QUEENSLAND COURTS

Office of the State Coroner

Annual report 2012–2013

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12 December 2013

The Honourable Jarrod Bleijie MP
Attorney-General and Minister for Justice
GPO Box 149
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Dear Attorney

Section 77 of the *Coroners Act 2003* requires the State Coroner to provide to the Attorney-General at the end of each financial year a report for the year on the operation of the Act. In accordance with that provision I enclose the report for the period 1 July 2012 to 30 June 2013.

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.

The guidelines issued under section 14 of the Act were comprehensively reviewed during the reporting period. They are publicly available and can be accessed at http://www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications.

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

Yours sincerely

Terry Ryan
State Coroner

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State Coroner's Overview

The tenth anniversary of the assent to the *Coroners Act 2003* took place on 9 April 2013. Soon after the Act was assented to Mr Michael Barnes was appointed as Queensland's first State Coroner on 1 July 2003. His 10-year tenure saw Queensland establish a modern, coordinated and accountable coronial system.

Following the 2012 State election the Queensland Government acted quickly to implement its commitment to establish the position of Central Coroner. The appointment of Mr David O'Connell to the role on 9 August 2012 means that all reportable deaths in Queensland are now dealt with by specialist coroners and support staff. The allocation by the Chief Magistrate of an additional magistrate to coronial work in Brisbane, together with the establishment of a full-time coronial registrar, have also been pivotal in achieving this outcome.

The success of the coronial registrar pilot saw this role being established on a permanent basis. The registrar has significantly improved the coronial systems' response to apparent natural causes deaths, health care related deaths and deaths arising from mechanical falls in the Brisbane catchment.

The benefits of the full-time coroner model can be seen in the way the Queensland coronial system continues to deal with its increasing workload efficiently and effectively. During 2012–13 there were 4,762 deaths reported to coroners – more than in any other year. The number of matters finalised was also the highest on record with 4,999 matters being cleared, representing a clearance rate of nearly 105 per cent. Significantly, during this reporting period coronial teams have been able to reduce the percentage of matters that are more than 24 months old from 14 per cent to 10.2 per cent. I express my sincere appreciation to my fellow coroners for their ongoing efforts in providing unwavering service to the community.

Improvements in the coronial system could not be achieved without the ongoing partnerships enjoyed by the Office of the State Coroner. I acknowledge the contribution made by our partner agencies, including the Queensland Police Service and Queensland Health, to the performance of the coronial system.

It is pleasing to note that the Government has continued to publish on the Department of Justice and Attorney-General website a compendium of responses to coronial recommendations in the form of the Queensland Government's Response to Coronial Recommendations. Coroners are increasingly engaging with agencies in developing preventative recommendations and this publication demonstrates a commitment to transparently outlining how those recommendations are responded to.

Finally, I would like to acknowledge the contribution made by the staff of the Office who each day deal with difficult and confronting circumstances in a dignified and respectful way.

Office of the State Coroner

Role and achievements

The Office of the State Coroner (OSC) supports the State Coroner to administer and manage a coordinated state-wide coronial system in Queensland. The office is also responsible for providing a central point of contact and publicly accessible information to families and the community about coronial matters. The OSC manages and maintains a register of reported deaths and supports the state's involvement in the National Coronial Information System (NCIS). Data provided to the NCIS is used to inform death and injury prevention activities for a wide range of stakeholders, including coroners, government agencies and researchers.

Recent years have seen a significant increase in demand for coronial services state-wide with reported deaths increasing by 36 per cent from 3,514 in 2007–08 to 4,762 in 2012–13. This increase is a result of a number of factors including increased awareness of reporting obligations and changes to the types of deaths that are required to be reported to a coroner. A number of significant developments have been implemented to support and enhance the delivery of coronial services in Queensland during 2012–13.

Coronial Registrar

A major initiative during 2011–12 was the trial of a coronial registrar role for an initial period of six months commencing in January 2012. The coronial registrar is appointed under the *Coroners Act 2003* and operates under a delegation from the State Coroner which enables the registrar to investigate deaths reported under s. 8(3)(e) of the Act (death certificate not issued and not likely to be issued – apparent natural causes deaths) and to authorise the issue of cause of death certificates for reportable deaths under s. 12(2)(b) of the Act and to determine whether a death referred under s. 26(5) of the Act is reportable. The registrar investigates deaths reported directly by medical practitioners. Medical practitioners can report deaths directly to a coroner using a 'Form 1A' in circumstances where the doctor is either seeking the coroner's advice about whether a death is reportable or seeking the coroner's authority to issue a death certificate for a reportable death because the cause of death is known and no investigation appears necessary.

These deaths represent the high volume, less complex range of matters routinely reported to coroners. The aim of the registrar trial was to improve coronial efficiency by diverting these cases from the Brisbane based coroners so they could focus on more complicated investigations and inquests. It also provided an opportunity to proactively streamline and formalise strategies to manage apparent natural causes deaths.

The trial was extended for 12 months from 27 July 2012. It continued to operate in the Brisbane reporting catchment, which from 1 October 2012 was expanded to cover the Sunshine Coast region north to Gympie and South West Queensland. Having demonstrated system efficiencies and cost savings, and contributing to improved coronial performance over the trial period the registrar position was made permanent from 27 July 2013.

Of the 2,708 deaths reported in the Brisbane catchment during 2012–13, 744 were reported to police under s. 8(3)(e) of the Act and 699 were reported as Form 1A deaths.

The registrar dealt with 1,352 of the 2,708 deaths reported in the Brisbane catchment (49.9 per cent), finalising 1,265 matters within the reporting period.

One of the key achievements of the registrar trial has been the development of a triage process for apparently natural causes deaths that make their way into the coronial system simply because a death certificate has not issued. This multidisciplinary approach engages clinical (forensic pathologist, clinical nurse, forensic medical officers) and non-clinical (coronial counsellor) resources provided by Queensland Health to identify deaths where a cause of death certificate can appropriately be issued by either a treating doctor or the duty pathologist, rather than the death being subjected to a full coronial investigation.

Application of the triage process has demonstrated that over a third of the deaths reported under s. 8(3)(e) of the Act can be appropriately diverted from the coronial system. In Brisbane during 2012-13, 744 of the 1540 deaths reported to coroners by police were reported because a cause of death certificate had not been issued (49.5per cent of Form 1 reports). Of these 744 apparent natural causes deaths, 256 certificates were issued as a result of the triage process (34.4per cent). The certificates were issued by either treating doctors (50.8per cent) or the duty pathologist (49.2 per cent). The process has assisted in offsetting increasing demand on coronial resources in the context of the steadily increasing number of deaths reported to coroners each year.

More broadly, the registrar's role has increased the efficiency of the coronial system by improving the time taken to finalise apparent natural causes death investigations, and reducing the number of matters older than 12 and 24 months. For example, a comparison of overall coronial performance data at the beginning and end of the first 12 months of the trial showed a 19 per cent improvement in the time taken to finalise an investigation of a natural causes death, a 9 per cent decrease in the number of cases pending between 12-24 months and a 7 per cent decrease in the pending cases older than 24 months.

The registrar role has also helped improve the medical profession's understanding of and confidence in, the coronial system. The registrar regularly presents at hospital clinician education forums and is responsible for developing and maintaining productive working relationships with hospital administrators and the patient safety officer network within the Brisbane reporting catchment.

The registrar trial has highlighted a disappointingly limited understanding by community clinicians of their coronial reporting and death certification obligations. Consequently, one of the future focuses of the registrar role will be to identify opportunities for the coronial system to engage more meaningfully with the medical profession and its representatives to address this knowledge deficit.

The registrar investigates the bulk of health-care related deaths and deaths arising from mechanical fall-related injuries reported in the Brisbane catchment. With an ageing population and increasingly sophisticated medical interventions, the number of

deaths reported under these reportable death categories continues to rise. The registrar is well placed to review and evaluate the coronial system's response to these deaths.

Review of the State Coroner's Guidelines

The State Coroner may issue guidelines under s. 14 of the Coroners Act to coroners and to persons carrying out functions under the Act. The State Coroner's Guidelines were issued in 2003 but are subject to ongoing review in light of continuing developments in coronial practice. During 2012–13 the State Coroner completed a major review of the 2003 guidelines to ensure best practice in the delivery of coronial services. The registrar contributed significantly to this review. The revised guidelines were issued in June 2013 and provide more comprehensive guidance regarding investigations, findings, inquests and access to coronial information. The State Coroner's Guidelines can be accessed at: http://www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications.

