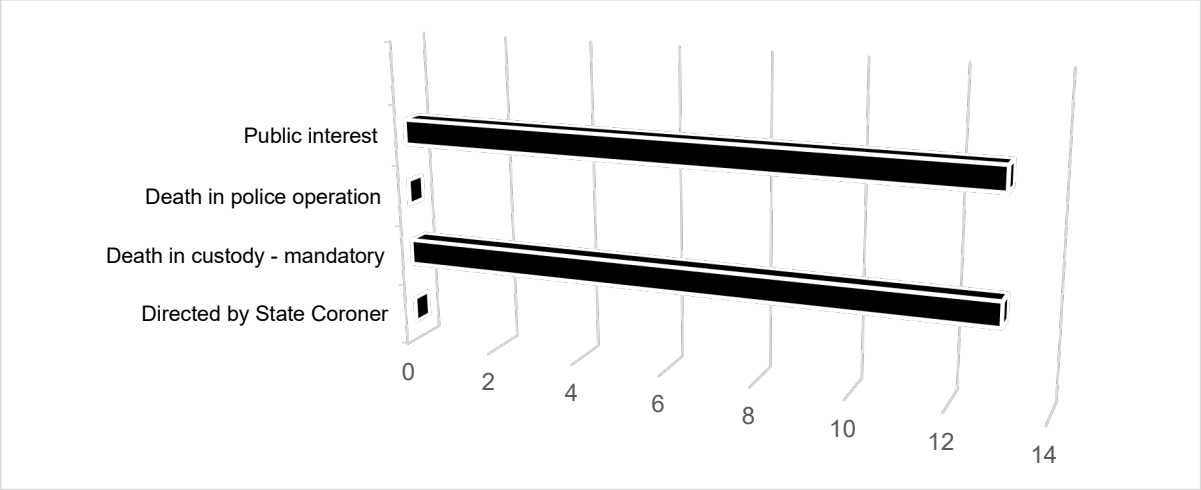


Table 6 – Finalised inquests during 2020–21

Name of inquest/deceased	Coroner	Counsel Assisting	Key catchwords
Jesse KEARNEY	Bentley	Mr David Funch Ms Rene Jurkov	Missing person, methylamphetamine, searches, police investigation
Shandee BLACKBURN	O'Connell	Mr John Aberdeen	Young woman attacked while walking home after work at night-time, suffered fatal stab wounds, Recommendations as to increase in CCTV locations and quality.
Master CARR and Jaylen	Clements	Ms Avelina Tarrago	Death after high-speed car crash, vehicle stolen, juvenile driver, family concerns re facts, cultural issues.
Seth LUHRS	Wilson	Mr Joseph Crawfoot	Fall from height, hotel balcony, drug toxicity, LSD, MDMA.

Barry HAYNES	Ryan	Ms Sarah Lio-Willie	Death in custody, natural causes, terminally ill prisoner, capacity issues, substituted decision maker, palliative care, Human Rights Act 2019.
John MARTYN	Ryan	Ms Sarah Lio-Willie	Death in custody, natural causes, terminally ill prisoner, palliative care, parole.
Richard HOBBS	Ryan	Ms Sarah Lio-Willie	Death in custody, natural causes.
Alexander AITKENHEAD	Ryan	Ms Sarah Lio-Willie	Death in custody, natural causes.
Maxwell MURPHY	McDougall	Ms Joanna Cull Ms Alana Martens	Ingestion of Bacban, poison, nursing home, staff responses, hospital responses, standard of care.
Cindy MILLER	Ryan	Ms Sarah Lio-Willie	Death in custody, police watchhouse, mixed drug toxicity, assessment and monitoring of prisoner health, police CPR skills and training, investigation of police related deaths.
Daniel SPRINGER	Wilson	Ms Melinda Zerner	Mining accident, BHP Billiton Mitsubishi Alliance Coal Operations, Goonyella Mine, excavator bucket, external steel vertical wear plate package, indentions, build up of stored energy, air carbon arc gouging, 1.150 metre spring-back event, fatal injuries to head due to industrial accident, death of qualified boilermarker, no prior industry knowledge regarding magnitude of spring-back.
Robert FULLERTON	Ryan	Ms Rene Jurkov	Death in custody, natural causes.
Dennis PETZLER	Ryan	Ms Josephine Villanueva	Death in custody, natural causes.
Anna DAMJANOVIC	Clements	Ms Sarah Lane	Pedestrian hit by car, difficult intersection, S46 comments from inquest, accident, weather conditions
Ashley HORNE	Ryan	Ms Sarah Lio-Willie	Death in custody, self-inflicted stab wound, police dog, Taser, first aid response.
Constance BURRETT	Bentley	Ms Kate McMahon	Heroin, methylamphetamine, injecting another.
Scott HAMBLY	Ryan	Ms Sarah Lio-Willie	Death in custody, natural causes, life prisoner lost to follow-up.
Jayden PENNO TOMPSETT	Wilson	Mr Joseph Crawfoot	Missing person, road trip Newcastle to Charters Towers, consumption of illicit drugs, MDMA, ice, ecstasy, pingers, fatigue, dehydration, 40-degree temperatures, isolated location, delay to report missing, police investigation and search, death by exposure to the elements.
Margaret CAHILL	Wilson	Mr Joseph Crawfoot	60mgs intramuscular morphine injection prescribed by general practitioner, morphine interaction with tapentadol and other central nervous system suppressants, mixed drug toxicity, medical management by general practitioner, doctor / patient relationship, post intra-muscular morphine observations by general practitioner and caregiver husband, delayed emergency response.
Dylon AHQUEE	Ryan	Ms Rhiannon Helsen	Death in custody suicide of young prisoner, transition from youth justice to adult prison, information sharing, hanging, whether death was suspicious, risk assessment.
SVE	Ryan	Mr Matthew Hickey	Suicide, death in custody, remand prisoner, risk assessment, hanging points.

Liam SCORSESE	Ryan	Ms Sarah Lio-Willie	Death in custody, police shooting, edged weapon, tasers, body-worn cameras, information sharing, mental health support for parolees.
Kirra-Lea MCLOUGHLIN	Bentley	Mr John McInnes Ms Rene Jurkov	Domestic abuse, domestic and family violence, choking, strangulation.
Damon MCCOY	Wilson	Mr Joseph Crawfoot	Re-open findings; motor vehicle collision, identity of driver.
Phillip WUST	Ryan	Ms Rene Jurkov	Death in custody, natural causes.
Tiahleigh PALMER	Bentley	Ms Kate McMahon	Child Safety, foster care, missing children, murder, rape, incest, Thorburn.

Public interest inquests

Shandee Blackburn

Central Coroner, David O'Connell – 21 August 2020

During 2020–21 interest in the coronial jurisdiction continued with the handing down of high-profile inquest matters, notably the Tiahleigh Palmer, Kirra-Lea McLoughlin, Shandee Blackburn, Daniel Springer, Master Carr and Jaylen, and Anna Damjanovic inquests received considerable community and media attention.

The following is a summary of the ''public interest' matters that received a significant amount of media attention.

Circumstances of the death

At the date of her death Ms Shandee Blackburn worked in the coffee shop at Harrup Park Country Club, at Milton Street, Mackay. On 8 February 2013 Ms Blackburn worked her evening shift at the Country Club, Milton Street, Mackay. Her shift appeared to be routine and uneventful. She finished at around midnight and walked along Juliet Street towards her mother's residence at Boddington Street. The approximate distance is about 1.2 kilometres. She can be seen in various CCTV footage walking along the western side of the street along the footpath. Ms Blackburn is walking alone. Whilst she walked along the street a number of vehicles also travelled through the area, but the traffic was very light. She is not seen to encounter any person as she walked along Juliet Street.

At about 12.15 a.m. on Saturday morning, 9 February 2013 Ms Blackburn was attacked on Boddington Street, near the intersection with Juliet Street. She was merely metres from arriving home safely. A taxi driver, Jaspreet Pandher, drove along Boddington Street, from Sydney Street before turning right into Juliet Street. Mr Pandher saw a lady with a man, and they appeared to be fighting over what he presumed to be a handbag. The assailant was of fairly slim build and was dark skinned. Mr Panher continued to drive along Juliet Street where he received a fare and then commenced to do a three-point turn in Juliet Street. He also radioed to his base that an incident was occurring on Boddington Street, and that the police should be called. As he completed his turn, he saw a figure run from where the assault was occurring, across a vacant allotment and away from his view. The person ran very freely and was possibly holding something.

The Coroner found that Ms Blackburn was assaulted by a single person who took her by surprise, delivering a number of stab wounds, one of which damaged her larynx with the result she could not call out. It occurred very quickly, and with considerable force.

The investigation and Supreme Court trial
The police conducted an extensive investigation and eventually identified thirteen possible persons of interest. The coroner agreed with their process of identifying these persons. Ultimately police charged Ms Blackburn's ex-boyfriend, Mr Peros, with her murder. Following a Supreme Court trial, Mr Peros was found not guilty by the jury.

The inquest
The inquest heard from 53 witnesses, had available the committal and trial transcript, numerous CCTV recordings, and also audio recording of particular conversations. The inquest brief itself was comprised of 24 lever arch folders, before audio recordings and CCTV recordings are considered which themselves filled 70 electronic storage devices. The inquest ran for eleven days.

The Coroner noted that the inquest was more comprehensive than the Supreme Court trial as to the available evidence which it could receive. Every inquest has the benefit of receiving additional evidence not permitted at a criminal trial, specifically hearsay evidence, but importantly in this case the complete CCTV footage including the 'timed compilation' and enhancement stills, and also quite significantly explanations from those persons who examined it and who could assist the court in understanding it. In addition, Mr Peros himself gave evidence, which was the first time he had actually given evidence and been subject to questioning in a courtroom. The Coroner also had the opportunity to assess Mr Peros' credibility and reliability whilst he gave his evidence.

The evidence
All but one of the thirteen persons of interest gave evidence at the inquest (one had died by the time of inquest but had been ruled out on the basis of the investigation carried out by police). The Coroner ruled out involvement of all persons of interest except Mr Peros based on their own evidence and detailed witness evidence as to their movements and motivations.

Mr Peros claimed privilege from giving evidence. The Coroner directed him to answer questions in the public interest. At the time in question Mr Peros lived alone in Evan Street, only about 700 metres or so from Boddington Street. He had been in a relationship with Ms Blackburn from mid-way through 2011 until mid-2012 (they broke up for a month at some stage and got back together). It appears that he had some difficulty in dealing with the ending of that relationship, even though he ended the relationship. He sought psychological and psychiatric assistance for this and other issues in his life. He had criminal history and no domestic violence history.

The Coroner accepted the evidence of three witnesses who said that, at an Australia Day party in 2013, Mr Peros had been extremely upset about the breakup and made statements to the effect that he "hated her" and that "she'd be better off dead", which comments were out of character for him. The Coroner found that Mr Peros had made the statements despite the fact that Mr Peros denied making them, and that Mr Peros made the statements well over six months after his relationship with Ms Blackburn had ended, and two weeks before the incident which resulted in her death.

The Coroner noted that Mr Peros' movements the day before Ms Blackburn died were known up to a point. He went boating with friends at Seaforth in the morning, attended a work function at the Mackay harbour through the day, then went home and possibly had an afternoon nap and did not go out that evening, preferring to stay home and watch television although he '*might have gone for a drive*'. Mr Peros was not definite about his movements that evening, even though asked about them by police only two days later. He signed a statement at that time to that effect.

The only vehicle Mr Peros then owned was a white Toyota Hilux dual-cab utility. A vehicle matching Mr Peros' vehicle was identified CCTV footage driving near the scene of Ms Blackburn's death around the time she was fatally stabbed. Mr Peros said he couldn't tell whether it was his vehicle on the CCTV.

The Coroner noted that due to the nature of the CCTV footage no number plate can be deciphered on the vehicle, but that, with the help of evidence to the inquest given by police officers, a large number of other individual features or attributes which made it distinguishable, or even unique, could be identified. These included the make, model, colour, year range, cab and tray configuration, bulbar and rearstep with towbar, aftermarket wheel arch flares (except driver's side front which was missing), Sunraysia wheels and lift kit, as well as decals on the side, a spot of rust on the passenger side of the tailgate, three vertical bars in the back window, and a lack of the usual TOYOTA lettering on the back tailgate. The Coroner was satisfied that these features showed that the car shown on CCTV was Mr Peros' vehicle. The Coroner noted that there is no footage which clearly shows the driver, although footage does confirm that there appears to be just one person in the vehicle. Accordingly, the Coroner found that it was Mr Peros who was driving his own vehicle that evening, and that he was the person driving the vehicle when it is seen in the CCTV footage.

The CCTV footage from 18 Juliet Street also captures a person seen loitering, or waiting, in the foliage of the yard of the Girl Guide hut. At the time that person is concealing themselves in the foliage, Ms Blackburn walks by on the other side of the street. As she approaches Boddington Street, the figure in the bushes is seen to run across Juliet Street, across part of a vacant lot, and goes out-of-view on the western side. Nothing is then seen for a short period, before the running person returns to view from the west, running east, before again exiting out of the field of view towards the lower end of Sydney Street. The Coroner found that the person seen running in the video across Juliet Street and the grass paddock was the person who interacted with Ms Blackburn, and that they would have had sufficient time to assault her in the time they were off camera.

Findings and comments
On consideration of all of the evidence available at the inquest, the Coroner found that the vehicle-of-interest was Mr Peros' vehicle, and that Mr Peros was the driver. Mr Peros was the person who concealed himself in the foliage outside the Guides Hut while Ms Blackburn passed, then ran towards her as she was nearing Boddington Street, attacked her, and caused the injuries which resulted in her death. Mr Peros then ran back, across Juliet Street, re-entered and started his vehicle, and then drove to the end of Sydney Street, where he turned left into Evans Street, in the direction of his home.

The Coroner commented that he did not make any referral to the police under section 48 of the *Coroners Act* 2003, as the police were already in possession of all relevant information, and there was no new or fresh and compelling evidence available for use in a criminal court and/or in respect of fresh charges against Mr Peros.

Recommendation
The coroner recommended that the QPS and the Mackay Regional Council undertake steps to identify areas of high risk and look at upgrading existing street lighting, or adding additional street lighting, where required and installing additional CCTV facilities to capture people's movements.

The findings of the inquest are available on the Queensland Courts website at:
https://www.courts.qld.gov.au/__data/assets/pdf_file/0007/656044/cif-blackburn-sr-20200821.pdf

Master Carr and Jaylen

Brisbane Coroner, Christine Clements – 27 August 2020

Circumstances of the death
On Saturday 21 April 2018, two local residents were travelling south on the Gore Highway towards Goondiwindi. As they drove across a bridge on Wyaga Creek, they saw, on the bank of the creek below, a wrecked vehicle. They noticed no signs e.g., dust, or smoke, indicating a recent accident. As they were late for a previous commitment, they drove on, and were able

to return to the creek about an hour later. They stopped and made their way down to where the vehicle was resting. The car, they observed, had suffered extensive serious damage, with the only identifiable mark as to the make of the car being a Holden symbol on a tyre rim. As they searched the area, they found the body of a deceased person lying on the ground two to three feet from the back of the vehicle. Further searching located a second person, also deceased, trapped inside the car. They notified authorities by way of mobile phone, and police investigators later attended at the scene.