Full time coroner model and reporting centres

To accommodate the continued increase in demand for coronial services, an additional full time coroner covering the Central Queensland region was appointed in August 2012. The reporting of new deaths to this position commenced from 1 October 2012.

Prior to the appointment of a full-time Central Coroner, 70per cent of reportable deaths were reported to five full-time coroners, situated in Brisbane, Southport and Cairns. The remaining 30 per cent of deaths were reported to local magistrate coroners in 16 Magistrates courts across the state. In 2012 the Chief Magistrate allocated an additional Brisbane magistrate to coronial work to assist local magistrate coroners with complex investigations and inquests which are difficult to fit around general court duties.

These additional appointments together with the continuation of the coronial registrar role have enabled the full-time coroner model to be extended state-wide from 1 October 2012. Consequently there are only four centres in Queensland where deaths are reported. The centres are situated in Cairns, Mackay, Brisbane, and Southport. As a result of these changes all reportable deaths across the State are now investigated by a dedicated full-time coroner or registrar and specialist support staff.

The appointment of full-time coroners enhances justice service delivery by relieving local magistrates of the responsibility for the management of coronial investigations and improving access for regional Queenslanders. These amendments have contributed to improved efficiencies in the processing of coronial matters, ensured consistency in the delivery of services state-wide and increased productive working relationships with local coronial partners, including police and hospitals. It is anticipated that the quality and timeliness of coronial investigations will continue to improve and the current backlog of cases will be reduced further in the next year as a result of these amendments.

Coroners' investigations

Purpose of coronial investigations

The purpose of a coronial investigation is to establish the identity of the deceased, when and where they died, the medical cause of death and the circumstances of the death. Coroners also consider whether changes to policies or procedures could contribute to improvements in public health and safety, or the administration of justice, or reduce the likelihood of other deaths occurring in similar circumstances. Inquests are held so that coroners can receive expert evidence upon which to base such recommendations.

Autopsies

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

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

Although family members may not prevent an autopsy being undertaken if a coroner considers it necessary, a coroner who wishes to override a family's concerns must give the family reasons. The coroner's decision can then be judicially reviewed. No such review applications were received in 2012–13 and family concerns have been able to be assuaged with the assistance of coronial counsellors from Queensland Health Forensic and Scientific Service (QHFSS).

Data from 2009–10 to 2012–13 about autopsies is provided in Table 1 and 2.

During 2012–13, there was again a reduction in the number of autopsies performed overall. This is likely to be due to the increasing use of the Form 1A process to report deaths in a medical setting. It's also due to the increased focus on exploring all options for obtaining a cause of death certificate for apparent natural causes deaths and the application of the registrar's triage process.

There was also an increase in the proportion of external and partial or targeted internal autopsies ordered.

Table 1: Percentage of orders for autopsy issued by type of autopsy to be performed

Type of autopsy ordered	2009–10	2010–11	2011–12	2012–13
External autopsy	11.64%	16.42%	20%	23.01%
Partial internal autopsy	12.54%	19.83%	23%	29.09%
Full internal autopsy	75.82%	63.75%	57%	47.90%
Order on cremated remains	0%	0%	0%	0%

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

Type of autopsy ordered	2009–10	2010–11	2011–12	2012–13
External autopsy	349	473	544	629
Partial internal autopsy	376	571	639	795
Full internal autopsy	2,274	1,836	1,559	1,309
Order on Cremated Remains	0	0	0	0
Total	2,999	2,880	2,742	2,733

Measuring outcomes

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

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

Clearance rate

There has been a significant growth in demand for coronial services since the enactment of the Coroners Act in 2003. From 2004–05 (the first full financial year of reporting under the new legislation) to 2011–12 reported deaths increased by 47 per cent from 3,043 to 4,461. In 2012–13 there was a more modest increase with deaths reported increasing by only 6.75 per cent to 4,762.

The number of investigations finalised by coroners each year has also increased. In 2012–13, coroners finalised 4,999 matters (228 more than in 2011–12) achieving a clearance rate of 105 per cent.

The increase in medical matters reported to the coroner since 2007–08 can be tracked by looking at the increase in Form 1As which can be used by medical practitioners to report deaths to coroners. Table 3 shows a state-wide increase of 232 per cent in the use of Form 1As since 2007–08. The bulk of these matters are reported to Brisbane coroners where the state's major tertiary hospitals are located.

Table 3: Form 1As

Financial year	Form 1As State-wide	Form 1As Brisbane
2007–08	314	223
2008–09	423	295
2009–10	732	482
2010–11	880	514
2011–12	1,043	571
2012–13	1,044	699

Many matters reported to coroners are, following review of medical records and circumstances of death, found to be not reportable or reportable but not requiring

autopsy and further investigation. During 2012–13 of the 4,999 deaths finalised, 1,274 were found not to be reportable within the meaning of s. 8(3) of the Coroners Act.

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

Backlog indicator

Coroners are aware that delays in finalising coronial matters can cause distress for family members and strive to conclude matters expeditiously. However, coroners are dependent upon other agencies completing their parts of the investigative process, and must balance the benefits of timeliness against the importance of conducting comprehensive and robust case investigations.

As at 30 June 2013, 211 or 10.2 per cent of pending matters were more than 24 months old down from 328 or 14 per cent per cent in 2011–12. This figure exceeds the national benchmarking target of 0per cent largely due to the increasing number of lodgements and the more rigorous investigation required under the Coroners Act. The finalisation of a coronial investigation also depends on the completion of autopsy, toxicology and police reports. Coroners also await the outcome of other expert investigations and criminal proceedings.

As at the end of the reporting period, of the 211 matters that were older than 24 months, 57 per cent (120 matters) were waiting for police or other expert investigations or the outcome of criminal proceedings. Excluding these cases, 91 matters i.e. 4 per cent of pending matters are older than 24 months.

Appendix 1 details the lodgements and finalisations during the reporting period.

Managing the provision of coronial autopsy and government undertaking services

The OSC is responsible for overseeing arrangements for the transportation of deceased persons for autopsy under the Coroners Act and burials and cremations under the *Burials Assistance Act 1965*. Funeral directors and local authorities across the state are contracted to provide these services.

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

The transportation of bodies for autopsy is necessitated by the Coroners Act which requires an autopsy to be performed where a reportable death is investigated by the coroner. There is an exception for cases where the coroner decides to stop investigating because, although the death is reportable, the cause of death is known and no further investigation is required. This often occurs for hospital related deaths

that have been reported directly by medical practitioners using the Form 1A process. In these cases, because no autopsy is required the family can collect the body from the hospital mortuary. The State Coroner encourages the use of the Form 1A process where appropriate.

Autopsies may be performed by forensic pathologists, pathologists or government medical officers (GMOs) who are credentialed to perform autopsies. At the end of 2012–13 autopsies were performed in seven centres across the State: Cairns, Townsville, Rockhampton, Nambour, Brisbane, Toowoomba and on the Gold Coast. As a rule, external autopsies can be performed by GMOs but pathologists perform internal autopsies. However, in practice all autopsies in Queensland are performed by qualified pathologists or forensic pathologists. Under the State Coroner's Guidelines, the more complex autopsies (e.g. multiple deaths, suspicious deaths, child deaths, deaths during childbirth and deaths in custody) are required to be conducted by a forensic pathologist. Forensic pathologists are only located in Brisbane, the Gold Coast, Nambour, Rockhampton, Townsville and Cairns. Additional specialist pathologists who can perform other less complex internal autopsies are located in Cairns, Toowoomba and on the Gold Coast. An ongoing challenge for the coronial system is the availability of pathologists to perform autopsies in regional areas.

Coroners and their support staff – roles and responsibilities

At the end of June 2013 there were seven full time coroners: the State Coroner, Deputy State Coroner, two Brisbane Coroners, Northern Coroner, Southeastern Coroner and Central Coroner.

State Coroner

The State Coroner, Mr Michael Barnes, was reappointed on 1 July 2008 for a period of five years ending on 30 June 2013. The State Coroner is responsible for coordinating and overseeing the coronial system to ensure it is administered efficiently, and that investigations into reportable deaths are conducted appropriately.

As part of this coordinating role, the State Coroner may issue guidelines under s. 14 of the Coroners Act to coroners and to persons carrying out functions under the Act. The State Coroner also provides advice and guidance to coroners in relation to specific cases and liaises with other professions and organisations involved in the coronial process, for example, police, pathologists and counsellors.

Only the State Coroner or Deputy State Coroner may investigate deaths in custody and deaths happening in the course of or because of police operations. The State Coroner also conducts inquests into more complex deaths where deemed necessary.

During 2012–13, 36 matters were reported to the State Coroner. The State Coroner conducted 27 inquests and finalised 40 investigations without proceeding to inquest.

Brisbane based coroners

The Deputy State Coroner, Ms Christine Clements, and two Brisbane Coroners, Mr John Lock and Mr John Hutton, are based in Brisbane. Prior to 1 October 2012, the Brisbane based coroners were responsible for investigating deaths in the Greater Brisbane area including Caboolture, and Redcliffe. From 1 October 2012 with the

state-wide extension of the full time coroner model the reporting catchment increased to include the Sunshine Coast region north to Gympie and South West Queensland.

In 2012–13, 2,708 matters were reported to the Brisbane based coroners and the registrar. 2,559 investigations were finalised, including 22 following an inquest.

Northern Coroner

Deaths in the area from Thursday Island to Proserpine, north to the Papua New Guinea border and west to the Mt Isa district are reported to the Northern Coroner, Ms Jane Bentley, who is based in Cairns. In 2012–13, 596 deaths were reported in the region and 695 matters were finalised, including six following an inquest.

Southeastern Coroner

The Southeastern Coroner, Mr James McDougall, investigates deaths in the area covering Rochedale South to the border of New South Wales, Beenleigh and Logan. In 2012–13, 700 deaths were reported in the region and 722 matters were finalised including three following an inquest.

Central Coroner

The Central Coroner, Mr David O'Connell, investigates deaths reported in the Central Queensland region which covers an area from Proserpine to Gayndah. From 1 August 2013, 526 deaths were reported in the region and 425 matters were finalised.

Regional Coroners

Prior to the implementation of the full-time coroner model, deaths were reported to local magistrate coroners at 16 magistrates courts across the State. Local magistrate coroners finalised 592 matters, including 10 following an inquest.

Support staff

At the end of June 2013, the OSC comprised 41 staff members with 28 based in Brisbane, four in the Northern Coroner's office in Cairns, four in the Southeastern Coroner's office in Southport and four in the Central Coroner's office in Mackay.

In-house counsel assisting at inquests

Coroners are assisted by counsel assisting during an inquest. Outside Brisbane, police prosecutors sometimes perform this role although this is becoming more infrequent. In 2012–13, the Queensland Police Service (QPS) Police Prosecution Corps assisted a local coroner in only two of the 66 inquests held.

Each of the full time coroners is assisted by a legal officer. These legal officers are increasingly performing the role of counsel assisting and during 2012–13 assisted in 49 inquests. Having in house counsel assisting is beneficial as coroners are supported by lawyers with specialised skills and experience in the jurisdiction and inquest costs are kept to a minimum.

Domestic and Family Violence Death Review Unit

The Domestic and Family Violence Death Review Unit (DFVDRU) provides assistance to coroners who are investigating homicides, murder suicides and suicides identified as related to domestic and family violence. Domestic and family violence

death review mechanisms are based on the premise that these fatalities are rarely without warning; and are generally preceded by violent or abusive incidents that indicate a heightened risk of future harm. Reviews of this nature are designed to examine the contact that the deceased and perpetrator may have had previously with services for the purposes of improving systems and potentially preventing future deaths.

Cases are referred to the DFVDRU for review based on an assessment of whether the death involved domestic and family violence as defined by the *Domestic and Family Violence Protection Act 2012*; which covers intimate partner, family and informal care relationships. In contrast to a police investigation which focuses on establishing whether a criminal offence has been committed, the function of the coroner is to examine the cause and circumstances of the death. The DFVDRU provides support to this role by ensuring that information about the history of domestic and family violence is gathered and examined.

Established as a trial in 2011, with the support of the Department of Communities, Child Safety and Disability Services and the QPS, the unit became permanent during this reporting period.

The DFVDRU maintains a dataset of homicides and suicides identified as related to domestic and family violence to assist in the monitoring and identification of any patterns or trends. It should be noted that as this data includes both open and closed coronial matters it may be subject to change, pending the provision of further information.

Approximately 45 per cent of all homicides occurring between 2006 and 2012 in Queensland were identified as being related to domestic and/or family violence.

Table 4: Domestic and family violence related deaths by relationship type and gender (2006-2012)

	2006	2007	2008	2009	2010	2011	2012	Total
Number of homicide victims	59	52	55	53	45	44	49	357
Number of domestic and/or family violence related homicides	33	23	27	17	19	25	17	161
Intimate partner relationship	13	8	16	11	15	14	12	89
Family relationship	20	15	11	6	4	11	5	72
Murder suicide victims	6	2	0	0	4	5	4	21
Deceased – Female	16	13	17	11	16	15	12	100
Female deceased murdered by:								
Intimate partner	8	6	13	9	15	11	10	72
Family relationship	8	7	4	2	1	4	2	28
Perpetrator – Female	7	5	2	3	1	5	2	25
Deceased – Male	17	10	10	6	3	10	5	61
Male deceased murdered by:								
Intimate partner	5	2	3	2	0	3	2	17
Family relationship	12	8	7	4	3	7	3	44
Perpetrator – Male	26	18	23	14	18	20	14	133

In 2012–13, seventeen homicides were identified as occurring within the context of a domestic or family relationship; of which four were murder suicides[1] equating to a total of 20 deaths. Of these homicides, 82 per cent occurred within a private residence while 53 per cent occurred within a residence shared by the deceased and the perpetrator.

In conducting reviews, the DVFDRU considers a range of factors including the circumstances of the incident, prior interaction with services, potential points of intervention as well as the nature and history of the relationship between the deceased and the perpetrator. Understandably the review process may differ for individual cases, dependent on the complexity of issues involved and the level of information available to inform the review. Similar to other coronial matters, investigations for some cases may be delayed pending further information from a third party or awaiting the finalisation of the criminal investigation.

The DFVDRU examines domestic and family related deaths from a systemic perspective, including conducting an assessment of the victim's contact with services and the support offered to them. In reviews conducted within this reporting period, the deceased and/or perpetrator were most likely to have contact recorded with police or the Magistrates Courts. After this, informal networks of family and friends were the most common source of support and assistance, followed by hospitals and mental health service providers.

Research indicates that there are a number of factors that may increase the risk of being either a victim or perpetrator of an intimate partner homicide. The most common risk factors identified during the review process were previous history of domestic violence, actual or pending separation, alcohol and/or drug use (perpetrator), and failure to comply with authority (perpetrator). The victim's intuitive sense of fear of the perpetrator, history of violence outside of the family (perpetrator) and a new partner in the victim's life were also identifiable risk factors across multiple cases.

Common themes identified through the reviews includes increased vulnerability of the deceased as a result of social and geographical isolation, a history of domestic violence with both current and previous partners and limited identifiable contact with domestic and family violence support services. Family and friends as witnesses to the violence and who may have intervened directly in an attempt to stop the abuse, was also a common factor in the cases that were reviewed by the DFVDRU over the past year.

Monitoring responses to coronial recommendations

When a matter proceeds to inquest, a coroner may make recommendations aimed at preventing similar deaths in the future. This is one of the most important objectives of a modern coronial system. Many of the recommendations made by coroners during 2012–13 are highlighted in the Inquests section in this report.

In 2006, the Ombudsman reported that the capacity of the coronial system to prevent deaths would be improved if public sector agencies were required to report on responses to coronial recommendations. In 2008, the Queensland Government

[1] One perpetrator survived his suicide attempt.

introduced an administrative process for monitoring responses to recommendations involving government agencies reporting to the Attorney-General about implementation of recommendations and compilation of an annual report.

The first report considering recommendations made during the 2008 calendar year was released in August 2009. The most recent report in relation to 2011 recommendations was published in December 2012.