The investigation
Neither of the deceased persons carried any identification, and it was late on the night of 21 April that the deceased could be identified as two young people, who were only 16 and 17 years old. The car involved was identified by its registration plates as a light green Holden Commodore, which was reported as having been stolen the previous morning from the Sunshine Coast. Both young people were examined by medical practitioners, who were able to state that their deaths were due, in each case, to multiple injuries, which were consistent with their being involved in a high-impact motor car accident.

The inquest
The task for Coroner Clements was to determine how these young people died. This involved the gathering of evidence, from a number of sources, as to the movements of the Holden leading up to the accident. Police were advised of the finding of the car at 1:00pm on 21 April, and a qualified police traffic investigator was able to attend at the scene within 30 minutes of that advice. The investigator walked through the approach to the creek from the north some 300 metres. He saw track marks in the grass on the side of the road, which led to the car. He continued searching the area, and found scrape marks in a drain area, consistent with contact with the undercarriage of a vehicle as it left the road surface.

A map was later prepared for the Coroner, which included measurements taken by the investigating officers. Police investigations also noted an impact mark on a very large tree in the path which seemed to have been taken by the car. An experienced crash investigator from Toowoomba joined the investigation on 26 April.

That officer observed that the car had very extensive damage; he had not seen, in his years of experience, a more badly damaged vehicle. He was of the view that the incident had occurred when the car left the road at a very high speed. The car's airbag control computer was able to be retrieved from the car, and its contents were downloaded. The data indicated that, some 2 seconds prior to impact with the very large tree, the car had been travelling at about 175 kph. The data showed that the car then slowed to 164kph, and then to 156kph. Police also noted that the speedometer in the car was frozen at 156kph.

The inquest was able to access data from various traffic cameras, and from witnesses who had seen the Commodore in the period leading up to the incident. The car was at Gatton at 2:04pm on 20 April, and later sightings indicated a westerly direction of travel. At 9:38pm, the car was sighted at Toowoomba, and footage from a CCTV camera captured the car at a service station there at 10:15pm. At 12:35am on 21 April, the car was again caught on CCTV at a service station at Captain's Mountain, confirming a continuing west/south-westerly track.

At 12:59am, an experienced heavy-vehicle driver had just passed the Kindon School. He saw lights coming up behind him, at a very high rate of speed. He was concerned by the apparent speed and moved over to the left. The dash-cam on this truck then recorded a green Commodore overtaking the truck at speed. The driver stated that the Commodore "shot past" him, and he watched the car disappear from sight, still travelling south-west towards Wyaga. The driver was able to advise the inquest that there were no cars following after the Commodore, with the only other vehicle at about that time being what he believed was a small truck, travelling in the opposite direction. The distance from Kindon School, to Wyaga Creek, where the Commodore was found, was a little under 15 km.

The truck drove over Wyaga Creek but did not pick up any indicator that an accident had occurred there. The truck driver, who regularly drove on the Gore Highway, was able to tell the inquest that, in his opinion, the Gore Highway in that vicinity could be described as "shocking", in that it was uneven and rough.

Findings and comments
The Coroner found that the Commodore containing the two young people crashed at Wyaga Creek between about 1:15am and 1:30am on 21 April, and that both occupants suffered fatal injuries as a result. The accident, it was found, occurred when the driver of the Commodore lost control at high speed and ran off the road. The Coroner also found that no other vehicle or person had been involved in causing the accident and was assisted in making that finding by the truck's dash-cam footage, which showed no other vehicle overtaking the truck, and the absence of any evidence at the scene indicating possible involvement by others. The truck driver was also able to tell the inquest that he passed no police vehicles during the relevant period.

Recommendations

The Coroner recommended:

(i) that phone coverage in the area of the accident be improved, as those who found the car had difficulty in contacting assistance by phone;
(ii) in the interim, that signage be placed at the Wyaga Creek Rest Stop to assist people to know the direction and distance to the nearest place of assistance;
(iii) that funding from the Commonwealth, which had responsibility for the highway, be prioritised to upgrade the Wyaga Creek crossings;
(iv) that signage indicating that the road narrowed through the creek crossings;
(v) that the road be widened;
(vi) that an emergency contact point be established;
(vii) that the speed limit at the crossings be reviewed;
(viii) that the Police Service review and upgrade their information systems concerning CCTV camera coverage, as a flood camera had been operative at Wyaga Creek Crossing, of which the police were unaware, until after the relevant data had been overwritten;
(ix) that the Dept of Transport and Main Roads consider review of their data systems to require preservation of CCTV footage for 60 days, or longer if a fatality had occurred in the vicinity of any camera.

The findings of the inquest are available on the Queensland Courts website at:
https://www.courts.qld.gov.au/__data/assets/pdf_file/0004/656356/cif-mastercarrandjaylen-20200827.pdf

Daniel Springer

Northern Coroner, Nerida Wilson – 23 February 20201

Circumstances of the death
Mr Daniel Springer was an experienced boilermaker by trade and was employed by Independent Mining Services (IMS) at Goonyella Riverside Mine, 220km south west of Mackay. The mine was operated by BM Alliance Coal Operations Pty Ltd (BMA). The tenure holder was BHP Coal Pty Ltd.

On 5 August 2017 at approximately 12:56am, Mr Springer was working in the maintenance bucket shop removing an external wear plate from an excavator bucket using an air carbon arc gouger. He was removing welds holding a large middle section vertical plate to the basket structure. He was cutting the large plate into smaller pieces of approximately 800mm x 800mm

for ease of handling. He was working from a scaffolding platform approximately 1.7m from the top of the bucket.

As a result of heavy use, the external wear plate on the bucket had become indented, creating a build-up, stored energy, or tension. This build-up was released when Mr Springer was gouging causing one of the metal plates to biaxially spring back, meaning it occurred in both forward and lateral direction, and struck him in the head which immediately rendered him unconscious. He was airlifted to the Mackay Base Hospital and then to Townsville Hospital. Despite life saving efforts at Townsville Hospital, he succumbed to his fatal injuries on 7 August 2017. The medical cause of death was the result of head injury, due to, or as a consequence of industrial accident.

The inquest
The inquest into Mr Springer's death was conducted over a total of eight (8) dates, on 23 May 2019, 2 – 6 March and 2 June 2020. The coronial investigation brief tendered at inquest was extensive. Seventeen (17) witnesses were identified and called to give oral evidence at inquest. A total of eight (8) issues were considered at the inquest.

At the conclusion of the inquest, the Northern Coroner had the benefit and regard to the comprehensive written submissions by:

- Counsel Assisting the inquest;
- The Department of Natural Resources and Mines [now Resources Safety and Health Qld]
- BHP Billiton Mitsubishi Alliance Coal Operations Pty Ltd (BMA)
- Independent Mining Services (MIS)
- ESCO Australia Holdings Pty Ltd
- BAE Engineering

Nature and Cause Investigation Report for Chief Inspector of Coal Mines
The Mines Inspectorate (Coal) through the Department of Natural Resources and Mines Qld (DNRM) investigated Mr Springer's death and prepared a *'Nature and Cause Investigation Report for Chief Inspector of Coal Mines*.' The investigation concluded that the mine did not identify any potential risks associated with modifying the external floor wear plates on the excavator buckets by changing from the thing horizontal wear plates to the two large wear plates. This was primarily due to a lack of knowledge by the mine and the coal mining industry as a whole, of the behaviour of metal under such conditions. Specifically, in this instance, what could cause a build-up of tension in the large external floor wear plates on excavator buckets.

The report made a total of five (5) recommendations. The DNRM decided not to proceed with prosecution in relation to the incident.

BHP Investigation
BHP undertook a systematic safety investigation analysis to investigate the circumstances around the incident. Following the investigation, a report was prepared by the Mine Site Senior Executive for the purpose of section 201 of the *Coal Mine Safety and Health Act 1999.* The key findings from the investigation included, the mine's risk management process did not identify the hazard (being the plate); the excavator buckets do not have an effective maintenance strategy, and the contract management process resulted in an ambiguity about onboarding and supervision of the contractor personnel. A number of key organisational lessons were identified from the investigation.

A number of actions and recommendations were made in order to address absent/ failed defences, and organisational factors. Some of those actions had already been implemented, however some of the actions were general improvements and, by themselves, would not necessarily have prevented a similar incident.

Findings and comments
The Northern Coroner took into account that there were no previous near misses of this type (that resulted in Mr Springer's death); no fatality arising in the same circumstances; no issue of inadequate or deficient training, resulting in the almost unanswerable question, that is whether knowledge of a spring-back event of this magnitude under these conditions could have been acquired earlier.

The Norther Coroner accepted the ultimate submission of BMA that the lack of knowledge meant that BHP, ESCO, DNRM did not and could not have recognised the potential for the wear plates to dislocate to the magnitude as occurred in this incident. This lack of knowledge applied across the coal mining industry and the boiler-making and steel fabrication industry.

The Northern Coroner found that, Mr Springer's risk of injury was not within an acceptable level, concluding that a lack of knowledge regarding the behaviour of the metal plates under such conditions does not, and did not, negate the obligation to ensure the risk was acceptable and to keep him safe in the workplace. As a result of this incident, BHP classified large wear plates of this type as a prohibited item.

The Northern Coroner endorsed the recommendations contained within the Nature and Cause Investigation Report prepared for the Chief Inspector of Mines.

The Northern Coroner acknowledged and endorsed the analysis commissioned by BHP and the findings, recommendations and implemented improvements arising therefrom.

Recommendations
The Northern Coroner made three recommendations to DNRM (or Resources Safety and Health Qld as it is now).

The findings of the inquest are available on the Queensland Courts website at:
https://www.courts.qld.gov.au/__data/assets/pdf_file/0009/669879/cif-springer-d-20210223.pdf

Anna Damjanovic

Brisbane Coroner, Christine Clements – 25 February 2021

Circumstances of the death
At 7:38pm a CCTV camera at the intersection of Swann Road and Moggill Road in Taringa captured footage of a person thought to be Ms Anna Damjanovic walking from Moggill Road into Swann Road. This is the route Ms Damjanovic would have taken if she was walking home from the bus stop on Moggill Road or from the grocery store near the bus stop.

At approximately 7:40pm, Vanessa Clark was driving her black Volkswagen beetle along Swann Road, heading towards the intersection with Moggill Road. Just before that intersection Swann Road dips down and turns right, and then passes over the Ipswich railway line by way of a bridge. The speed limit for the road was 60km per hour at the time. The road is sealed with bitumen with one lane in each direction.

Ms Clark, who was also 19 years of age at the time of the accident, told the court that she was driving along Swann Road towards the intersection with Moggill Road. As she came around the corner before the rail bridge, she was driving at the speed limit. She checked the roads to the left and right for cars as she headed towards the two intersections with York Street on the left and Cunningham Street on the right. She noticed a person, who we now know was Ms Damjanovic, crossing Swann Road at the end of the bridge near the intersection with Cunningham Street. Ms Damjanovic was crossing in front of Ms Clark from right to left. Ms

Clark gave evidence that Anna appeared to be moving quite slowly, appeared to be looking down, and did not appear to be aware that her car was approaching.

Ms Clark said that she braked as soon as she thought that Ms Damjanovic would not be able to cross the road in time. She thought that she was approximately 16m away at that time. She said that the front of her car hit the pillar of the bridge on the left-hand side, the car rotated and the back hit something, and she was scared she would go over the bridge. Ms Clark said that she did not see the car hit Ms Damjanovic.

Jessica Wood and Elinor Irvine were sitting on the patio of their townhouse on the corner of York Street and Swann Road. They heard wheels skidding, brakes squealing, and then a crunch and a loud pop of metal on metal. Ms Wood and Ms Irvine ran out through their gate and saw Ms Clark's car crashed against the left-hand side of the bridge, and facing towards them, which was the opposite direction that Ms Clark had been travelling. Ms Wood and Ms Irvine saw that the car had its lights on, and smoke was coming from the inside of the car. Ms Wood ran towards the car and saw Ms Clark trying to get out of the car as fast as she could. She heard Ms Clark scream and say, "I hit someone". Ms Wood went to assist Ms Clark, who was shaking, hyperventilating, and crying. Ms Wood looked under and around the car but could not see anyone else in the vicinity.

Ms Irvine called Triple 0 on her mobile as she was approaching the scene of the accident. This call was made at 7:44pm. While she was talking to the operator Ms Irvine could hear Ms Clark screaming, and saying "there was someone on the road", "why didn't they stop?", "why didn't they see me?". Ms Wood and Ms Irvine could not see any person on the road. But when they looked over the railing of the bridge, they saw a person lying to the left of the train tracks.

Police and ambulance arrived within minutes of Ms Irvine's call to Emergency Services, and one of the first police officers to arrive was Senior Constable Julia Kenny. Senior Constable Kenny activated her body worn camera on arrival, and subsequently spoke to Ms Clark, who was still shaking and distressed. Senior Constable Kenny gave evidence that Ms Clark told her that she was driving at the speed limit when she came around the corner before the rail bridge. She said that at that point, she saw a person crossing the road ahead of her from right to left and noticed that the person seemed to be walking very slowly. She braked to avoid hitting the person, who did not appear to have noticed her car. Her car then slid on the road, spun around, and hit the left-hand side of the bridge. Ms Clark said that she did not know what happened to the person crossing the road.

Ambulance officers attended to Ms Clark, and police conducted a breath test for Ms Clark's blood alcohol level, which gave a result of zero. Ambulance officers and police also attended to Ms Damjanovic. She had fallen 15 metres from the bridge, and officers found her unconscious and not breathing. They were able to resuscitate Ms Damjanovic and she was taken to the RBWH by ambulance. On examination, Ms Damjanovic was found to have suffered fractures to her skull, right leg, and left shoulder blade. Her neck was broken, and she had a spinal cord injury. She had suffered extensive bruising and internal injuries. Despite treatment, her condition deteriorated, and she died the following evening, at 7:02pm on 20 May 2017.

The investigation

An investigation into the circumstances surrounding Ms Damjanovic's death was conducted by the Forensic Crash Unit (FCU). A coronial report was provided and included various witness statements and transcripts, QPS incident logs, photographs, and videos.

The inquest

The hearing of evidence in relation to Ms Damjanovic's death took place in Brisbane on 4 March 2020 and 27 January 2021. The evidence of six QPS and eyewitnesses were heard, and all of the statements, records of interview, photographs and materials gathered during the investigation were tendered at the inquest. The fundamental task of the inquest was to identify the factual circumstances surrounding the incident, including the road and weather conditions,

lighting, pedestrian access to the road, speed limit, and consider whether any recommendations could be made to prevent deaths from happening in similar circumstances in the future.

Findings and comments
The Coroner found that on the night of the accident, it was dark and raining slightly, and although there was enough light provided by the streetlights for them to be able to see the road and the bridge, the visibility on the night was made more difficult due to the rain. The intersection had no marked pedestrian crossings and, as is the case in most suburban intersections, relied on pedestrians using their own judgement if trying to cross.

It was accepted that the evidence showed Ms Damjanovic's death occurred as a result of a tragic accident and neither Ms Damjanovic nor Ms Clark was at fault for the accident. Rather, it was a combination of those factors above that led to the circumstances in which Ms Damjanovic was crossing the road in the path of a car, and the driver attempted to avoid her but was unable to do so.

It was noted that at the time of the accident the speed limit on Swann Road was 60km/h and has since been lowered to 50 km/h.

Recommendations
The Coroner noted that there was nothing in the evidence that showed that there was any particular deficiency in the design or infrastructure of the intersection at which the accident happened which caused Ms Damjanovic's death, but that the intersection appears to be known to locals as one at which vehicles often have difficulties.

The Coroner made one recommendation: that the Brisbane City Council and Queensland Rail review the area of Swann Road at the bridge and at the intersections of York and Cunningham Street in order to determine whether any improvements to the safety of the intersection could be made, including the height of the chain-link fencing, the lighting, and the safety of the road surface in wet conditions.

The findings of the inquest are available on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0011/669890/cif-damjanovic-a-20210225.pdf

Kirra-Lea McLoughlin

Deputy State Coroner, Jane Bentley – 7 June 2021

Background
Ms Kirra-Lea McLoughlin lived at a property at Wolvi that had been her matrimonial home when she was married to Roger McLoughlin, the father of her four children. Ms McLoughlin and Mr McLoughlin separated in August 2013. Ms McLoughlin's defacto partner Paul McDonald had resided with her since 25 August 2013. Ms McLoughlin's children were living with her then but, in July 2014, Mr McLoughlin took the children to live with him because Mr McDonald was violent and aggressive.

A family lived next door to Ms McLoughlin – F and M and their three children C1, C2 and C3. Whilst he initially denied it to police, C1 later admitted that he and Ms McLoughlin had a sexual relationship over about two months which ended before she commenced her relationship with Mr McDonald. This family and other neighbours often heard Ms McLoughlin and Mr McDonald fighting and knew that Mr McDonald was violent to Ms McLoughlin all the time.

The investigation
Detectives of the Criminal Investigation Branch investigated the circumstances surrounding the death of Ms McLoughlin. They obtained the following information obtained from relevant parties, witnesses, and telephone records.

On 16 July 2014 Mr McDonald's mother Ms Anderson, his sister, Tamiqua McDonald, her four-year-old daughter, D, and her 18-year-old niece, Jessie McDonald were at Ms McLoughlin's house. Ms McLoughlin started drinking wine at about 1pm, and the others were drinking as well. Ms Anderson left Ms McLoughlin's house at about 7.10pm. At about 7.30pm Ms McLoughlin started arguing with Tamiqua and Jessie. Mr McDonald and Ms McLoughlin then argued about Ms McLoughlin's relationship with C1, and Ms McLoughlin started yelling at Mr McDonald and pushing him. Tamiqua defended him and she and Ms McLoughlin and Tamiqua got into a physical altercation during which Tamiqua punched Ms McLoughlin to the head twice and Ms McLoughlin fell down twice. Mr McDonald was trying to get between them, and Ms McLoughlin picked up a tin of red paint and threw it at Mr McDonald. Ms McLoughlin slipped in the paint and fell over and hit her head on the verandah railing. Tamiqua, Jessie and D left the house and Mr McDonald left after them.

While Ms McLoughlin was at the house alone, she was on the phone to Roger McLoughlin. She was upset and crying, saying that she missed her children and asked him to come back to live with her and the children. About 10 seconds before the end of the call she became aggressive, told him that she'd stab him in his sleep and hung up. Mr McDonald had come home at that time, which just before 9:30pm. At 9:30pm C2 heard Ms McLoughlin yelling, "I don't love you anymore", and heard screaming and banging which was even louder than that which occurred earlier in the evening. Ms McLoughlin was screaming like she was being hurt. It then went quiet, and he heard Mr McDonald's voice only. No one heard Ms McLoughlin's voice or had contact with her after this time except Mr McDonald.

Mr McDonald called an ambulance at 2:14pm the next day, 17 July. McDonald told paramedics that Ms McLoughlin told him about midnight that she had taken about 20 Allegron tablets. He said there was a party and between midnight and 2am his sister had punched Ms McLoughlin in the face multiple times, but she wasn't knocked unconscious. After the fight everyone left, and he and Ms McLoughlin went to bed at about 3.30am. He woke up about 7am and thought she was sleeping, woke again at 1.30pm and saw she had wet the bed and was unresponsive. He carried her to the shower, undressed her and washed her and carried her back to bed and dressed her. He called 13HEALTH and the operator told him to call an ambulance. Paramedics transported Ms McLoughlin to the Gympie Hospital arriving there at 3.23pm. At 8.45pm Ms McLoughlin was flown to the Gold Coast University Hospital. At 9.20pm on that night Mr McDonald was arrested by police for the offence of grievous bodily harm. He declined to be interviewed by police and was released at 11.15pm without charge.

Domestic and Family Violence Death Review Unit report

The Domestic and Family Violence Death Review Unit of the Coroners Court of Queensland compiled, from the records of the Queensland Police Service, a report summarising the documented history of domestic and family violence of Ms McLoughlin, as well as documented domestic and family violence involving Mr McDonald's previous and subsequent partners. The Deputy State Coroner found that Mr McDonald's criminal history revealed him to be a serial perpetrator of severe domestic abuse, including over 70 convictions for domestic violence related offending as well as lengthy periods of imprisonment, relating to three other women.

In 2018 Mr McDonald was in a relationship with Ms J, who he also abused. He confessed to Ms J that he had banged Ms McLoughlin's head on the floor after they argued about C1, and told her, "I have got away with murder, and I'll kill you if you ever say anything to anybody."

The inquest

Twenty-six witnesses gave evidence at the inquest including police officers, doctors, family and neighbours of Ms McLoughlin and Mr McDonald. Mr McDonald chose not to give evidence.

Findings and Comments

The Deputy State Coroner found that Ms McLoughlin died from hypoxic-ischaemic encephalopathy due to head injury at 3.10pm on 18 July 2014 at the GCHU. She found that Ms McLoughlin's death was caused by Mr McDonald either choking her or inflicting head

injuries which restricted oxygen and/or blood to her brain. The Deputy State Coroner found that it is very unlikely that the injuries Ms McLoughlin sustained during the altercation with Tamiqua were sufficient to cause her death or cause the majority of the 102 bruises which were found on her body at autopsy.

The Deputy State Coroner found that Mr McDonald and Ms McLoughlin started to argue later in the night when he returned, and it is likely that she told him she wanted to end the relationship. The Deputy State Coroner did not accept that Ms McLoughlin's death was explained by any of the scenarios put forward by Mr McDonald, instead finding that her injuries were caused by Mr McDonald during the argument. It is probable that he hit her head into the back of the toilet wall, struck her to the forehead (very possibly with a baseball bat) and hit the back of her head on the floor. It is likely that he struck her with a broom stick. It is highly probable that he choked her. It is likely that by 11.30pm Mr McDonald had caused the injuries that killed Ms McLoughlin, that she was unconscious as a result of those injuries and that Mr McDonald knew that Ms McLoughlin was seriously unwell. He did not call an ambulance to assist her until the following afternoon.

The findings of the inquest are available on the Queensland Courts website at:
https://www.courts.qld.gov.au/__data/assets/pdf_file/0007/686248/cif-mcloughlin-k-20210607.pdf

Tiahleigh Palmer

Deputy State Coroner, Jane Bentley – 18 June 2021

Circumstances of the death
At the time of her death Tiahleigh was aged 12 years and 6 months. She was living with foster carers Richard Thorburn, his wife, Julene, and their sons, Joshua, and Trent. At about 5.15pm on 5 November 2015 three men looking for a fishing spot found Tiahleigh's near naked and decomposed body on the water's edge of the Pimpama River on Kerkin Road North. She was obviously deceased and had been for some time. An autopsy was conducted but the cause of Tiahleigh's death could not be determined due to the level of decomposition. The Thorburn family told police that Tiahleigh had gone to school on the morning of 30 October 2015 and that she did not come home.

In 2016 Richard Thorburn was arrested and charged with murdering Tiahleigh on the night of 29 October 2015. He was also charged with attempting to pervert the course of justice for lying to police and with interfering with a dead body. He pleaded guilty to all charges (although he did not disclose how he killed Tiahleigh) and in the Brisbane Supreme Court on 25 May 2018 he was sentenced to life imprisonment.

It was discovered that Trent had been having a sexual relationship with Tiahleigh and he was charged with incest, attempting to obstruct the course of justice and two counts of perjury. Julene was charged with attempting to pervert the course of justice and perjury. Joshua was charged with attempting to pervert the course of justice and perjury. Trent, Julene and Joshua pleaded guilty to those offences and were sentenced to various periods of imprisonment.

On 4 May 2016 Mr Thorburn was charged with thirteen sexual offences in relation to two girls who, in 2015, had attended the family day care operated by Julene at their house. The girls were 4 and 11 years old at the time. Mr Thorburn entered pleas of guilty to those offences but attempted to withdraw his pleas on the basis that he had complete amnesia and was pressured into pleading guilty by his legal representatives. Mrs Thorburn told his solicitor that he had lost his memory, didn't recall who she was and could not make phone calls. That information was inconsistent with observations of Mr Thorburn at the prison making phone calls and the opinions of numerous psychologists who considered that he was "malingering". The application to withdraw the pleas was rejected by His Honour Judge Chowdury DCJ who found that Mr Thorburn was a dishonest witness and he had entered the pleas of his own free will. Mr Thorburn was sentenced for those offences in the Beenleigh District Court on 20

November 2020, to a head sentence of five years imprisonment with a parole eligibility date of 12 September 2038.

Tiahleigh's involvement with the Department of Child Safety

By the time she was killed at the age of 12 years, Tiahleigh had been effectively rejected by both of her parents and had lived in nine different households and a residential care facility. In the two years prior to her death, she was subject to a short-term custody order granting custody to the Chief Executive, Department of Child Safety, Youth Justice and Multicultural Affairs (the department).

The department first received concerns about Tiahleigh's welfare less than a month after her birth. The concerns were in relation to domestic and family violence, her mother's parenting capacity and motivation, and her mother's substance misuse, including reports that Tiahleigh had gone through drug withdrawal at birth. After Tiahleigh went into out-of-home care when she was seven years old, she was diagnosed with Reactive Attachment Disorder (this diagnosis was changed in November 2014 to Adjustment Disorder), and she demonstrated ongoing challenging behaviours. This was unsurprising considering her tumultuous life and her lack of attachment to a primary care giver.

An application for a Long-Term Order (LTO) granting guardianship to the chief executive was made on 22 October 2015. Shortly prior to her death Tiahleigh's mother indicated to the department that she had decided to relinquish guardianship of Tiahleigh and would not contest the LTO.

The inquest

The inquest commenced on 8 June 2021 after a pre-inquest hearing on 11 May 2021. The only issue to be explored at the inquest was how Tiahleigh died. Four witnesses were called: Richard, Julene and Trent Thorburn, and one of the police officers who was involved in the murder investigation. A brief of evidence was tendered which included the complete Queensland Police Service brief in relation to the charges against the Thorburn's relating to Tiahleigh, and the brief in relation to the child sexual offending to which Mr Thorburn pleaded guilty.

The brief also included records obtained from Queensland Corrective Services in relation to Mr Thorburn since his incarceration and recordings of phone calls he made to Julene from the prison for the periods 1 to 15 October 2019 and 2 May 2021 to 1 June 2021.

Mr Thorburn commenced his evidence at the inquest by producing a typed signed statement which he read to the court. He said that on the night of her death, Tiahleigh had tried to run away, and when he was trying to get her back to the house, "I must have accidentally suffocated her with my hand over her mouth and holding her so tightly around the waist and tummy." Under questioning from Counsel Assisting Mr Thorburn said he in fact had no independent recollection of what happened to Tiahleigh and he was relying on a note he had apparently written some years before as he had completely lost his memory in prison.

Findings and comments

The Deputy State Coroner found that there was a lack of permanency planning for Tiahleigh by the department. At no time in her short life had she experienced any real stability. The case planning for Tiahleigh was not focused on what was in her best interests, but instead, on supporting her mother and ensuring that her mother's interests and "rights" were considered. However, the most concerning aspect of the department's involvement with Tiahleigh was the lack of concern or action when it was known that she was missing from about lunch time on 29 October 2015. The circumstances seem to indicate a failure to prioritise the danger that Tiahleigh may have been in and instead concentrate on administrative procedures (although not as a matter of any urgency).

However, the Deputy State Coroner noted that the departmental involvement with Tiahleigh has been the subject of numerous reviews and reports and that the many recommendations made have been addressed and implemented – by the department and other involved

agencies. The Deputy State Coroner therefore made no recommendations in relation to this aspect of the coronial investigation.

The Deputy State Coroner did not accept that Mr Thorburn has no memory of Tiahleigh's death. His claimed amnesia is inconsistent with opinions of prison psychologists, observations of prison employees and phone calls between him and his wife. The Deputy State Coroner found that Mr Thorburn deliberately killed Tiahleigh, and that it is most likely that he choked or asphyxiated Tiahleigh. Mr Thorburn may have killed Tiahleigh because he was concerned that she would disclose her relationship with Trent, or because Mr Thorburn was himself having a sexual relationship with her, but the former reason was more likely.

The Deputy State Coroner found that Mr Thorburn is completely without remorse for any of his offending, and respectfully recommended that if and when he applies for release on parole the Parole Board Queensland take into account these findings particularly in relation to his lack of remorse for killing Tiahleigh and his lack of cooperation with this inquest.

The findings of the inquest are available on the Queensland Courts website at:
https://www.courts.qld.gov.au/__data/assets/pdf_file/0008/687131/cif-palmer-ta-20210618.pdf

Accessing 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:

Rebecca Keane, *BJus, LLB(Hons), DipGovSec,* PhD Candidate, Faculty of Law at the Queensland University of Technology (QUT)
Undertaking a project to establish the differences between offenders in the context of a domestic and terrorist siege, their respective motivations, and ideologies, what drives offending, and whether this influences their response to negotiation techniques used in domestic sieges. The project aims to determine whether domestic policing siege methodologies and crisis negotiation techniques are appropriate in the crisis response to a terrorist siege.