Publishing responses to coronial recommendations enhances the death prevention role of the coronial jurisdiction by increasing the likelihood that public sector agencies will give them due consideration. It also provides an important feedback mechanism to coroners. The report can be accessed at the Department of Justice and Attorney-General website: http://www.justice.qld.gov.au/corporate/general-publications

Communication and stakeholder relations

During 2012–13, the OSC continued to engage successfully with its major partners: the QPS whose officers investigate on behalf of the coroners and QHFSS, which provides forensic, pathology, mortuary and counselling services for coroners. Each of these agencies is represented on the Interdepartmental Working Group (IWG), chaired by the State Coroner, which meets to review and discuss state-wide policy and operational issues. The IWG also includes other Queensland Health representatives from CFMU, the Patient Safety Unit, and the Mental Health Alcohol and Other Drugs Branch (MHAODB).

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

Coronial investigators – a multi-agency approach

The CSU coordinates the management of coronial processes on a state-wide basis within the QPS. Four police officers located within the OSC in Brisbane provide direct support to the Brisbane based coroners as well as assisting regional coroners as required. A permanent Detective Senior Sergeant position was established in Cairns in 2012 to assist the Northern Coroner. Officers located at the QHFSS facility at Coopers Plains attend autopsies and assist in the identification of deceased persons and preparation of documents for autopsy.

This unit also liaises with investigators, forensic pathologists, mortuary staff and counsellors. The CSU officers bring a wealth of experience and knowledge and are actively involved in reviewing policies and procedures as part of a continuous improvement approach. Post 1 July 2013 all the police positions are now coordinated centrally by the Detective Inspector, CSU. This restructure is anticipated to deliver greater coordination of coronial support throughout the State.

The Disaster Victim Identification Squad (DVIS) is also part of the CSU. Their main role is to remove and identify the remains of deceased victims of mass fatality incidents, air disasters and natural disasters.

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

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

The full time coroners have been greatly assisted by the clinical expertise provided by the CFMU. GMOs are available on an 'as needed' basis to assist the coroner's preliminary assessment of a reported death, particularly those that occur in clinical settings. GMOs from the CFMU review the report of the death and the deceased person's medical records, and then alert the coroner to any clinical issues requiring further follow up or independent clinical expert opinion.

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

Mental health reviews

The OSC and the MHAODB successfully negotiated an agreement for the MHAODB to provide assistance to coroners by triaging deaths where the adequacy of mental health treatment may be an issue. The purpose of this review is to assist coroners to identify early on in the investigative process whether the treatment was adequate or whether further investigation or specialist review is necessary. This triaging service commenced on 11 July 2012 and has proven to be useful to coroners investigating these matters.

Queensland Suicide Advisory Group

In late 2012 Queensland Health convened the Queensland Advisory Group on Suicide (QAGS) with the aim of improving strategic monitoring and coordination of suicide mortality data in Queensland. QAGS aims to facilitate early access to information about emerging trends and provide advice to support cross-agency responses. QAGS membership includes representatives of Queensland Health, QPS, the Commission for Children Young People and Child Guardian, the Australian Institute for Suicide Research and Prevention and the State Coroner. The State Coroner is represented as a data custodian as all suicides are reported to coroners. During the reporting period QAGS agreed on a process to activate an informed and coordinated response to the portrayal of suicide rates in the media and public arena.

Research

Genuine researchers

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:

- A/Professor Alex Forrest, Professor Peter Ellis, Dr Nathan Milne and Ms Brittany Wong

- Ms Kylie Heggie – Director - Family Studies Program - Department of Veterans' Affairs

- Ms Donna McGregor - Lecturer in Anatomy, Queensland University of Technology, Police Officer (Queensland Police Service), Consultant forensic osteologist for Australian Army, Miss Nicolene Lottering - Doctor of Philosophy (Science) Candidate 2012, Dr Laura Gregory - Senior Lecturer in Anatomy, Queensland University of Technology, Course Coordinator Bachelor of Biomedical Sciences - Queensland University of Technology, Mr Matt Meredith - Senior Radiographer, Queensland Health Forensic Scientific Services, Miss Nicolene Lottering - Research Assistant/Student and Miss Kaitlyn Gilmour - Research Assistant/Student – Queensland University of Technology Research Project – Queensland University of Technology

- Mr Sean Hogan, Cohort and Assessment Manager and Professor Richie Poutlon, Director – Dunedin Multidisciplinary Health and Development Research Unit, Dunedin School of Medicine - University of Otago – New Zealand

- Dr Susan Ballantyne – Director – Drugs of Dependence Unit - Department of Health

- Professor Raphael Grzebieta - Chief Investigator and Project Leader, Adjunct A/Professor. George Rechnitzer - Co-Chief Investigator and Project Manager, Adjunct A/Professor Andrew McIntosh - Co-Chief and Biomechanics Researcher and Mr Declan Patton - Biomechanics Researcher - Quad Bike Performance Project - Transport and Road Safety - University of New South Wales.

The full list of researchers can be found at Appendix 2.

Inquests

This section contains a summary of coronial investigations into all deaths in custody, as required by s. 77(2)(b) of the Act, and other inquests of note conducted during the

reporting period. The complete inquest findings are posted on the Queensland Courts website at: http://www.courts.qld.gov.au/courts/coroners-court/findings

Deaths in custody

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

Angus William Keith Ferguson

Angus Ferguson was an 18-year-old man who died when his motorcycle collided with a guard rail during an attempted police intercept along Duporth Avenue at Maroochydore on the evening of 6 March 2011. Police had observed Mr Ferguson overtaking a car on the left as he negotiated a right-hand turn at a set of traffic lights, despite there being only a single lane at that point. Police who were travelling in the opposite direction at that time decided to intercept the motorcycle, but were unable the close the distance between themselves and Mr Ferguson before the motorcycle crashed about 850m from where police had first seen it. Mr Ferguson died despite prompt medical attention from a doctor who lived nearby the scene.

Mr Ferguson's death was investigated by the QPS Ethical Standards Command (ESC). The two police officers involved in the attempted intercept were separated pending arrival of the ESC investigator. Both officers provided breath and urine specimens for analysis. Traffic accident investigation officer and scenes of crime officers examined the scene. ESC investigators interviewed the two involved police officers in the early hours of 7 March 2011. The ESC investigation was informed by examination of audio recordings from the police vehicle to Maroochydore QPS Communications; mechanical inspection of the motorcycle; interviews with occupants of the vehicle overtaken by Mr Ferguson shortly before the attempted intercept and a forensic crash analysis conducted by the QPS Forensic Crash Unit. During the course of the ESC investigation, it became apparent that one of the involved officers had failed to provide a digital recording of the lead up to the crash to the investigators. Consequently, the ESC investigation extended to examine this issue and the extent to which this officer's actions were known by other police officers. The State Coroner was satisfied that the investigation was professional and thorough.

Autopsy revealed that Mr Ferguson died from chest injuries sustained in the crash. Toxicology detected no alcohol or other drugs.

The State Coroner found that:

- Mr Ferguson lost control of his motorcycle on a sharp bend as a result of his inexperience and excessive speed – the State Coroner considered it was likely that Mr Ferguson noticed the police car coming towards him when passed the other vehicle at the traffic lights and he was probably attempting to evade police when he crashed
- the officers were entitled under the QPS Pursuit Policy to attempt to intercept Mr Ferguson but a pursuit had not commenced at the time Mr Ferguson crashed – the officer's manner of urgent duty driving was reasonable in the circumstances and sanctioned by the QPS Pursuit Policy

- the day after the incident, one of the involved officers destroyed the memory card that is likely to have stored on it vision of the events leading up to the crash.

The State Coroner noted that aspects of the QPS liaison with Mr Ferguson's family were less than optimal but resisted a formal recommendation aimed at re-enforcing the need for QPS to communicate effectively with bereaved families.

The State Coroner noted that the issue of motorcycle licensing was the subject of ongoing Parliamentary Committee review.

The State Coroner considered the issue of whether the officer who destroyed the memory card should be referred to the Director of Public Prosecutions (DPP) for determination whether he should be charged with an offence of damaging evidence with intent. The State Coroner did not consider a DPP referral was appropriate as he accepted that the officer was severely distressed and not thinking clearly at the time he destroyed the memory card; that he did so because he thought the officer driving the car might be disciplined for breaching QPS policy for urgent duty driving and police pursuits and that the inquest was not in the officer's contemplation at that time. The State Coroner noted that the officer had since resigned from the QPS and the QPS was considering taking administrative action to enable a formal finding to be made in respect of the officer's actions. The State Coroner also noted that disciplinary action had been taken against the other involved officer for his failure to report information given to him by his colleague about the withheld evidence from the memory card.

Barry William Cavanagh

Barry Cavanagh was a 30-year-old man who died when his motor vehicle crashed on the Kennedy Highway approaching Innot Hot Springs during an attempted intercept by police in the early hours of 30 October 2010. Mr Cavanagh had consumed eight glasses of beer at the Club Hotel in Ravenshoe earlier that evening. Shortly after leaving the hotel, he was pulled over by police for disobeying a stop sign. He was found to have a high blood alcohol level, charged and released at about 1:30am. Although banned from driving for 24 hours, Mr Cavanagh returned to his vehicle and drove south along the Kennedy Highway, towards his parents' home. He came to police attention at about 2:00am when he passed a highway patrol at high speed. The officers, who had intercepted Mr Cavanagh earlier that evening, were travelling in the opposite direction. They set off after Mr Cavanagh but soon lost contact. They found Mr Cavanagh's vehicle upside down in a ditch by the side of the road at Innot Hot Springs. On gaining access to the vehicle, the officers found Mr Cavanagh suspended upside down, and believed he had broken his neck. They could not find a pulse and waited for paramedics to arrive. Autopsy later revealed no bone fractures but showed Mr Cavanagh had asphyxiated due to inhalation of blood.

Mr Cavanagh's death was investigated by the QPS ESC. The initial management of the scene was conducted by the Acting District Officer, in consultation with ESC officers. The ESC investigation was informed by forensic crash analysis; interviews with involved police officers and local residents, and seizure of QPS communications recordings, job log records, notebook entries and call charge records for all telephones used in the course of the incident and its aftermath. The officers involved in the incident were breath tested within an hour and provided urine samples later that day.

A re-enactment with the officer who was driving was recorded the following day. Mr Cavanagh's vehicle was inspected by a QPS mechanic. The State Coroner was satisfied the investigation was thorough but expressed concern that the report was not provided to him until 21 months after the incident. The State Coroner was also satisfied that although the two police officers seemed to have had a brief opportunity to speak to each other about the incident, they were separated at an appropriately early time and there was no indication of collusion.

The State Coroner found:

- Mr Cavanagh died from positional asphyxia
- police attempted to contact Mr Cavanagh's parents after Mr Cavanagh became hostile when first intercepted – Mr Cavanagh became increasingly annoyed at his predicament and chose to go off by himself, albeit with no offer by police to transport him anywhere. There was no obligation on the officers to do more than they had already done
- there was no pursuit of Mr Cavanagh but the urgent duty driving policy entitled the officers to exceed the speed limit to attempt to intercept him. The State Coroner was satisfied the officers' subsequent driving was appropriate in the circumstances
- the observations of blue lips, cold hands, an apparently broken neck and absence of a pulse allowed the officer/s to reasonably conclude Mr Cavanagh was dead
- the officers made reasonable attempts to gain access to the vehicle shortly after their arrival on the scene – effective resuscitation efforts would not have been possible until 7-8 minutes after the crash even in the best case scenario. Consequently, the State Coroner concluded there was no reasonable opportunity to save Mr Cavanagh.

The State Coroner made no preventative recommendations.

George Robert Lowe

George Lowe was an 80-year-old man who died in a motor vehicle collision on the Kennedy Highway on the Kuranda Range on 25 September 2009, shortly after an attempted police intercept was abandoned. Mr Lowe had come to police attention when a member of the public reported concerns about the manner of his driving. Police located Mr Lowe's vehicle driving erratically on the western side of the Kuranda Range travelling towards Cairns. Police issued a direction to stop by using their siren and emergency lights. Mr Lowe's vehicle twice steered to the left, apparently to pull over, only to return to the eastbound lane and continue at moderate speed. The driver of the police vehicle decided to abandon the attempt to intercept Mr Lowe at the same time as the Cairns based pursuit controller issued an order to do so. Minutes later police received notification that Mr Lowe's vehicle had been involved in a collision while descending the eastern side of the range. His vehicle had veered into the opposite lane colliding with a prime mover and killing him instantly.

Autopsy revealed the cause of death to be multiple injuries due to the motor vehicle collision.

Mr Lowe's death was investigated by the QPS ESC. The initial management of the scene was conducted by police officer who drove during the attempted intercept.

Thereafter officers from Cairns took over until the arrival of ESC officers from Brisbane that afternoon. The ESC investigation was informed by a forensic crash analysis; interviews with the involved police officers and the Mareeba communications officer who had performed the role of pursuit controller and statements from civilian eye witnesses and Mr Lowe's son. The driver of the police vehicle provide a urine sample for testing that afternoon and later participated in a recorded re-enactment of the incident. Both Mr Lowe's vehicle and the prime mover were inspected by QPS mechanics. The State Coroner was satisfied that the investigation was thorough, but expressed concern that he did not receive the investigation report until 22 months after the incident.

The State Coroner noted that Mr Lowe's behaviour on the day of his death was completely out of character. He strongly suspected Mr Lowe suffered a sudden and undiagnosed health related event that degraded his judgement and ability to properly control his vehicle.

The State Coroner concluded there was a pursuit of Mr Lowe and that the officers' approach in this case closely adhered to the QPS Pursuit Policy. The State Coroner was satisfied that the actions of the police officer who attempted to intercept Mr Lowe in no way contributed to the death.

The State Coroner made no preventative recommendations.

Meleta Eliza Oakley

Meleta Oakley was a 16-year-old Indigenous girl from Woorabinda who died when the vehicle in which she was a passenger lost control shortly after the driver failed to stop when directed to do so by police to submit to a breath test.

Meleta's death was investigated by the QPS ESC and the Crime and Misconduct Commission (CMC). The initial stages of the investigation were overseen by the Regional Crime Coordinator, Central Region pending the arrival of ESC and CMC investigators. The two involved police officers were separated and required to provide a breath specimen for testing. The scene was examined by a forensic crash officer who conducted a crash analysis. The investigation was informed by interviews with both police officers and witnesses and recordings of radio transmissions. The State Coroner considered that the timing of the officers' separation and breath testing had to be considered in the context of the incident having occurred in a remote police division and further, the investigators were justified in not conducting a door knock given it was a small close-knit community in which anybody with evidence to give would soon come to light. The State Coroner considered the investigation accessed all relevant sources of information.

The State Coroner found:

- the sole cause of the crash was the reckless drunken driving by the driver
- Meleta was not wearing a seatbelt
- the attempted interception of the vehicle by police precipitated the driver driving at high speed out of town
- the police vehicle followed the car for a short distance but at no time did the police vehicle reach a speed above 30km/hr and at no time were the emergency lights and siren activated

- the terms of the QPS Pursuit Policy were not strictly adhered to but it was a minor and not unreasonable breach in the circumstances
- the police officers made reasonable attempts to comply with the Pursuit Policy – none of their actions were dangerous or reckless and nothing they did contributed directly to the death, as the fatal crash happened far away and long after the attempted interception was abandoned.

The State Coroner accepted expert evidence that in order for Meleta to have had even a chance of survival, it would have been necessary for her to be extricated from under the vehicle and been in the care of paramedics within 2-3 minutes of the crash.

The State Coroner referred the conduct of the driver of the vehicle to the DPP for consideration of whether the driver should be prosecuted for dangerous operation of a vehicle causing death.

The Deputy State Coroner conducted one inquest during the reporting period into a death that occurred in the course of a person being detained and/or restrained by police or custodial officers.

Antonio Carmelo Galeano

On 10 June 2009 Antonio Galeano was restrained by police after they found him acting in a bizarre manner while walking on a rail line in the town of Brandon in North Queensland. He was taken to Ayr Hospital and then transferred to Townsville Hospital where he was diagnosed with acute amphetamine toxicity. A mental health assessment concluded that Mr Galeano was not suffering from a mental illness and he was discharged the following morning. In the early hours of 12 June 2009 police were contacted by a female friend of Mr Galeano and advised that he was becoming disturbed and incoherent, that he was destroying property in her flat and becoming physically threatening towards her.