Michelle Johnston, Senior Chemist, Forensic Toxicology at Queensland Health Forensic and Scientific Services (FSS)
Undertaking a project to analyse a case report related to the ingestion of the drug, Kratom and other illicit substances. Kratom can cause effects similar to both opioids and stimulants. Two compounds in Kratom leaves, *mitragynine* and *7-α-hydroxymitragynine*, interact with opioid receptors in the brain, producing sedation, pleasure, and decreased pain, especially when users consume large amounts of the plant. Mitragynine also interacts with other receptor systems in the brain to produce stimulant effects. When Kratom is taken in small amounts, users report increased energy, sociability, and alertness instead of sedation. However, Kratom can also cause uncomfortable and sometimes dangerous side effects.

Dr Melissa Thompson, Staff Specialist Forensic Pathologist at Gold Coast University Hospital, Dr Alex Olumbe, Eminent Forensic Pathologist and Associate Professor at

Gold Coast University Hospital, Jairus Landolt Griffith University School of Medicine, MD stream
Undertaking a research project which is a retrospective review of autopsy files of drowning/immersion deaths on the Gold Coast during the period 2015 to 2020. The project aims to collect demographic, medical, toxicological, location and activity data related to drowned decendents, with particular emphasis on known risk factors.

Freya McLaughlan, Dr Bridget Harris, and Dr Claire Ferguson – School of Justice – QUT
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 and 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.

Information requests in 2020–21:

5	**1,297**	**1,046**
Genuine Researchers approved	Individual requests for documents on finalised maters	Phone call enquiries received

Reducing preventable deaths

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 Brisbane Coroner, Christine Clements into the two youth deaths referred to as Master Carr and Jaylen. Master Carr and Jaylen died on 2 April 2018 in a single vehicle crash on the Gore Highway, 35 Kilometres north of Goondiwindi. Coroner Clements made six recommendations[18] with responses to the recommendations provided by the Department of Transport and Main Roads, Queensland Police Service and Queensland Health.

[18] Queensland Government response to Master Carr and Jaylen coronial inquiry recommendations https://www.justice.qld.gov.au/__data/assets/pdf_file/0007/677239/qgr-carr-jaylen-20210713.pdf

Systemic death review initiatives

Domestic and Family Violence Death Review Unit (DFVDRU)

The DFVDRU is based within the CCQ and provides specialist advice and assistance to coroners in their investigations 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 identifies trends and patterns regarding domestic and family violence related homicides and suicides to assist in identifying opportunities for prevention.

The DFVDRU supports other death prevention activities within the CCQ and provides advice on national and state policy and practice initiatives, as they relate to the coronial jurisdiction. Data held by the DFVDRU is shared with government and non-government sectors to inform policy and practice reforms.

The DFVDRU is 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 DFVDRU maintain two comprehensive statistical databases:

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

In the 2020–21 financial year, the DFVDRU completed 63 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 Deputy State Coroner Jane Bentley's findings at inquest in the death of Kirra-Lea McLoughlin and the non-inquest findings into the deaths of:

- Intimate partner homicide/suicide of Teresa and David Bradford – Deputy State Coroner Jane Bentley
- Intimate partner homicide of Tara Brown – Deputy State Coroner Jane Bentley
- Intimate partner homicide of Fabiana Palhares – Deputy State Coroner Jane Bentley

The DFVDRU also provides secretariat support to the Domestic and Family Violence Death Review and Advisory Board (The Board). 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 legislation, policy, and practice to prevent or reduce the likelihood of domestic and family violence deaths.

Further information about the Board can be found in the Board's annual reports available on the Queensland Courts website[19].

Sudden and Unexpected Death in infancy (SUDI) Multiagency Advisory Meeting Pilot – partnership with the Queensland Paediatric Council

The infant mortality rate in Queensland is higher than the rest of Australia for reasons that currently remain unclear. It is recognised that while the coronial process, through autopsy, may determine a cause of death, it is not always able to identify or examine the complex set of risk and contributory factors that may be present in the events leading to the infant's death that could inform death prevention opportunities.

[19] 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

During the 2020-21 financial year, the CCQ partnered with the Queensland Paediatric Quality Council (QPQC) to pilot a process to improve the coronial investigation of Sudden and Unexpected Deaths in Infancy (SUDI).

The purpose of the multiagency advisory meeting process is to provide advice and make recommendations to the investigating Coroner in relation to SUDI deaths reported under the *Coroners Act* 2003 and to coordinate timely and tailored support to families bereaved by SUDI.

The meetings are convened by CCQ through the DFVDRU which provides secretariat support for the trial and includes various experts and professionals from QPS, Queensland Health, QPQC and the Queensland Family and Child Commission. The pilot process will be evaluated in the 2021-22 financial year in partnership with the QPQC, and this process will inform prevention initiatives and th development of investigation guidelines for SUDI.

Systemic review of male suicide deaths – partnership with the Queensland Mental Health Commission

In recognition of the need for a deeper understanding of the context in which male suicides occur, *Every life: The Queensland Suicide Prevention Plan 2019-2029*[20] committed to undertaking a trial systemic review process to inform a comprehensive strategy for men's suicide prevention.

Systemic death review processes have been established across jurisdictions to facilitate these types of deeper learnings. They currently operate within the Queensland coronial jurisdiction for domestic and family violence related homicides and suicides and the deaths of children known to the child protection system (including suicides).

The CCQ has agreed to partner with QMHC to deliver this project and to build upon the existing expertise to review these types of deaths within the court. Learnings from this review process will also be used to inform the development of investigation guidelines for apparent suicides to assist all coroners in their investigations of these types of deaths. This is intended to support a more consistent approach to such investigations, which over time will lead to improvements in the type of information that is available to inform research and prevention activities.

A report which collates the systemic findings from this review process will also be compiled which will be used to inform the development of a targeted strategy for men's suicide prevention, and future activities to be undertaken in the next phases of *Every Life*.

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.

Barry Haynes
State Coroner, Terry Ryan – 16 November 2020

[20] The QLD Suicide Prevention Plan 2019-2029 (Every Life)
https://www.qmhc.qld.gov.au/sites/default/files/every_life_the_queensland_suicide_prevention_plan_2019-2029_web.pdf

Mr Barry Haynes was a 58-year-old indigenous man who died on 3 April 2017. He died at the Princess Alexandra Hospital Secure Unit ('PAHSU') after being transferred there from Arthur Gorrie Correctional Centre ('AGCC') where he had been on remand since 16 December 2016. Mr Haynes was a Pitjantjatjara and Nunga man from Kamilaroi country in New South Wales.

Circumstances of the death

In June 2015, Mr Haynes was diagnosed with non-small cell lung cancer. He underwent chemotherapy at Gosford, New South Wales where he was living at the time. In August 2016, it was found that Mr Haynes had widespread metastases through his lungs, liver, bones, and lymphatics. In November 2016, a CT scan showed Mr Haynes had intracranial metastases.

Mr Haynes was remanded at Maryborough Correctional Centre on 15 November 2016 for domestic violence offences. He was ultimately transferred to AGCC because a higher level of palliative care and treatment could be provided to him there. Mr Haynes received palliative radiotherapy treatment at the Princess Alexandra Hospital ('PAH'). Despite this, his condition continued to decline, with advancing intracranial metastatic disease and deterioration in the appearance of his right lung and pleural effusion by January 2017.

On 9 March 2017, Mr Haynes was to be taken to the PAH palliative care outpatient clinic, however he had a fall and hit his head on the concrete. After being assessed and found to be hypoglycaemic he was taken to PAHSU where he remained until his death. A CT scan showed no injury to his head as a result of the fall. On 29 March 2017, Mr Haynes' condition deteriorated, and health checks were conducted every two hours. At approximately 3:20am on 3 April 2017, Mr Haynes was found unresponsive and not breathing. Mr Haynes was declared deceased at 3.50am.

The investigation

The Queensland Police Service Corrective Services Investigation Unit investigated Mr Haynes' death. A report, along with medical records and information about the circumstances of Mr Haynes death was submitted. There were no issues or concerns raised that indicated the death was suspicious.

An external autopsy examination with associated CT scanning and toxicology testing concluded the cause of death was metastatic non-small cell carcinoma.

The State Coroner was also assisted by a report from Dr Natalie MacCormick from the CFMU to address concerns raised by Mr Haynes' family that Mr Haynes did not receive chemotherapy treatment, he only received pain management and he was neglected by the prison health care system. Dr MacCormick conducted a review of Mr Haynes' medical treatment while he was in custody. Dr MacCormick found that My Haynes received excellent treatment despite his incarceration. Dr MacCormick could not identify any errors to Mr Haynes' care that would have hastened his death.

The inquest

As Mr Haynes died in custody, an inquest was mandatory under s 27 of the *Coroners Act 2003*. All statements, medical records and material gathered during the investigation into Mr Haynes' death were tendered to the court and submissions were made in lieu of any oral evidence being heard.

At the inquest, Mr Haynes family raised concerns about whether AGCC was suitable for a person in Mr Haynes' condition, that Mr Haynes' transfer to a better suited facility with appropriate palliative care was delayed, and that steps were not taken to have another decision maker when it was apparent that Mr Haynes did not have capacity to make personal, health care or legal decisions. In a supplementary written submission, the family emphasised that they were not critical of the actions of individuals at the AGCC medical centre. Their concerns related to systematic barriers that prevented Mr Haynes from receiving appropriate palliative care.

At the inquest, the Public Advocate (PA) was given leave to appear as an interested party. The PA endorsed the written submissions made by the family including the issue of appointing another decision-maker on behalf of Mr Haynes. The PA also made written submissions related to a bail application for Mr Haynes prior to his death that did not proceed.

Findings and comments

The State Coroner was satisfied that Mr Haynes died from natural causes and that he received adequate medical care during his time in correctional centres and the PAHSU.

In relation to Mr Haynes' capacity, the State Coroner commented that there was insufficient evidence to point out exactly when Mr Haynes lost capacity to the extent that he required the formal appointment of a substitute decision-maker. In relation the AGCC not being a suitable facility to provide palliative care, evidence was submitted that there is no dedicated palliative care unit in any of the correctional centres in Queensland. The State Coroner noted that, subsequent to Mr Haynes' death, Queensland Health had established the Office for Prisoner Health and Wellbeing (OPHW), which oversees that health services provided to prisoners are equivalent to those that are available in the wider community.

Recommendations

The State Coroner made two recommendations. The first was that the Queensland Government publish a policy on the provision of personal health care for prisoners who are ageing and/or requiring palliative care, addressing matters such as arrangements to support family contact with prisoners undergoing palliative care at the time of their death (including the circumstances in which restraints can be removed in secure hospital units), and consistency with National Palliative Care Standards.

The second recommendation was that QCS and the OPHW, in consultation with West Moreton Hospital and Health Service, the Office of the PA, and the Office of the Public Guardian, develop a framework to address the lack of awareness of the regime for the appointment of decision-makers as required by a person with impaired capacity in gaol.

The findings of the inquest are available on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/659607/cif-haynes-b-20201116.pdf

John Francis Alex Martyn

State Coroner, Terry Ryan – 11 December 2020

Mr John Francis Alex Martyn was an Aboriginal male, aged 75 years. He was serving a custodial sentence at the Southern Queensland Correctional Centre (SQCC) following his 1987 conviction for murder, for which he was sentenced to life imprisonment with hard labour.

Circumstances of the death

In 2012, Mr Martyn was diagnosed with bony lesions from metastatic prostate cancer. Whilst that condition initially responded to hormone therapy, it progressed to the stage where there was no longer any viable treatment that could be offered to Mr Martyn other than palliation.

On 24 April 2017, Mr Martyn, whilst receiving care within the Acute Care Unit (ACU) at SQCC, experienced a significant deterioration in his condition. His deteriorating condition was managed in accordance with the Advanced Health Directive (AHD) that he had completed on 14 April 2016. Mr Martyn was declared life extinct at 2:37pm on 25 April 2017. Following a post-mortem examination, his cause of death was determined to be metastatic prostatic cancer.

The investigation

The Corrective Services Investigation Unit (CSIU) investigated the circumstances surrounding Mr Martyn's death.

Based on the evidence they obtained (including witness statements from corrective services staff, nursing, and medical staff with the Princess Alexandra Hospital (PAH), and medical records) the CSIU concluded Mr Martyn was provided with adequate medical care and attention while he was in the custody at SQCC. The CSIU further concluded there were no suspicious circumstances surrounding Mr Martyn's death, nor any omission by any person which may have contributed to or caused it.

The inquest

At the time of his death, Mr Martyn was a prisoner in custody. Pursuant to s 8(3)(g) of the *Coroners Act 2003* Mr Martyn's death was a 'death in custody' and therefore an inquest was required.

The inquest was held on 17 June 2020. All witness statements, medical records and other material gathered during the investigation were tendered. No oral testimony was called, in lieu of which parties proceeded to make submission on the tendered material.

The Inquest examined Mr Martyn's history of release on parole, returns to custody and the medical treatment that he continued to receive through Offender Health Services. A review of that medical treatment by the Queensland Forensic Medicine Unit did not identify any basis for criticism of that medical treatment.

Public interest submissions by the Aboriginal and Torres Strait Islander Legal Service contended that the level of care provided to Mr Martyn within SQCC was not appropriate to his needs and that treatment within a community setting was more appropriate.

Findings and comments

The State Coroner found that Mr Martyn had been correctly diagnosed and experienced a significant deterioration in the weeks prior to his death. His death was from natural causes and there were no suspicious circumstances associated with it.

The State Coroner further found, with reference to the expert opinion of Dr Home, that Mr Martyn was given appropriate medical care by staff at SQCC and at the PAH while he was admitted there and that his death could not reasonably have been prevented.

The State Coroner commented that:

It is a recognised principle that the health care provided to prisoners should not be off a lesser standard than that provided to other members of the community.

In that regard the State Coroner found the evidence tendered at the inquest established the adequacy of the medical care provided to Mr Martyn when measured against this benchmark. It was further found that when SQCC was unable to manage Mr Martyn's medical care, he was appropriately transferred to PAH. At all other times, Mr Martyn's medical needs were capable of being met at SQCC.

As to whether a prisoner approaching their end of life, would more appropriately be treated in a community setting, the State Coroner further commented that:

The provision of such care could only apply to prisoners who are subject to an appropriate risk assessment and that the wishes of the prisoner must be balanced against the needs for community safety.

Recommendations relating to the provision of personal and health care for prisoners who are ageing and/or requiring palliative care were previously made in the November 2020 findings following the Inquest into the death of Mr Barry Haynes.

In the circumstances of Mr Martyn's death, there were no additional comments or recommendations that could be made, connected to his death, relating to public health or safety or the administration of justice.

The findings of the inquest are available on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0019/661132/cif-martyn-j-20201211.pdf

Alexander David Aitkenhead

State Coroner, Terry Ryan – 17 December 2020

Mr Alexander David Aitkenhead died at 86 years of age in the palliative care unit at Rockhampton Hospital. Mr Aitkenhead had been an inmate at the Capricornia Correctional Centre.