The two police officers who attended the flat found Mr Galeano naked, unresponsive to them and apparently irrational. Their attempts to restrain him lasted for around 25 minutes and included the use of capsicum spray and multiple applications of electrical charge from a Taser. Handcuffed, face down and with the two officers maintaining physical control of him, Mr Galeano became gradually more subdued and then lapsed into unconsciousness. He was found to have stopped breathing and attempts by police and, later, ambulance officers to resuscitate him were unsuccessful.

This death in custody was investigated by the Deputy State Coroner who held an inquest lasting six weeks in aggregate. The inquest heard from several pathologists and other medical experts in relation to the likely cause of death. Particular consideration was given to the possibility of a causal link between the multiple applications of the Taser by police and the medical cause of death. The inquest also examined the adequacy with which Mr Galeano was treated at Townsville Hospital and the particular actions of police in response to the 000 call of Ms Wynne. It considered the appropriateness of QPS policies and training on Taser use and in relation to the way officers respond to highly agitated people apparently suffering from psychosis.

The Deputy State Coroner found that:

- Mr Galeano's death was caused by excited delirium, probably caused by amphetamine toxicity induced psychosis
- there was no evidence the application of the Taser or capsicum spray directly caused the death. However, the Deputy State Coroner considered it was impossible not to include the Taser application and Mr Galeano's exertion as part of the contributory factors leading to the final cardiac event resulting in Mr Galeano's death
- the Taser was activated 28 times during the struggle but not all were conscious or deliberate
- although deploying the Taser at the specific time it was done breached QPS policy, because the officer was faced with a man in a "psychotic furore" the decision to use the Taser in these circumstances should not be subject to referral for disciplinary action
- there was no reliable evidence to support the contention that Mr Galeano had not been provided with adequate first aid after he lost consciousness
- the failure by another, more senior officer, to put in place arrangements to adequately preserve the scene should not be judged harshly or result in disciplinary action in the particular circumstances of this case.

The Deputy State Coroner made recommendations to the following effect:

- investigations should be made into the possible use in Queensland of a neurological tissue test used in the USA which would assist in identifying or negating excited delirium as a cause of death
- the QPS should review evidence from the inquest indicating variation in the methods of timekeeping within the organisation
- the Queensland Ambulance Service (QAS) and QPS should review their protocols and training relating to the manner in which officers deal with severely disturbed individuals
- the threshold for Taser use should require an "imminent risk" (of serious harm to a person)
- the QPS be required to review and audit every instance of multiple or prolonged Taser deployment
- the QPS investigate options to acquire safer and more technologically advanced weapons
- the QPS operational procedures manual sections addressing police interaction with mentally disturbed persons be reviewed to make them easier to reference
- the QPS review the safety equipment available to officers during the performance of CPR and, in particular, the adequacy of masks issued for that purpose
- processes should be put in place allowing police communications officers to alert front line police officers and QAS officers of relevant medical information on the QPS database relating to the person with whom they are dealing
- hospital notification to a patient's family and/or the QPS on the patient's discharge from a hospital mental service be considered
- a series of specific improvements be made to the manner in which deaths in police custody are investigated and evidence is prepared for inquest.

The State Coroner conducted one inquest during the reporting period into a death that occurred in the course of a person being detained and/or restrained by police or custodial officers.

Jason Paul Protheroe

Jason Protheroe was shot dead by a police officer at Bracken Ridge late on the morning of 17 April 2012. The officer wanted to speak to Mr Protheroe about alleged property offences. He claimed Mr Protheroe pointed what appeared to be a gun at him just prior to the shooting. This was supported in part by the evidence of another police officer at the scene but disputed by the only other eye witness, a female friend of Mr Protheroe. A replica pistol was seen near the body soon after the shooting.

The two week inquest examined the events which lead to the shooting and the adequacy of the investigation into the death which was conducted by officers from the QPS Internal Investigations Branch. It also examined the management of the crime scene; the interaction between police and the family of the deceased immediately after the shooting, and various statements made to the media by the President of the Queensland Police Union of Employees (QPUE).

The State Coroner found that:

- Mr Protheroe was shot and killed when he produced a replica firearm and pointed it at a plain clothes police constable
- the constable fired four shots with two striking Mr Protheroe and causing non-survivable injuries
- it was reasonable for the constable to have believed that his life was at risk and that it could only be preserved by firing at Mr Protheroe
- the positioning of the entry wounds (in the rear of the shoulder and right lower back) was readily explained by the twisting movement of Mr Protheroe, observed by two eye witnesses, as the four shots were being fired
- QPUE officials were given access to the outer cordon of the crime scene and to the investigation command post that was unnecessary for them to perform their industrial functions and, therefore, undesirable
- this was in contrast to the treatment of the family who were rudely told to leave the boundary of the outer cordon before they were provided with any information about the incident
- statements made in the hours after the shooting by Ian Leavers, President of the QPUE were inappropriate and in some cases factually incorrect
- the girlfriend of Mr Protheroe complained to the investigating officer that her and the deceased's "mug shots" and criminal history had been broadcast by media outlets. It ought to have been assumed that this confidential information was illegally provided to the media by a police officer yet nothing was done about the complaint.

The State Coroner recommended that the QPS review its policies and procedures relating to:

- security of critical incident scenes (in particular, who is given access)
- initial family liaison
- responsible media comment.

In relation to media comment the State Coroner noted the competing responsibilities that union officials (who are also police officers) have to both the QPUE and to the QPS. He recommended both of those organisations review the areas in which conflict is likely to arise and put in place protocols that will ensure the functions of the QPS are not compromised while QPUE officials conduct their legitimate industrial functions.

During the reporting period, the State Coroner conducted one inquest into prisoner deaths following assault.

Jayde Stephen Donovan Biddulph

Jayde Biddulph was a 33-year-old man who died from injuries sustained in an assault upon him by a fellow prisoner in the Capricornia Correctional Centre (CCC) on 16 December 2009. In July 2009 Mr Biddulph had commenced a relationship with the assailant's former partner. When the assailant became aware of the relationship he threatened to assault Mr Biddulph. Mr Biddulph was also imprisoned at the CCC in November 2009. The day of the fatal assault was the first time the two men had come face to face since their imprisonment.

Mr Biddulph's death was investigated concurrently by the QPS Corrective Services Investigation Unit (CSIU) and Queensland Correctives Services (QCS). The scene of the assault was secured by corrections staff soon after the incident and forensically examined. The assailant was taken to the detention unit where his clothes were removed and bagged and his injuries later photographed. CSIU investigators conducted an interview with the assailant and a large number of witnesses, including witnesses to the assault, other prisoners and corrections staff who had contact with both men in the weeks preceding the incident. The former partner was also interviewed and provided police with a series of letters from the assailant containing threats against Mr Biddulph. The CSIU investigation was also informed by the seizure of all corrections records relating to the two men, interrogation of the prison information management system, statements from all staff involved in allocating accommodation to Mr Biddulph, and seizure of tapes of telephone conversations made by the two men from CCC. The State Coroner considered the conduct of the investigation was commensurate with that of a matter the subject of a Supreme Court murder trial and he was satisfied it was conducted thoroughly and professionally.

The State Coroner noted the assailant was charged with murder on 17 December 2009, found not guilty of murder but guilty of manslaughter and sentenced to nine years imprisonment.

The State Coroner found:

- Mr Biddulph died from head injuries sustained in the assault
- the meeting between the two men on the morning of the assault was coincidental
- Mr Biddulph believed he could avoid the assailant if they were housed in different units
- even if the corrections officers had more actively engaged with Mr Biddulph's assessment, it was not clear that anything would have been done differently

- although both men had made it clear to each other and to the former partner that "*it would be on*" if they saw each other, neither man anticipated a punch up would result in the death of one of them.

The State Coroner was satisfied the QCS report adequately identified the systemic shortcomings, namely the prisoner protection system in place at CCC relied heavily on individual officer discretion about when and how information would be passed to those in a position to put in place practical measures such as cell allocation. This communication was not supported by timely record keeping or any backup measure. The State Coroner considered the QCS recommendations, if implemented, would address those shortcomings. The State Coroner heard evidence about the extent which QCS has responded to those recommendations. This includes:

- changes to the admission and assessment process to question incoming prisoners about whether they have concerns about prisoners already in the facility – this is done as part of the Initial Risk and Needs Assessment (IRNA)
- concerns noted in the IRNA process are notified to relevant officers including the secure supervisor
- a requirement for the recording of the prisoner's response to be recorded within 24 hours and lodged on the Integrated Offender Management System (IOMS)
- training for CCC staff in relation to the recording and dissemination of information potentially relevant to the prison intelligence section.

The State Coroner was satisfied no further recommendations needed to be made.

During the reporting period, the State Coroner conducted two inquests into prisoner deaths in police watch-houses.

Michael David Ley

Michael David Ley was a 30-year-old man who was found unresponsive in a cell in the Townsville Police watch-house on 4 June 2011. In the early hours of that morning, Mr Ley had been arrested for being drunk in a public place after he had been evicted from his former girlfriend's flat. Mr Ley appeared to fall asleep almost immediately after being placed in the back of the police van and was unresponsive when carried to the charge counter. He was then carried into a cell and placed on one of the beds. He was discovered not be breathing two hours later during a routine cell check. He was transported to the Townsville Hospital by ambulance and placed on life support. He died three days later without regaining consciousness.

Mr Ley's death was investigated by the QPS ESC. This investigation commenced prior to his death as the incident was immediately recognised as a likely death in custody. Pending the arrival of ESC investigators in Townsville later that day, the involved officers were sent home with a direction to not speak about the matter and to not consume alcohol. The ESC investigation was monitored by an officer from the CMC. The ESC investigation was informed by interviews with persons involved with Mr Ley prior to his death, seizure of relevant watch-house records including CCTV footage from the watch-house and other premises attended by Mr Ley before he was taken into custody. The OSC supplemented the ESC investigation with independent expert reports from an emergency medicine specialist. The State Coroner was satisfied the investigation was thorough and professionally undertaken.

Autopsy revealed significant hypoxic ischaemic brain injury and evidence of aspiration pneumonia which the pathologist considered was due to alcohol abuse.

The State Coroner commented on the alarming proportion of persons arrested who are severely intoxicated by alcohol and/or other drugs. The inquest examined the adequacy and appropriateness of QPS policies and procedures to assist officers in determining when prisoners need to be medically examined.

The State Coroner found:

- the arresting officers' decision that Mr Ley was unsuitable for release to a diversionary centre (because of his aggressive behaviour and indication that he wished to re-enter his former girlfriend's flat) was reasonable in the circumstances
- the arresting officers' failure to consider returning Mr Ley to his home address was not unreasonable given his aggression and lack of co-operation
- Mr Ley's condition at the time of the arrest was such that although he was obviously very drunk it was not to the extent that an immediate medical assessment was called for and consequently, the arresting officers' decision to take him to the watch-house rather than call an ambulance or take him to hospital was reasonable in the circumstances
- the watch-house keeper's management of Mr Ley was inexplicable in that despite Mr Ley's presentation as clearly, deeply unconscious, unable to be roused and unable to answer questions designed to help determine whether a medical assessment was needed, he falsely recorded that Mr Ley had refused to answer all of the questions – the watch-house keeper's actions were completely contrary to the applicable QPS policy and procedure
- it was highly likely Mr Ley would have survived had he been taken to hospital before he was put in a cell
- an opportunity to prevent Mr Ley's death may have been lost by the watch-house keeper's failure to adhere to appropriate QPS policies of which he should have been aware.

The State Coroner declined to refer the watch-house keeper to the Director of Public Prosecutions as he was satisfied the failure to comply with QPS policy did not amount to criminal negligence.

The State Coroner did not make any preventative recommendations.

Herbert John Mitchell

Herbert John Mitchell was a 50-year-old Indigenous man who was found unresponsive in the Townsville Police watch-house on 17 April 2011. Mr Mitchell had been arrested earlier that day for being drunk in a public place. Police initially took him to a diversionary centre but when he acted inappropriately there, he was taken to the watch-house. He was reviewed by paramedics soon after admission to the watch-house and considered sufficiently well to remain in custody in the watch-house. That afternoon Mr Mitchell was found unresponsive in his cell. He was transported by ambulance to the Townsville Hospital where he died the following day without having regained consciousness.

Mr Mitchell's death was investigated by the QPS ESC. The ESC investigation was informed by interviews with persons involved with Mr Mitchell prior to his death and seizure of relevant watch-house records including CCTV footage from the watch-house. The ESC investigation was monitored by an officer from the CMC. The OSC supplemented the ESC investigation with an independent expert report from an emergency medicine specialist. The State Coroner was satisfied the investigation was thorough and professionally undertaken.

Coronial autopsy suggested the cause of death was hypoxic-ischaemic encephalopathy due to alcohol toxicity. Mr Mitchell's family engaged an independent forensic pathologist to perform a second autopsy, which suggested the cause of death was hypoxic brain damage following cardiorespiratory arrest due to acute alcohol intoxication, with blunt force injury causing rib fractures contributing to the death. Although it was agreed that some of the fractures were consistent with and possibly attributable to resuscitation efforts, the independent forensic pathologist considered it possible that some of the fractures and bruising may have been sustained during or in the period prior to Mr Mitchell's incarceration.

The State Coroner found:

- Mr Mitchell died from global hypoxic brain injury suffered during a cardiac and respiratory arrest caused by acute alcohol intoxication. The State Coroner was unable to make a finding about how the rib fractures were sustained
- the decision to take Mr Mitchell to the watch-house was reasonable
- the paramedic assessment of Mr Mitchell after admission to the watch-house was made in accordance with the then current QAS policy. Once cleared by the paramedics as fit to remain in the watch-house, the decision to keep him there was reasonable and in accordance with all relevant QPS policies
- the monitoring of Mr Mitchell in the watch-house was carried out in accordance with QPS policy.

The State Coroner noted that QPS is continuing to develop new watch-house procedures with expert assistance and made the following observations:

- QAS and Queensland Health should be involved in the development of new watch-house policies that deal with health issues
- the policies of the respective agencies should be complementary
- QAS policies should be developed to cater for the specific needs of watch house prisoner patients
- it is essential for health care providers who come to a watch-house to assess a prisoner to be given all relevant information known to police, preferably in written form
- health care providers should provide their assessment and patient management needs to police in writing if the prisoner is to remain in policy custody
- mechanisms for monitoring a prisoner's condition need to effectively distinguish between sleeping and unconsciousness and should enable an officer to ascertain whether a prisoner's level of consciousness is deteriorating or symptoms requiring immediate treatment are escalating

- stipulation of observable, clearly defined symptoms or numerical values as a basis for obtaining medical attention are more likely to lead to consistent outcomes
- electronic record keeping should facilitate compliance with policies e.g. by incorporating forcing functions
- a more simplified decision tree using the methodology employed in clinical pathways used in the health sector could be adapted and developed
- junior officers should be given the means to bypass rank obstacles when safety is at risk without fearing retribution
- mechanisms for assessing the level of compliance with policies are essential.

During the reporting period, the State Coroner conducted three inquests into prisoner deaths by suicide.

David John Bucknall

David John Bucknall was a 41 year old man who was found deceased in his cell at the Wolston Correctional Centre (WCC) on 16 March 2012. He had declined to attend a scheduled appointment with his treating psychiatrist that day and then failed to attend a course that afternoon. He was found hanging from the cell door with a cord from a prison laundry bag wrapped tightly around his neck. Despite emergency resuscitation efforts, Mr Bucknall was unable to be revived.

Mr Bucknall's death was investigated concurrently by the QPS CSIU and the Office of the Chief Inspector, QCS. The whole residential unit was closed and secured immediately after the death was discovered. The scene was forensically examined. The CSIU investigation was informed by accounts from corrections officers and prison nursing staff; statements from Mr Bucknall's friends and family members; interviews with all prisoners in Mr Bucknall's residential unit and three surrounding units; and statements from two treating doctors and staff of the Prison Mental Health Service (PMHS), including Mr Bucknall's treating psychiatrist. Recordings of phone calls made by Mr Bucknall in the months prior to his death were seized and transcribed. Mr Bucknall's medical records were also seized. The State Coroner considered the CSIU investigation was professional and thorough.

Autopsy revealed the cause of death to be consistent with hanging. Toxicological analysis detected paracetamol and the antipsychotic medication Quetiapine in therapeutic levels and the antidepressant medication Mirtazapine in above therapeutic but well below known fatal levels.