Circumstances of the death
Mr Aitkenhead was received into custody on 23 June 2015 at the age of 82 years. He suffered from many chronic illnesses including chronic obstructive pulmonary disease, atrial fibrillation, emphysema, osteoporosis, osteoarthritis, hypertension, and reflux.

During his incarceration he had several hospital admissions and Assistant in Nursing staff were specifically hired to assist him with daily living activities whilst he was in prison. He was regularly visited by the visiting medical officer and seen by staff at the prison health centre. He confirmed with a visiting medical officer that he wished for a 'Not for Resuscitation' order he had previously signed to remain in place.

The investigation
The Corrective Services Investigation Unit conducted an investigation into his death which concluded that he had received adequate medical care as a prisoner and that his death was unavoidable, there being no act or omission by any person that resulted in his death.

A police investigation found that Mr Aitkenhead died of natural causes and there were no suspicious circumstances associated with his death.

The inquest
At the time of his death, Mr Aitkenhead was a prisoner in custody. Pursuant to s 8(3)(g) of the *Coroners Act 2003* Mr Aitkenhead's death was a 'death in custody' and therefore an inquest was required.

The inquest did not hear any oral testimony and all statements, medical records and material gathered during the investigation were tendered.

Findings and comments
The State Coroner agreed with the findings of the police investigation that Mr Aitkenhead died of natural causes and without suspicious circumstances. Against the benchmark that prisoners should receive health care that is no lesser standard than that provided to other members of the community, the health care provided to Mr Aitkenhead was adequate. He found there was no basis for adverse comments about the care and attention Mr Aitkenhead received whilst in custody, none of the Corrective Officers involved contributed to his death, and that he was given appropriate medical care by staff at the jail and the hospital. He found that his death could not have been reasonably prevented.

The findings of the inquest are available on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0009/661473/cif-aitkenhead-a-20201217.pdf

Richard Hobbs

State Coroner, Terry Ryan – 17 December 2020

Mr Richard Hobbs was 48 years old at the time of his death on 21 November 2017 at the Brisbane Correctional Centre. Mr Hobbs had been sentenced to a three-and-a-half-year term of imprisonment on 10 October 2017, to be suspended for four years after serving 12 months.

Circumstances of the death
Mr Hobbs had a number of comorbidities, including diabetes, obesity, blood pressure and cardiac problems. He had been prescribed at least 12 different medications. On 13 September 2017, he underwent a balloon angioplasty and had a drug-eluting stent inserted for severe coronary artery disease. He experienced further chest pain post procedure for which he was admitted to the Royal Brisbane and Women's Hospital (RBWH) from 25 to 27 September 2017.

On 19 October 2017, Mr Hobbs was found to be in a semi-conscious state and a Code Blue was called. Mr Hobbs complained of chest pain and said he felt like he had been hit by a truck. He was transferred to the PAHSU for treatment and was discharged back to BCC that same day. Then on 13 November 2017, he attended the RBWH for a review at the cardiology clinic and returned to BCC that same day. The following day the VMO made medication changes to his chart following his visit to the RBWH the previous day. On 17 November 2017, he was taken to the PAH following a review of his pathology results. A chest x-ray revealed "alveolar opacification suggestive of pneumonic consolidation" which likely represented a small pleural effusion. He was discharged that day and returned to BCC. Two days later, Mr Hobbs was reviewed at the health centre and found to have a mildly elevated temperature, oxygen saturations of 92% and his chest was slightly wheezy. He was commenced on oral antibiotics for a chest infection.

At about 5am on 21 November 2017, a code blue was called for Mr Hobbs. He complained of shortness of breath and nurses noted wheezes in the right lung. He informed the nurses that he had started antibiotics and he was sleeping on his side when he woke up feeling distressed and short of breath. He self-administered 2 puffs of Ventolin and this appeared to improve his breathing. He was advised he would be reviewed at 7.30am when he attended the health centre for his blood sugar check.

At his 7.30am review, a mild right sided wheeze was noted, and he otherwise appeared well enough to return to his unit. At 12.30pm, Mr Hobbs refused to leave his cell or accept other visitors because he had diarrhoea and wanted to rest. Nurses attended his cell and asked if they could see him, but Mr Hobbs declined. Arrangements were subsequently made for his insulin to be made available for his night-time check at 3.30pm at the health centre.

A short time after 3pm, Mr Hobbs was observed by his cellmate, laying on a mattress on the floor, groaning and saying he could not get up. Correctional officers were notified and called a code blue for medical staff to attend the cell. The nurses arrived within 5 minutes. Mr Hobbs disclosed he had gastro all day with diarrhoea and vomiting, and when he stood up, he felt weak and fell on the ground, badly hurting his right shoulder. He was then taken by stretcher to the health centre.

The nurse practitioner observed him to be grossly swollen with normal colour, in pain, distressed, short of breath and sweaty. It was opined that Mr Hobbs was possibly suffering from pneumonia, sepsis, or congestive cardiac failure. He was administered pain relief, antibiotics and QAS were called at 4.15pm.

When QAS arrived, Mr Hobbs was wheeled to the ambulance bay on the stretcher trolley. Once at the back of the ambulance bay Mr Hobbs had to be taken off the stretcher and walk down the stairs to the ambulance, as there was no ramp, and the trolley could not be taken down the stairs. Mr Hobbs was mildly short of breath as he walked the 4 metres with assistance. He was then assisted onto the stretcher and loaded into the ambulance.

At this time, Mr Hobbs had a cardiac arrest and lost consciousness, and a Code Blue was called at 4.53pm. Mr Hobbs was removed from the ambulance, and paramedics began CPR. Nursing staff arrived from the health centre and assisted in resuscitative efforts, including CPR and the administration of adrenaline. Mr Hobbs was declared life extinct at 5.26pm.

The investigation

An investigation into the circumstances surrounding Mr Hobbs' death was conducted by the Corrective Services Investigation Unit (CSIU). A coronial report was provided and included various statements from doctors and correctional officers, transcripts of interviews and medical records from the correctional centre. The report found that Mr Hobbs received adequate care and there was nothing suspicious about his death.

Following Mr Hobbs' death, a Human Error and Patient Safety (HEAPS) analysis report was conducted by West Moreton Hospital and Health Services, which identified a number of contributing factors to Mr Hobbs' death. Those factors included information sharing between the Royal Brisbane Womens Hospital and Brisbane Correctional Centre, progress notes and handover information for medical staff, and the absence of a ramp at the ambulance bay.

All recommendations had been accepted and completed as at 23 November 2018. In addition, the ramp in the ambulance bay was constructed on 8 March 2019.

An independent medical review was provided to the Coroner's Court by the CFMU on 2 September 2020. This review considered whether Mr Hobbs had access to and received appropriate medical care whilst he was in custody. The review concluded that the lack of assessment and consultation with a nurse practitioner or VMO following the code blue on the morning of Mr Hobbs' death and decision to return him to his cell, was reasonable. Particularly because Mr Hobbs was not agreeable to that. She also concluded that the requirement for him to walk the 4 metres to the ambulance from the health centre was 1 of several factors that contributed to Mr Hobbs' cardiac event and death.

Ultimately the review concluded that Mr Hobbs received appropriate medical care while incarcerated at the BCC, however, did express concerns about the communication between RBWH to the BCC Health Centre following the cardiology outpatient review and medication changes and the diagnosis of costochondritis, pain from which may mimic that of a heart attack or other heart conditions.

Ultimately had these issues been handled differently, it would not have been outcome changing for Mr Hobbs.

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 noted that it is an accepted 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, including the CFMU review, established the adequacy of the medical care provided to Mr Hobbs when measured against this benchmark. The issue identified in relation to the absence of a ramp from the health centre was addressed and as such, the circumstances of Mr Hobbs' death did not call for any comments or recommendations.

The findings of the inquest are available on the Queensland Courts website at:
https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/661416/cif-hobbs-r-20201217.pdf

Cindy Leigh Miller

State Coroner, Terry Ryan – 22 January 2021

On the night of 20 April 2018, Ms Cindy Leigh Miller was a passenger in a vehicle that was stopped during a routine registration and driver licence check. After Queensland Police Service (QPS) Officers established her identity, they identified Ms Miller had two outstanding warrants. One of those warrants was connected with failing to appear at court. She was arrested on those warrants, charged with two fresh drug-related offences, then taken into custody at the Ipswich Watchhouse.

Circumstances of the death
At 1:35am on 21 April 2018 Ms Miller was found by a watchhouse staff member in an unresponsive state in a secure cell. Efforts at resuscitation were unsuccessful and Ms Miller was declared life extinct at 2.10am. Ms Miller was aged 44 years. An autopsy examination determined that Ms Miller's cause of death was mixed drug toxicity. Toxicology analysis of a femoral blood sample had confirmed the presence of amphetamine, methylamphetamine within toxic levels, ephedrine/pseudoephedrine at non-toxic levels and paracetamol and tramadol within the usual therapeutic range.

The investigation
The QPS Internal Investigations Group (IIG), Ethical Standards Command, investigated the circumstances surrounding Ms Miller's death. The investigation was informed by statements and recorded interviews with the relevant watchhouse and police officers and Queensland Ambulance Service (QAS) staff. CCTV footage and documentation relating to policies and procedures at watchhouses were also obtained. Forensic analysis was conducted. All police investigation material was tendered at the inquest.

The inquest
The inquest was held in Brisbane on 11 and 12 August 2020. In addition to the tendered evidence, oral evidence was heard from nine witnesses, including officers with the Queensland Police Service connected with Ms Miller's arrest and watchhouse placement.

The evidence
Mr Miller's medical records did not identify any diagnosed conditions. She last received medical care in 2014 and a review of her PBS and Medicare information determined she had not made any claims for the 12 months preceding her death. Ms Miller had a criminal history that included drug use with associated criminal offending.

When processed at the watchhouse, an assessment of Ms Miller's suitability to be held in custody, including a health questionnaire was completed with her. She denied having consumed any illicit substances in the preceding 24 hours or having an addiction or dependency to drugs of any kind. The were no observable signs to indicate any concerns for Ms Miller's wellbeing. There were no observable indicia of Ms Miller being affected or under the influence of any intoxicating drug or substance. A physical (non-intimate) check of Ms Miller did not locate any items of interest.

Ms Miller was denied bail on account of her risk of failing to appear. She was categorised as a 'Level 1' prisoner for the purpose of frequency of observations, this required watchhouse staff to check on Ms Miller at least every 60 minutes. Checks were performed within the required timeframes and no complaints or concerns were raised as to Ms Miller's wellbeing although CCTV footage identified "*loud and abnormal*" breathing at 11:57pm. The last time signs of life were documented prior to Ms Miller being found unresponsive was at 12:41am (54 minutes prior).

There was nothing to hinder observations of Ms Miller, although practices within the watchhouse were such that there was no immediately proximate check made of her and the quality of CCTV footage was such that only overt movements by Ms Miller were capable of detection.

Upon Ms Miller being found unresponsive there was a delay in securing her airway due to the lack of resuscitation masks, although CPR was commenced immediately as was a call for medical assistance. Whilst attending paramedics identified the CPR as effective, they did give advice to watchhouse staff to alter their technique. Of the ten relevant watchhouse staff that had been rostered around the time of these events, only three had completed first aid or CPR training (in September and November 2017).

No items of interest were located inside Ms Miller's cell however a subsequent physical examination identified the presence of a clip seal bag containing a quantity of methylamphetamine, that had been concealed within a body cavity. It was unable to determined when Ms Miller had ingested methylamphetamine. Whilst it was possible that Ms Miller already a high level of methylamphetamine in her system, it was also possible that the clip seal bag she had concealed had failed and the drug was absorbed that way.

Findings and comments

The State Coroner found there was no evidence to suggest any misconduct on the part of the QPS Officers who had dealt with Ms Miller, there was nothing in Ms Miller's behaviour which would have justified an application for an intimate search, no adverse comment was warranted about the conduct of individual officers with respect to Ms Miller's intake and health assessment and there was no basis for her to be monitored any more closely or regularly than the hourly cell checks to which she was subject.

The State Coroner found that, on review of CCTV footage, there were no obvious movements by Ms Miller after 12.03am and that she was likely deceased from that time. In those circumstances, there was a missed opportunity to identify Ms Miller as medically compromised at the 12:41am check.

While Ms Miller's airway was not adequately managed for the period from when CPR commenced to the arrival of the Paramedics due the absence of resuscitation masks, the State Coroner found that issues relating to the currency of CPR training and CCTV maintenance had been addressed by the time of the inquest.

Recommendations

The State Coroner made two recommendations. The first was that the QPS consider revising the script associated with health questionnaires to ensure prisoners understand the purpose of the questions is to ensure their health can be managed in the watchhouse and to assure prisoners their answers about any past consumption of drugs would not result in any additional charges.

The second recommendation was that the Queensland Government consider whether to commission an independent review of the current arrangements for the investigation of police-related deaths on behalf of the coroner and the oversight of those investigations.

The findings of the inquest are available on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/663468/cif-miller-c-20210122.pdf

Robert Martin Fullerton

State Coroner, Terry Ryan – 24 February 2021

Mr Robert Martin Fullerton was a 59 year-old indigenous man from Palm Island, who died on 19 January 2019. At the time of his death, Mr Fullerton was remanded at the Townsville Correctional Centre (TCC) for multiple offences. He was remanded in custody on 3 December 2018 by the Townsville Magistrates Court. On 5 December 2018, he was transferred to TCC.

Circumstances of the death

On 5 December 2018, after being transferred to TCC, Mr Fullerton was admitted to the Townsville Hospital after he complained to a nurse that he was not able to void faeces without urinating, his bowel movements were infrequent, he had lower abdominal pain and he had lost a significant amount of weight due to his pain. A CT scan of his abdomen found a large heterogeneous and lobulated cystic-like mass centred within the lower pelvis.

By 13 December 2013, Mr Fullerton was diagnosed with terminal cancer. He continued to have abdominal and back pain.

On 13 January 2019, Mr Fullerton was transported from TCC to the Townsville Hospital for ongoing pain management. A CT scan of his abdomen and pelvis showed a worsening primary and metastatic disease in comparison to previous a CT scan. An x-ray performed on 17 January 2019 found some peri-bronchial thickening and patchy consolidation at the lung bases, as well as some small nodular densities in the right lower lobe in keeping with the history of metastatic disease. Mr Fullerton developed left leg swelling and calf tenderness, however an ultrasound revealed no thrombosis.

On 19 January 2019 at 1.50pm, Mr Fullerton reported difficulty breathing. Medical staff attended to him and, as per his Acute Resuscitation Plan, did not call MET or start resuscitation. At 2.11 Mr Fullerton died with his family present.

Mr Fullerton had previous medical history including, hypertension, dyslipidaema, ischemic heart disease (2018), hyperlipidaemia (2018) and myocardial infarction (2006). He had an extensive smoking history that included up to 40 cigarettes and 20 cannabis rollups a day. Mr Fullerton had a history of engaging in alcohol binges and not complying with his medications as required, due to his location on Palm Island and lack of access to pharmacies. He had a record of attendance at the Joyce Palmer Health Services from as early as 1995 due to various medical issues including wound care, general health issues and treatment as a result of being assaulted.

In 2013, after complaints of chest pain it was determined that he suffered a possible cardiac event. In 2017, he was flown to the Townsville Hospital Cardiology Department for cardiac treatment after he developed constant pain in his chest as a result of being punched. An angiogram found 70% stenosis in the left anterior descending artery, a progression from the 40-50% stenosis on a previous angiogram.

In early September 2018, he was found to have an enlarged prostate. Mr Fullerton was on numerous medications prior to his death.

The investigation
The QPS CSIU investigated Mr Fullerton's death. A report, along with medical records, correctional records, statements from medical staff and information about the circumstances of Mr Fullerton's death was submitted. There were no issues or concerns raised that indicated the death was suspicious. Mr Fullerton died from natural causes.

An external autopsy examination, toxicology and review of Mr Fullerton's medical records concluded the cause of death was disseminated carcinoma on a background of emphysema.

The inquest
As Mr Fullerton died in custody an inquest was mandatory under s 27 of the *Coroners Act 2003*. All statements, records of interview, medical records, photographs, and materials gathered during the investigations were tendered at the inquest. No oral evidence was heard at the inquest.

Findings and Comments
The State Coroner accepted that Mr Fullerton's death was from natural causes and that there were no suspicious circumstances. The State Coroner was satisfied that the care provided to Mr Fullerton at Townsville Hospital and TCC was appropriate in the circumstances.

The findings of the inquest are available on the Queensland Courts website at:
https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/669750/cif-fullerton-r-20210224.pdf

Dennis Michael Petzler

State Coroner, Terry Ryan – 24 February 2021

Mr Dennis Michael Petzler was a prisoner at the Capricornia Correctional Centre (CCC). On 2 July 2018, he was admitted to the Rockhampton Base Hospital (RBH) and was diagnosed with metastatic lung/liver cancer of unknown origin. On 5 July 2018, he was discharged from the hospital and returned to the CCC and referred to oncology for further management. On 15 July 2018, he returned to the hospital and was diagnosed with pneumonia. He remained in hospital until he died aged 59 years on 23 July 2018 of carcinomatosis (cancer spread widely throughout the body) as a consequence of adenocarcinoma of the pancreas.

Circumstances of the death
Mr Petzler's medical history included Hepatitis C, gastroesophageal reflux disease (GORD) and chronic right shoulder and back pain. He had been a smoker and previously abused illicit substances and alcohol. His criminal history was lengthy, with entries for property offences, drug-related offence and offences of violence. On 27 September 2017, he was remanded in custody for offences of entering a dwelling with intent to commit an indictable offence in the night and with violence, threatening violence, wilful damage, and assault occasioning bodily harm. He remained in custody at the CCC pending the outcome of the charges.

On 21, 26 and 28 June 2018, Mr Petzler attended the CCC medical clinic complaining of persistent abdominal pain and nausea. A urine test showed traces of blood however those were not significant, and he had no other urinary issues. The doctor's principal diagnosis was 'settling gastritis' but the blood in his urine was to be investigated. On 2 July 2018, Mr Petzler attended the clinic again and was transferred to the RBH for tests. A CT scan of Mr Petzler's chest, abdomen and pelvis at the hospital revealed widespread cancer in his lungs, liver, and lymph nodes. The scan also showed a fracture in a vertebrae in his lower back which may have been caused by cancer or by a non-cancerous tumour. Mr Petzler was prescribed pain relief as required and further investigations were undertaken. On 5 July 2018, Mr Petzler was seen by a hospital doctor and was advised that his cancer was not curable. He was discharged from the hospital and returned to the CCC.

Mr Petzler was readmitted to the RBH on 15 July 2018 where he was diagnosed with pneumonia/severe lower respiratory tract infection. On 16 July 2018, Mr Petzler's condition worsened, and he was referred to the ICU team. He was reviewed and, given the incurable nature of his cancer, was advised he was not a candidate for intubation/ventilation or ICU admission. He was also considered an unsuitable candidate for chemotherapy due to his very poor prognosis. Mr Petzler was moved to the general ward. On 19 July 2018, it was noted that his pneumonia had progressed in both lungs. On 20 July 2018, was commenced on a syringe driver for pain relief.

On 22 July 2018, after consultation with Mr Petzler's family, it was decided that he would be given palliative care. At 9.53pm, Mr Petzler appeared comfortable but had difficulty breathing and was in the company of his son and daughter. On 23 July 2018 at around 3.56am, a custodial officer who was guarding Mr Petzler observed Mr Petzler had died and notified medical staff.

The investigation
Detective Sergeant Stephen Carr from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) led the investigation into the circumstances leading to Mr Petzler's death. The investigation was informed by Mr Petzler's correctional records, his medical files from the CCC and the Rockhampton Hospital and by statements from the relevant nursing and medical staff at the CCC and the Rockhampton Hospital. DSS Carr concluded that Mr Petzler died from natural causes, and that he was provided with adequate medical care at the CCC. He also found that there were no suspicious circumstances associated with the death. The State Coroner was satisfied that the CSIU investigation was professionally conducted, and that all relevant material was accessed.

Dr Ian Home from the CFMU also examined Mr Petzler's medical records. Dr Home noted that it is not uncommon for pancreatic cancer to be diagnosed late in the disease process. He considered that even if Mr Petzler had been sent to hospital following his initial presentation, the diagnosis and outcome would have been unchanged. Dr Home saw no reason to be critical of the care provided to Mr Petzler by the CCC or the RBH.

The inquest
As Mr Petzler died while in custody an inquest was required by s 27 of the *Coroners Act 2003*. All statements, records of interview, medical records, photographs, and materials gathered during the investigations were tendered at the inquest.

Findings and comments
The State Coroner found that Mr Petzler died from a cancer that was not diagnosed until after it had metastasised extensively. There was nothing that could have been done to prevent his death and there were no suspicious circumstances associated with the death.

There was no opportunity for the medical and nursing staff at the CCC or the Rockhampton Hospital to intervene earlier than they did. Mr Petzler died just over one month from his initial presentation with back and stomach pain at the CCC. His illness could not be treated.

The State Coroner also found that Mr Petzler had been afforded a level of health care of a standard no less than he would have received in the community.

The findings of the inquest are available on the Queensland Courts website at:
https://www.courts.qld.gov.au/__data/assets/pdf_file/0005/669758/cif-petzler-d-20210224.pdf

Ashley Thomas Horne

State Coroner, Terry Ryan – 09 March 2021

Mr Ashley Thomas Horne was 49 years old when he died at the Toowoomba Hospital at 12:17am on 31 March 2021. Shortly before his death police had responded to a call from Mr Horne's former partner who had reported that Mr Horne was on her property and was potentially violent.

Circumstances of the death

Police attended the property of Mr Horne's former partner with a police dog which located Mr Horne hiding in bushes at a nearby property. He was in possession of a backpack containing ropes, a hammer, gas cannisters, a blow torch, secateurs, and alcohol. After being challenged by police officers he intentionally stabbed himself in the chest.

During the confrontation, police deployed tasers on Mr Horne twice. A police officer then removed the knife from his chest. He was handcuffed and first aid was rendered to him by police. Ambulance officers then arrived. Police did not initially remove the handcuffs saying they were concerned he might still be violent. Paramedics advised that he was deteriorating rapidly and was too unwell to be violent, at which time the police removed his handcuffs. Mr Horne later died of his injuries in hospital.

Prior to that night Mr Horne was not known to the police and had no declarable criminal history. He suffered from anxiety and depression and there was some evidence of escalating domestic violence behaviour, in the lead up to his death, directed at his former partner.

The investigation

As Mr Horne's death was classed as a death in custody, the investigation into the circumstances leading to his death was conducted by the Queensland Police Service (QPS) Ethical Standards Command Internal Investigations Group. The investigation found no evidence to support any criminal offence, breach of discipline or misconduct against any police officer regarding Mr Horne's death.

An external and partial internal post-mortem examination was performed, and the cause of death determined to be a stab wound to the chest. There was no evidence that the tasering had either caused or contributed to his death.

A Clinical Review was also undertaken by the Queensland Ambulance Service (QAS), which did not result in any adverse comments about their response to Mr Horne nor offer recommendations about alternative management or treatment offered to him by paramedics.

The inquest

An inquest was held in Toowoomba on 8 and 9 March 2021. All the police investigation material was tendered, and evidence was heard from five police witnesses as well as Doctor Stephen Rashford, medical director of the QAS.

Dr Rashford said that Mr Horne's injury was always going to result in his death, regardless of whether the knife was removed by the QPS officer or remained in situ until his cardiac arrest. He concluded that the overwhelming determinant of survival in this case was the severity of the injury, the rapidity of deterioration to cardiac arrest, and the distance to hospital once this deterioration occurred. Those factors conspired to represent a zero chance of survival for Mr Horne.

Sergeant Lucas Finney, QPS Operational Skills and Tactics training officer, provided an opinion that the two instances where police deployed tasers were both justified in that each time Mr Horne still had capacity to pull the knife out of his chest and use it as a weapon such that it posed a serious risk to police.

Sergeant Finney stated that whilst the basic rule in first aid for penetrating trauma was to leave the object in place as it could be slowing the bleeding, the training that police are provided about that is based on best practice medical interventions where there is good light, and the patient is not combative. Moving forward to control Mr Horne and apply first aid while the knife was in his chest and unsecured would have unnecessarily placed police at risk. Sgt Finney considered that the decision by police to remove the knife was appropriate in the circumstances to ensure, as far as possible, the safety of the responding police and paramedics.

Findings and comments
The State Coroner found that, at the time he was confronted by the police, the contents of Mr Horne's backpack suggested it was likely that he had planned some form of retaliation in response to the decision of his former partner to end their relationship. The State Coroner agreed with Sergeant Finney's conclusions that the deployment of the taser was justified and that the decision to remove the knife was appropriate.

Findings were made that Mr Horne died because of his own actions after he inflicted a stab wound to his chest and that none of the attending police officers contributed to or caused his death in any way. No adverse comments were made about the police officers who were acting in the execution of their duty. The actions and decisions made by the attending police officers in the immediate lead up to Mr Horne's death were appropriate and timely, and consistent with the requirements of the Operational Procedures Manual. His death could not have reasonably been prevented by the attending officers.

Dr Rashford's opinion that the removal of the knife did not change the outcome for Mr Horne was accepted.

The findings of the inquest are available on the Queensland Courts website at:
https://www.courts.qld.gov.au/__data/assets/pdf_file/0011/671654/cif-horne-a-20210309.pdf

SCOTT HAMBLY

State Coroner, Terry Ryan – 04 May 2021

Mr Scott Hambly was 38 years of age when he died at the Wolston Correctional Centre (WCC). He was serving a sentence of life imprisonment for murder. On 17 December 2018, he was found unresponsive in his cell. Resuscitation efforts were unsuccessful, and he was declared life extinct at 3.21pm that day.

Circumstances of the death
Mr Hambly had a family medical history of heart disease. He had also suffered an acquired brain injury at the age of 15 years after he was struck by a car while he was riding a bicycle and was in a coma for a period following this accident. Mr Hambly also had epilepsy. It appears that he had had only two generalised seizures, one as a teenager and one in 2017.

Mr Hambly had relatively minor criminal history. On 24 April 2003, however, he was taken into custody on charges relating to the murder of a 79-year-old man at Keperra in April 1997. He was convicted of the murder on 27 July 2006 and sentenced to life imprisonment. Mr Hambly said that, since his brain injury, he had experienced biblical delusions and that God had commanded him to commit the murder. Mr Hambly had been diagnosed with reactive psychosis in 1998. Once he was in custody, Mr Hambly received treatment for his psychosis and was admitted to hospital on a number of occasions. In November 2014, Mr Hambly displayed grandiose/religious delusions and was diagnosed with schizophrenia. He was subsequently admitted to The Park, Centre for Mental Health (The Park), High Secure Inpatient Service for psychiatric review.

In January 2015, during his admission to The Park, it was discovered that Mr Hambly had heart problems. As a result, he was referred to the Outpatient Cardiology Clinic (OCC) at Ipswich Hospital for further investigation. He attended twice: on 2 April and 4 June 2015, was diagnosed with mild left ventricle dysfunction and commenced on medication. After the second appointment an update was written to his treating Consultant Psychiatrist at The Park. On 16 July 2015, Mr Hambly was discharged from The Park and returned to WCC. He did not attend the next two scheduled OCC appointments and was subsequently removed from the clinic, as the clinic recorded that he was "unable to be contacted". Mr Hambly was not seen by cardiology services again.

On 17 December 2018, Mr Hambly had taken his daily medication. The other prisoners in his unit were aware that he took *"*heavy psych meds*"* and have said that it was not uncommon for Mr Hambly to be "passed out". Custodial Correctional Officers (CCO) report having seen Mr Hambly at approximately 7.00 am during morning muster. After muster he returned to his cell and went to sleep. Other prisoners who were in the unit at the time heard Mr Hambly snoring heavily and muttering in his sleep during the morning. Prisoner Kirby went into Mr Hambly's cell at least twice to check on him and rolled him onto his side. Mr Hambly was still asleep and snoring at the 10:30 or the 1:30 musters and was not awakened for either muster. At approximately 2.30pm prisoner Kajewski went into Mr Hambly's cell, saw that he was not breathing, and yelled for help. Mr Kirby commenced CPR while another prisoner went to advise the CCOs. A Code Blue emergency was called, and an ambulance was also called. Despite continuing resuscitation efforts Mr Hambly could not be revived, and he was declared life extinct at 3.21pm.

The investigation

Senior Constable McGregor of the Corrective Services Investigation Unit (CSIU) carried out the investigation into the circumstances surrounding Mr Hambly's death. A Coronial Report was provided which included witness statements, WCC incident logs, Mr Hambly's correctional records and his medical files. The CSIU investigation concluded that Mr Hambly died from natural causes, and that he was provided with adequate medical care in prison. It also found that there were no suspicious circumstances associated with the death.

An autopsy was conducted by Dr Nathan Milne on 20 December 2018 at Queensland Health Forensic and Scientific Services. Dr Milne concluded that the cause of death was acute aspiration pneumonia, but that the cause of aspiration was uncertain. It was possible that Mr Hambly had an epileptic seizure, or an abnormal heart rhythm (arrythmia) developing as a complication of dilated cardiomyopathy.

The West Moreton Hospital and Health Service (WMHHS) completed a Root Cause Analysis (RCA) in February 2020 in response to Mr Hambly's death. Several issues were identified during the review, including loss of follow-up to cardiology services, clinical handover, and fragmented information systems.

Dr Ian Home from the CFMU also examined Mr Hambly's medical records and reported on them for the Coroners Court. Dr Home concluded that appropriate medical care at WCC should have identified the need for further cardiology review for Mr Hambly. However, the magnitude of Mr Hambly's loss to follow-up remained uncertain as there was no conclusive evidence that ongoing review by cardiology would have prevented his death. He said that individuals with cardiomyopathy can develop arrhythmias, and sudden death can occur at any stage of the disease, even with optimal treatment. Dr Home concluded that the continued fragmentation of medical record systems between health and custodial facilities, combined with the absence of reliable chronic health surveillance within the prison system mentioned in the RCA Report, means inmates remained at risk. In the absence of coordinated health care,

appointments may be missed, known diseases poorly managed and new conditions not identified in a timely manner.

The inquest
At the time of his death, Mr Hambly was a prisoner in custody under the *Corrective Services Act 2003.* Mr Hambly's death was a 'death in custody' and an inquest was required by the *Coroners Act 2003*. All statements, medical records and material gathered during the investigation into Mr Hambly's death were tendered.

Findings and comments
The State Coroner found that Mr Hambly had a heart condition that was identified in 2015 as needing follow-up with the Ipswich Hospital cardiology clinic as an outpatient. He was lost to the referral system and removed from the clinic's list. In retrospect, it is difficult to understand how Mr Hambly was not followed up as he was a prisoner serving a life sentence. At the same time, there is no indication that Mr Hambly attended the WCC medical centre with any complaints related to his heart or breathing. Even if the cardiology clinic reviews were conducted when they should have been, it was reasonable to expect that Mr Hambly might have attended to seek medical attention if he felt regular chest pain.

Based on Dr Home's opinion, the State Coroner was satisfied that Mr Hambly was given appropriate medical care by staff at The Park. Although he was lost to follow-up at WCC, there is insufficient evidence to conclude that his death could have been prevented.

The findings of the inquest are available on the Queensland Courts website at:
https://www.courts.qld.gov.au/__data/assets/pdf_file/0004/679477/cif-hambly-s-20210504.pdf

DYLON JAMES AHQUEE

State Coroner, Terry Ryan – 24 May 2021

Mr Dylon James Ahquee was just 19 years of age when he died in protective custody at the Townsville Correctional Centre (TCC). On 26 December 2015, Mr Ahquee was found hanged from a bed sheet tied to the exposed bars above the cell door in a shared cell. Despite assistance rendered by Custodial Correctional Officers (CCOs), prison nursing staff, and Queensland Ambulance Service (QAS) officers he was unable to be revived.

Circumstances of the death
Mr Ahquee's mother expressed that she found it extremely difficult to care for Mr Ahquee. As a child, he was moved over 60 times between his family, foster carers, residential care, and youth shelters. Unsurprisingly, Mr Ahquee ultimately ended up in juvenile detention and then in adult prison. As a child, Mr Ahquee had attempted or threatened suicide or self-harm on several occasions between 2007-14. During his induction into TCC in March 2015, Mr Ahquee did not declare any self-harm or suicidal ideation, however, a self-harm episode history flag should have been raised following his disclosure of self-harm as a juvenile.

At approximately 8:30 pm on 26 December 2015, a headcount was conducted. The headcount included a visual check of all the cells to confirm the apparent good health of the prisoners. Cell 3, which housed Mr Ludlow and Mr Ahquee, was examined during this headcount. The correctional officer recalled that he observed a sheet placed over the cell window which he directed the prisoners to remove. Despite some initial resistance, the sheet was removed. The correctional officer shone his torch into the cell and saw the two prisoners sitting on the same bed. Both appeared to be in good health.

At 9:12 pm Mr Ahquee was found apparently deceased in Cell 3 by Mr Ludlow. He claimed he had woken up to find Mr Ahquee hanged from the cell door with a bed sheet fashioned into a noose. Mr Ludlow contacted the control room immediately through the internal intercom system. He asked whether he should cut Mr Ahquee down and was directed by a correctional officer to hold his weight as officers were on their way.

Mr Ludlow stated that he had gone to bed sometime between 8:00 and 9:00 pm after head count and during a televised 'Big Bash' cricket game. He recalled handing the television remote control to Mr Ahquee before wrapping a t-shirt around his head to reduce light and noise. Mr Ludlow said that when he went to use the cell toilet, he noticed that Mr Ahquee appeared to be seated in an unusual position. He asked Mr Ahquee what he was doing, and when he received no response, he realised that he was hanging. Mr Ludlow cut Mr Ahquee down with a prison issued razor and made the call to correctional officers at 9:12pm. Correctional officers attended the cell immediately, as well as a nurse, who assessed Mr Ahquee with an Automatic External Defibrillator and administering oxygen. The Queensland Ambulance Service was called at 9:18pm and two Advanced Care Paramedics attended. At 9:50pm, further QAS teams arrived, including a Critical Care Paramedic. Mr Ahquee was declared deceased at 10:21pm, and a crime scene was immediately declared.

The investigation
An investigation into the circumstances surrounding Mr Ahquee's death was conducted by the Corrective Services Investigation Unit (CSIU). A coronial report was provided and contained statements and interviews of witnesses, medical and offender records, CCTV footage and photographs. The report noted that, 'in retrospect there were signs Mr Ahquee may have been considering suicide such as covering his head and attempting to choke himself on Christmas Day and talking about 'slashing up'.'

In relation to the response times and assistance provided by CCOs and QAS, the report concluded that the response times and measures taken were more than satisfactory. The report did not implicate any person in Mr Ahquee's death.

Following this police investigation, the Office of the Chief Inspector (OCI) appointed investigators to examine the circumstances of Mr Ahquee's death under the powers conferred by s.294 of the *Corrective Services Act 2006*. In 2017, a comprehensive report was completed. The report noted a number of issues, one being that under the practices in place at TCC at the time, Mr Ahquee had been missed by various processes several times, including identification via the 'self-harm flag' or the EBLR process, and was later missed for follow up by Assessment Services. Ultimately, the OCI report concluded that a number of issues occurred in the TCC, with six recommendations stemming from the report's findings.

The inquest
The hearing of evidence in relation to Mr Ahquee's death had been scheduled to be held in Townsville in April 2020 but was adjourned due to COVID-19 restrictions. The inquest was subsequently held in Brisbane on 10 February 2021. The evidence heard included four witnesses: the investigating officer, Mr Ahquee's cellmate, the correctional supervisor and the QCS Deputy Commissioner.

The issues at inquest were:

1. The findings required by s 45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death.
2. Confirm whether any third party contributed to Mr Ahquee's death.
3. Determine whether the authorities charged with providing for Mr Ahquee's mental health and physical care at the Townsville Correctional Centre prior to his death adequately discharged those responsibilities.

4. Whether sufficient information was shared in relation to Mr Ahquee between juvenile detention centres, Youth Justice and Townsville Correctional Centre upon entering adult custody.
5. Consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or other contribute to public health and safety or the administration of justice

Findings and Comments
The State Coroner found that Mr Ahquee caused his own death and was satisfied that there was no basis to suggest any other party caused or contributed to Mr Ahquee's death. It was found that, in relation to issue (3), Mr Ahquee's presentation was very complex, and while it was recognised that Mr Ahquee should have been accommodated in a suicide resistant cell given his history of risk behaviour, that did not occur, and the evidence suggested that there was no overt indication he was feeling suicidal on 26 December 2015. In relation to issue (4), the State Coroner found that during the time Mr Ahquee was in care, there was sufficient collaboration and information sharing between Child Safety and Youth Justice (including the Cleveland Youth Detention Centre) and TCC and various placement providers. It was also accepted that Youth Detention Centres can transfer relevant information about a young person to QCS, and that information sharing has been supported by the 2019 amendments to the *Youth Justice Act 1992*.

The State Coroner noted that the findings in relation to the death of SVE recommended that the Queensland Government publish annual updates detailing its strategy for the implementation of safer cells. The Coroner found that the measures being implemented and considered by TCC and QCS State-wide Operations in response to the OCI Report were appropriate and was satisfied that the recommendations already made will contribute towards preventing a death in similar circumstances. No other comments or recommendations were made.

The findings of the inquest are available on the Queensland Courts website at:
https://www.courts.qld.gov.au/__data/assets/pdf_file/0006/684744/cif-ahquee-d-20210524.pdf

SVE

State Coroner, Terry Ryan – 24 May 2021

At approximately 8:55pm on 16 March 2019, SVE, a 43-year-old male, was found hanging, deceased in his secure cell at Arthur Gorrie Correctional Centre (AGCC). SVE had constructed a device from a fragment of prison clothing, that he then secured to overhead prison bars to hang himself. SVE had been arrested on 25 November 2018 and charged in relation to sexual offences against children. The nature of the charges was such that SVE faced a potential head sentence of 10 years' imprisonment. He had been remanded to AGCC on 28 November 2018. This was his first time in custody.

The investigation
The Queensland Police Service (QPS), Corrective Services Investigation Unit (CSIU) investigated the circumstances surrounding SVE's death. A scenes of crime examination of SVE's cell did not identify any suspicious circumstances. SVE's prison and medical records were seized, and interviews conducted with prisoners held in the same Unit as SVE, in addition to corrective services staff.

Queensland Corrective Services (QCS) conducted a thorough parallel investigation and produced a report, recommendations from which were considered at inquest.

The inquest
As a prisoner in custody, and pursuant to s 8(3)(g) of the *Coroners Act 2003*, SVE's death was a 'death in custody' and therefore an inquest was required. The inquest was held at Brisbane on 13 May 2021. All investigation material was tendered. QCS and GEO Group Australia Pty Ltd (the operators of AGCC) were both granted leave to appear. Two staff members of AGCC were called to give evidence as was the Assistant Commissioner, QCS.

The evidence
Upon being remanded SVE participated in an intake (medical) assessment. He did not disclose any history of mental illness, suicide attempts or suicidal ideation. SVE disclosed having engaged with psychologist every six weeks but did not disclose anything about the nature of those visits. SVE was referred to the AGCC's Health and Psychology Services and given advice on how to request a review by a doctor in addition to accessing Prison Mental Health Services. He was assessed as being at low risk of harm to himself. Whilst there was evidence of his being medically assessed, there was no evidence of SVE having been through an induction at AGCC.

SVE was first housed in Unit B5 (a special needs unit) before being moved to Unit B1 (a protection unit), on 8 December 2018. During his time on remand, SVE experienced emotional distress associated with separation from his sons, the prospect of a lengthy custodial sentence and concern that the nature of his charges would make him a target for violence from other prisoners. On 23 January 2019, SVE was allegedly assaulted by another prisoner. SVE received medical attention for muscle soreness.

Whilst on remand SVE accessed prison counselling services on 18 December 2018 and 31 January 2019. He expressed fears for his safety on both occasions. During the first counselling session he disclosed 'passive thoughts of suicide' but disavowed any intention and identified protective factors. SVE's fears for his safety were more pronounced in the second counselling sessions, which followed the alleged assault. There were no disclosures of suicidal or self-harm ideation in that session.

Following a request by SVE on 14 February 2019 he was granted protection status, placed under a 'protection' Intensive Management Plan (IMP), and moved into a single cell within unit B2. AGCC is made up of older and newer units commonly referred to as 'old' and 'new' stock. Unit B2 was part of the old stock the design features of which still included ligature or hanging points such as security bars.

On 2 March 2019, SVE completed a prisoner request form to see a psychologist. The request did not disclose any suicidal or self-harm ideation, but renewed concerns for his personal safety within the prison. Prior to any consultation, SVE was interviewed to obtain more detailed information. He made no disclosures of suicidal or self-harm ideation during that interview. For reasons unknown, SVE's request for psychological counselling was ultimately not lodged in accordance with standard processes.

On 13 March 2019, SVE renewed concerns for his safety by two letters of complaint (known as blue letters) to the Correctional Manager, again raising concerns as to his safety.

The Office of the Chief Inspector (OCI), Queensland Corrective Services (QCS) prepared an incident report that formed part of the coronial brief of evidence. The OCI report made two recommendations to the Chief Superintendent, AGCC: that prisoner request systems are reviewed to ensure that request forms completed by prisoners are collected daily, are appropriately prioritised and escalated, and that adequate resources are available to respond to prisoners' requests, an oversight and assurance process is implemented to ensure that prisoners receive an adequate induction when they first arrive at AGCC.

An independent expert report commissioned by the Coroners Court concluded there was no

evidence to indicate SVE displayed any intent to die by suicide before his death nor any apparent indicators of missed opportunities for intervention that could reasonably be seen to have changed the outcome. The expert report was critical that SVE's request to consult with a psychologist was not facilitated in a timely manner however other relevant policies and procedures were generally appropriate.

Findings and comments
The State Coroner adopted the conclusions of the independent expert report and found that there was no evidence that SVE displayed any intent to die by suicide and no missed opportunities for intervention that would have changed the outcome (including contact with a psychologist). The State Coroner found that AGCC's relevant policies and procedures were generally appropriate and, while SVE was fearful, this should not be taken to indicate the presence of an underlying psychological condition that may have elevated his risk of suicide.

Noting the recommendations made in the OIC report, the State Coroner made no further recommendations in relation to those matters. However, the State Coroner commented that whilst the suicide risk management processes at AGCC were appropriate, it would not be possible to predict every attempt at suicide, therefore there was a continuing need for prevention strategies.

Recommendation
The State Coroner noted that the need for screening and removal of hanging points in Correctional Centres and police cells has already been the subject of numerous coronial recommendations. Whilst acknowledging the fiscal constraints associated with refurbishing older cells, the State Coroner recommended that the Queensland Government publish annual updated detailing its strategy for the implementation of safer cells and progress against that strategy.

The findings of the inquest are available on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0009/684729/cif-SVE-20210524.pdf

LIAM COOPER SCORSESE

State Coroner, Terry Ryan – 28 May 2021

Mr Liam Scorsese was 31 years of age at the time of his death on 25 February 2018. He died after being shot by police.

Circumstances of the death
On 25 February 2018, police were responding to a triple zero call from Mr Scorsese's partner's mother. Mr Scorsese was at the address to try and speak to his partner, Chireez Beytell, with whom he had been in a relationship for nearly four years. They had separated numerous times during the relationship. At the time of his death, they were engaged but estranged. Earlier in the day, Mr Scorsese had sent threatening messages to Ms Beytell. When Ms Beytell spoke to him outside the house, his behaviour became erratic resulting in Ms Beytell's mother pulling Ms Beytell back in the house and locking the door. Mr Scorsese became aggressive and kicked in the doors and windows.

When police arrived at the address, Mr Scorsese produced a knife and asked police to shoot him. Police retreated backwards down the street. One of the officers used a taser to subdue Mr Scorsese but this was unsuccessful. Police continued to retreat further down the street, where Mr Scorsese was fatally shot. It was found after the incident that the officer who shot Mr Scorsese had not turned on his body worn camera (BWC).

The investigation
An investigation into the circumstances surrounding Mr Scorsese's death was conducted by Detective Sergeant Dylan Brook of the Ethical Standards Command, Internal Investigations Group (IIG). A coronial report was subsequently provided with various annexures, including witness statements, digital recordings, offender, and medical records.

The IIG found that the police response to the initial broadcast was appropriate. The investigation confirmed both officers involved acted lawfully in the execution of their duty, with one officer using lethal force by discharging his service firearm, to avoid grievous bodily harm. That officer's actions on the day were lawful, authorised and justified in the circumstances surrounding the critical incident. A post-mortem examination found Mr Scorsese's cause of death to be gunshot wounds to the neck and chest.

The inquest
As Mr Scorsese was trying to avoid being put in custody when he died, an inquest was mandatory under Section 27(1)(a)(i) of the *Coroners Act 2003*. The inquest was held on 18 and 19 September 2020. All statements, records of interview, photographs and materials gathered during the investigations were tendered. Oral evidence was heard from a number of witnesses.

The evidence
Mr Scorsese had a violent criminal history that showed he had spent time in custody, was released and engaged with probation and parole in November 2017. He was known to be an associate of Outlaw Motorcycle Gangs, the Finks and the Comancheros.

Mr Scorsese also had ongoing mental health issues which appeared to be induced by his use of illicit drugs. Evidence was put before the Court relating to the management of his mental health issues in the community. While there was no formal diagnosis of any mental health condition, Mr Scorsese was prescribed medication for anxiety and depression. Mr Scorsese failed to engage, or continue engagement, with mental health professionals and the information probation and parole and other QCS staff relied on was his self-reporting of mental health concerns or symptoms. It is also clear from the various health practitioners he spoke to, that Mr Scorsese had insight that his paranoia was the result of the consumption of illicit substances.

In respect of the BWC, Queensland Police Service (QPS) officers use an Axon BWC which is manually turned on. Axon does have technology that would enable BWCs to be triggered by an event such as Bluetooth-enabled recording when a firearm was removed from a holster. This can automatically activate all BWCs within a 10-metre range but the QPS has not purchased this option.

Findings and comments
The State Coroner found that the action of the police officers was appropriate in the circumstances. Mr Scorsese's family had raised concerns in regard to the investigation of police by police and that police 'may have affinity for one another and may be open to allegations of being non-partisan'. It was submitted that this could be avoided through the use of independent evidence like a body worn camera (BWC). The State Coroner acknowledged that it is a matter of significant public interest that the community is confident in the independent investigation of police. He noted that recent Coronial recommendations for an independent review of the current arrangements for the investigation of police deaths are still being considered by the Queensland Government.

The State Coroner found that there is currently sufficient training and support to probation and parole officers to recognise and manage mental health risks for offenders under their

supervision. It was evident that Mr Scorsese was provided appropriate support to assist in the management of his mental health concerns whilst in the community.

The State Coroner found that the officer's failure to activate his body worn camera during this incident may be explained in part by the fact that he had only been given the BWC a few weeks before the incident. He was not familiar with arming the camera and activating the record function. This was a product of being inexperienced and lack of personal training as opposed to a deliberate act to not activate the camera.

Recommendations
The State Coroner made two recommendations. The first was that the QPS consider the viability of purchasing a Bluetooth enabled feature for Axon body-worn cameras.

The second recommendation was that the QPS use the capabilities of the Axon and BWC platform to conduct random audits to ensure officer compliance with policies relating to the use of body-worn cameras.

The findings of the inquest are available on the Queensland Courts website at:
https://www.courts.qld.gov.au/__data/assets/pdf_file/0010/685531/cif-scorsese-l-20210528.pdf

PHILLIP JOHN WUST

State Coroner, Terry Ryan – 11 June 2021

Mr Phillip John Wust was aged 56 years when he died from liver cancer at the Rockhampton Hospital on 8 January 2020. He had been convicted of murder on 31 October 1990 and was serving a life sentence at the Capricornia Correctional Centre (CCC).

Circumstances of the death
Mr Wust was born on 20 January 1963. He had had a limited criminal history that began at 18 years for property offences. His next conviction was eight years later for supplying a dangerous drug. Mr Wust had a medical history including chronic hepatitis C (2015), hepatitis A (2017) and osteopenia (2019). He had been smoking one pack of cigarettes per day prior to his imprisonment. He had also been drinking approximately two cartons of beer per week since age 17.

On 31 October 1990, at age 27, Mr Wust was convicted of murder and received a life sentence in the Rockhampton Supreme Court. On 3 November 2004, after 14 years in custody, Mr Wust was granted a release to work order which allowed for leave of absences for the purpose of employment. This continued with success until 7 April 2005, when Mr Wust was granted parole. In 2013 and 2014 Mr Wust provided a positive urine sample and was returned to custody before his parole was reinstated shortly afterwards. On 27 February 2016, Mr Wust was charged with common assault and his parole was suspended indefinitely, returning Mr Wust to custody on 8 March 2016. He was found guilty on 30 March 2016 and his parole was cancelled on 18 April 2016. He was moved to CCC the next year, on 12 July 2017.

Mr Wust was diagnosed with chronic liver disease in 2018. He was placed on screening regimes that included CT and MRI scans every few months at the Rockhampton Hospital. He was prescribed a number of medications to deal with the symptoms of the disease, including pain medications.

On 21 December 2019, Mr Wust was transported from CCC to the Rockhampton Hospital with dark coloured diarrhoea, shortness of breath and light-headedness. Mr Wust's pathology

showed hyperbilirubinemia (build-up of bilirubin in the blood) on a background of cirrhosis from his previously diagnosed hepatitis C. He was diagnosed with subsegmental pulmonary embolism and portal vein thrombosis with deranged liver enzymes. Blood tests and imaging were completed to evaluate his current liver status and determine whether there was evidence of malignancy. Treatment was commenced for his liver cirrhosis.

On 21 December 2019, a CT scan was conducted on his abdomen and pelvis with comparisons made with his previous CT scan from July 2019. The findings showed acute thrombosis (blood clotting) throughout the portal vein which had developed since the previous CT scan. While the results of further investigations were pending Mr Wust was discharged. A letter was sent to the RMO at CCC requesting a doctor see Mr Wust within one week to monitor his liver function and response to the treatment which was outlined by the hospital.

On 30 December 2019, Mr Wust was again taken to the Rockhampton Hospital with back pain and shortness of breath. After further investigations, oncology made a preliminary diagnosis of hepatocellular cancer involving the whole liver, which could not be treated. On 6 January 2020, a progress note confirmed the diagnosis, and that Mr Wust's his life expectancy was at most "a couple of weeks".

The following day it was noted that Mr Wust's liver function continued to deteriorate, and Mr Wust became encephalopathic and agitated due to liver failure. An oncology assessment found further clinical deterioration and that Mr Wust was not fit for oncology treatment, suggesting instead palliative/end of life care. Mr Wust's family were advised of his prognosis that day and told to visit him as "he may not last the night". His sister, Margaret, and brother, Alan, attended the hospital that night and spoke with Mr Wust's treating doctors, who explained the diagnosis of hepatocellular carcinoma with no treatment available.

In the early morning of 8 January 2020, Mr Wust's sister notified staff and correctional officers that Mr Wust had died. A life extinct certificate was issued at 1:45am.

Mr Wust's sister did not identify any issues with the care provided at CCC and expressed approval of the conduct of correctional staff both on the night of his death and throughout his time at that centre.

The investigation
A coronial report dated 28 June 2020 was prepared by Senior Constable Jason O'Halloran and provided to the Coroners Court. This report briefly outlined Mr Wust's medical history and circumstances of his time in hospital. The report concluded that it appeared that adequate medical care had been provided and there appeared to be no suspicious circumstances surrounding the death.

The inquest
As he was in custody when he died, an inquest into Mr Wust's death was required by the *Coroners Act 2003*. The inquest was held on 11 February 2021. All of the statements, medical records and material gathered during the investigation was tendered. Counsel Assisting proceeded immediately to submissions in lieu of oral testimony being heard.

Findings and comments
The State Coroner was satisfied that Mr Wust's death was the result of natural causes. He had consistent CT scans and ultrasounds for his chronic liver disease in the last two years of his life, none of which indicated any carcinoma. The State Coroner found that none of the correctional officers or inmates at the CCC caused or contributed to his death.

Following his diagnosis of hepatocellular cancer involving the whole liver on 30 December 2019, Mr Wust deteriorated rapidly. His condition was not amenable to treatment. His medical

records and the statements of treating doctors indicate that the investigation of his carcinoma was timely and thorough. The period between diagnosis and death was very short. His pain relief was regularly checked, and the comfort-based care provided was appropriate having regard to his diagnosis and limited life expectancy. There were no missed opportunities for intervention.

With respect to whether the care provided to Mr Wust in the CCC was adequate, the evidence shows that he was transferred to the Rockhampton Hospital as soon as his symptoms progressed. The CCC had facilitated Mr Wust's medical appointments following his diagnosis of chronic liver disease in 2018. The State Coroner considered that the CCC's treatment and care of Mr Wust was adequate when compared to the health care provided to members of the community outside the prison system.

The findings of the inquest are available on the Queensland Courts website at: https://www.courts.qld.gov.au/__data/assets/pdf_file/0011/686594/cif-wust-p-20210611.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.

Christensen & Anor v Deputy State Coroner **[2021] QSC 38 – 04 March 2021**

This decision involved an application to the Supreme Court for judicial review of the Deputy State Coroner's direction that a witness be excused from giving oral evidence where that witness was suffering from post-traumatic stress disorder (PTSD) and giving oral evidence would adversely impact the witness' mental state. The Deputy State Coroner had directed that the witness could provide sworn answers to questions in writing. The Supreme Court determined that the Deputy State Coroner did have the power to make these directions in respect of the witness' evidence and dismissed the application for judicial review.

The Deputy State Coroner was conducting an inquest into the deaths of Cory Christensen and Thomas Davy at Alva Beach. On 30 September 2018 Mr Davy and Candice Locke went to Alva Beach to spend the day fishing. During the afternoon they met Mr Christensen and his friend Mr Bengoa and agreed to watch the NRL final with them later that night near the surf club. Mr Davy left at around 9:30pm. Around that time, Ms Locke went for a drive with Mr Bengoa in his beach buggy. During the drive she fell from the buggy and injured her shoulder. She requested medical assistance and became upset when Mr Bengoa and Mr Christensen made light of the situation. After getting in and out of the buggy and disagreeing with the men, she went over to the first house opposite the exit to the car park.

Mr Webber was the sole person in the house and was asleep on the couch when Ms Locke knocked on his front door just before 1am. In his police interview he said that Ms Locke was unknown to him and was physically shaken and injured. She asked for help and said she had been thrown off a buggy by men Mr Webber could see sitting cross the road. Mr Webber made

a 000 call asking for an ambulance and police. The men bashed on the front door and Mr Webber asked them to go away. They did, but soon returned and broke in through the front door and assaulted Mr Webber. He used a kitchen knife to defend himself and Ms Locke by stabbing the intruders.

Police and ambulance officers arrived at 1:17am and located Mr Christensen and Mr Davy on the road outside the house. They could not be revived. Police considered that Mr Webber's actions were justifiable self-defence, and they did not charge Mr Webber in relation to the deaths.

The inquest was scheduled to commence in Cairns on 12 October 2020. At the commencement of the inquest, Counsel for Mr Webber made application for him to be excused from giving evidence on the basis of a psychiatrist's report which gave the opinion that Mr Webber suffered from moderate to severe PTSD and should be medically excused from giving evidence due to the impact on his mental state. The psychiatrist was called to give evidence on 15 October, and the Deputy State Coroner explored with him a number of options for Mr Webber to give evidence. The psychiatrist supported the option of Mr Webber answering questions that were put to him in writing and being given 48 hours to provide written answers.

The Deputy State Coroner made this direction, on the basis that giving evidence in person would cause Mr Webber considerable psychological distress and decompensation of his symptoms of PTSD, and that this may result in Mr Webber being unable to assist the inquest in any meaningful way. The Deputy State Coroner's direction, made on 16 October, was that any party wishing to ask questions of him provides those questions to the Deputy State Coroner by 6 November 2020, and that Mr Webber was to respond by sworn statement within 72 hours.

Mr Christensen's wife and Mr Davy's parents made the application for judicial review of the Deputy State Coroner's directions on the basis that the Deputy State Coroner did not have the power to make those directions, and that the parties' right to cross-examine witnesses overrode the power of the court to give directions. The Attorney-General gave notice of intervention in the proceeding.

The Supreme Court found that the applicant's submissions that the specific right to cross-examine witnesses should prevail over the general provision conferring a wide discretion upon the Coroner's Court to give directions and make orders as considered appropriate, cannot be accepted. It was within the power of the Deputy State Coroner to direct that Mr Webber provide answers in writing. The application must be dismissed.

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 would not 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 cannot, 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) would not have expected the health care to cause or contribute to the death, or for the death to occur at that time.

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 the 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 the 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 improves 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

02 October 2020:	Mater Adults Hospital Department of Emergency *When to make THAT phone call…*
08 October 2020:	University of Queensland – medical students *Never fear (if) the Coroner is here!*
09 October 2020:	Cairns Hinterland Hospital & Health Service Grand Rounds *The Coroner and Health Care Related Deaths*
16 December 2020:	Retrieval Services Queensland Coordination Training *Document! Document! Document!*
16 February 2021:	Hummingbird House Children's Hospice *Sometimes, not always: When and how to report a child death to the Coroner*
26 March 2021:	Royal Flying Doctor Service *When to make THAT phone call…*
23 April 2021:	Coroners Court of Queensland *What makes a death in care (disability)?*
05 May 2021:	Townsville Hospital & Health Service intern education *When to make THAT phone call…*
14 June 2021:	Princess Alexandra Hospital Medical Grand Rounds *Seeing the wood for the trees*

APPENDIX 4

Presentations by Acting Deputy Registrar, Alana Martens

15 January 2021:	Gold Coast University Hospital *Document! Document! Document!*
30 March 2021:	John Flynn Hospital *When to make THAT phone call…*
28 April 2021:	Queensland Nurses and Midwifery Union *Coroners Court of Queensland*
27 May 2021:	Royal Brisbane Women's Hospital interns *When to make THAT phone call…*

APPENDIX 5

Presentations by the Domestic and Family Violence Death Review Unit

13 August 2020:	Local Government Association of Queensland *Domestic and Family Violence Community of Interest Meeting*
17 September 2020:	Magistrates Court of Queensland *Learnings from Coronial Investigations of Domestic and Family Violence Related Deaths*
25 November 2020:	Australian National Research Organisation for Women's Safety (ANROWS) *Accurately identifying the person most in need of protection in domestic and family violence law*