The State Coroner found that:

- Mr Bucknall intentionally took his own life as the result of remorse for the impact of his crimes and despair at the loss of his relationship with his partner
- Mr Bucknall suffered from chronic depression that may have exacerbated the adjustment disorder he experienced in prison – the State Coroner was satisfied that Mr Bucknall received appropriate medical treatment for his psychological conditions while in prison, particularly from his treating psychiatrist
- the initial risk assessments on reception at both Brisbane Correctional Centre and WCC of Mr Bucknall not having an elevated baseline risk for suicide or deliberate self harm were reasonable

- there was no evidence that Mr Bucknall's condition had become acute in the days preceding his death – there was no basis on which any member of the WCC staff or the PMHS ought to have been aware that he was at heightened risk of suicide at this time
- corrections officers acted promptly and appropriately in attempting to revive Mr Bucknall.

The State Coroner noted that laundry bag cords (as well as hats with similar cords) were removed from use in the WCC accommodation areas immediately following Mr Bucknall's death, and further, all prison General Managers have been informed of the unique suicide method used in this case so they can develop prevention strategies.

The State Coroner noted that in response to a recommendation made by the QCS investigation, WCC staff have been directed to be more vigilant in following up prisoners who fail to respond to intercom calls.

The State Coroner also noted that the more than two-month period between referral and Mr Bucknall being seen by the PHMS arose because of the limited resources available to PMHS when measured against its enormous caseload. The State Coroner commented that this was 'at odds' with QCS' obligation to maintain equivalency between the health care provided to prisoners and that provided to other members of the community. The State Coroner queried whether the decentralising of prisoner health services would hinder or improve this aspect of care.

Adam Cartledge

Adam Cartledge was a 38-year-old man who was found hanging in his cell at the Arthur Gorrie Correctional Centre (AGCC) on 5 October 2010. The door to his cell was opened just under six minutes after a prisoner raised alarm (after scepticism from the first officer contacted as to whether there was an actual emergency). Despite emergency resuscitation efforts, Mr Cartledge was unable to be revived. Mr Cartledge had fashioned a ligature from a shredded towel which he fastened to the exposed bars above his cell door.

Mr Cartledge's death was investigated concurrently by the QPS CSIU and the Office of the Chief Inspector, QCS. The scene was secured and forensically examined. The CSIU investigation was informed by interviews with other prisoners housed in the same unit as Mr Cartledge, statements from corrections officers and medical staff at AGCC and all relevant documentation from AGCC concerning Mr Cartledge. The State Coroner was satisfied that the two investigations addressed all relevant issues and sourced all relevant information.

Autopsy revealed the cause of death to be consistent with hanging. Toxicological analysis detected higher than therapeutic but less than lethal levels of Tramadol and Venlafaxine.

The State Coroner found that:

- Mr Cartledge intentionally took his own life without assistance from or the knowledge of any other person
- Mr Cartledge was at chronic risk of self harm but there was no obvious deterioration in his mental state in the days or weeks preceding his death – the

State Coroner did not consider that the AGCC staff who had contact with Mr Cartledge in this period could reasonably have been expected to have been aware of his increased risk
- Mr Cartledge's access to psychiatric and psychological services was adequate when compared to that which is likely to have been available to him in person
- the decision to house Mr Cartledge in a cell which gave him ready access to a hanging point facilitated his death – however, the State Coroner accepted that it was a carefully considered and justifiable decision
- the officers who became aware of Mr Cartledge's situation on the evening of 5 October 2012 acted appropriately in responding to it by summoning assistance and administering first aid – Mr Cartledge was almost certainly already dead when he was first seen by the prisoner who summoned assistance and nothing could have been done to save him.

The inquest heard evidence that AGCC had since changed its procedures to ensure that all prisoners who are flagged as either a current risk of suicide or who have a history of attempted suicide are now housed initially in suicide resistant cells. The Integrated Offender Management System now differentiates those with a current risk of suicide or self harm (always housed in new suicide resistant cells) from those who a historical incidence of attempted suicide but are not considered to be at imminent risk (also housed in suicide resistant cells unless there is some significant operational impediment to achieving this). After the prisoner's initial placement, a panel assesses the prisoner's status and decides on the most appropriate accommodation, with reasons for the accommodation decision uploaded into IOMS. The QCS Incident Oversight Committee endorsed this new placement process in July 2012.

The State Coroner noted yet again that there are still 380 cells in use at the AGCC with exposed hanging points but acknowledged that progress has been made and that the proportion of unsafe cells has decreased. The State Coroner observed that preventable fatalities will continue to occur in Queensland correctional centres while prisoners continue to be housed in cells with readily accessible hanging points.

Lawrence McCarty

Lawrence McCarty was found deceased in his bed at AGCC late on the morning of 30 April 2011. He had significant wounds to his neck, his chest was covered in blood and a search of his cell revealed a number of blades which had been detached from disposable razors. One of those blades was found at the base of a sink which also contained droplets of blood. Mr McCarty had not been seen since "lockdown" on the evening of 29 April 2011 but electronic records showed that no one could have accessed his cell between that time and when he was found deceased.

An autopsy report tendered at the inquest concluded that Mr McCarty had died from an incised wound to the neck. Toxicology testing revealed the presence of Naproxen, Sertraline and Tramadol; the latter at potentially fatal levels.

The inquest examined Mr McCarty's medical and psychiatric history; his movements and the observations of him on 29 and 30 April 2011; the medical response when he was found deceased and the adequacy of the investigation into his death. The inquest heard directly from the forensic pathologist who performed the autopsy examination.

Two independent doctors provided opinions on the possible effects of the drugs identified on the toxicology report.

The State Coroner found that:

- when inducted at AGCC Mr McCarty denied any suicidal ideation but did disclose prior contact with a psychiatrist. No further enquiry was made in relation to this disclosure
- Mr McCarty inflicted the laceration to his neck without the assistance or knowledge of any other person
- it is unknown why Mr McCarty took his life
- it is unknown at what time Mr McCarty took is life and the inquest heard it was rare for forensic pathologists to be called to the scene of an apparent suicide
- there is little evidence, even in hindsight, that points to any deterioration in mood prior to his death
- there was no evidence that Mr McCarty was able to stockpile his medication and, because of various doubts raised by medical practitioners over the reliability of the toxicology results, the apparent mixed drug toxicity should be disregarded as a contributing factor in the death
- the investigation, while generally adequate, involved haphazard and inconsistent questioning of prisoners.

The State Coroner considered a number of recommendations already made by an independent review commissioned by AGCC management. He noted that these recommendations relating to welfare checks of prisoners, procedure during head-counts and "lockdown", preservation of crime scenes and CCTV monitoring had already been implemented.

The State Coroner made further recommendations that:

- Queensland Health amend relevant policies and forms to encourage further information to be sought from a prisoner who discloses prior contact with a psychiatrist or psychologist
- the Chief Forensic Pathologist develop a protocol to determine which cases the on-call pathologist will usually attend
- the officer in charge of the QPS CSIU procedures to ensure appropriate investigation planning is mandated.

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

Donald Mervyn Hay

Donald Mervyn Hay was a 67-year-old man who died at the Princess Alexandra Hospital (PAH) on 15 November 2011. He had been in custody at the WCC for seven months prior to having a cardiac arrest and being transported to hospital by ambulance. Despite extensive resuscitation efforts, Mr Hay was unable to be revived. Mr Hay had a lengthy history of heart disease with numerous hospital admissions throughout his three years in custody.

Mr Hay's death was investigated by the QPS CSIU. The CSIU investigation was informed by obtaining hospital and prison medical records, statements from corrections officers, prison nursing staff, paramedics and the hospital doctor and interviews with prisoners housed in the same accommodation unit as Mr Hay. The State Coroner was satisfied that the investigation was thorough and conducted professionally. The OSC supplemented the CSIU investigation with an independent clinical review by the Queensland Health CFMU of the health care provided to Mr Hay.

Autopsy revealed the cause of death to be acute myocardial infarction due to coronary atherosclerosis with diabetes and hypertension contributing to the death.

The State Coroner found that:

- Mr Hay died from natural causes
- Mr Hay was given adequate medical treatment during the seven months of his imprisonment at WCC prior to his cardiac arrest on 15 November 2011
- the emergency response to Mr Hay's collapse was appropriate
- the care provided to Mr Hay when he presented to the PAH was adequate and appropriate.

The State Coroner did not make any preventative recommendations.

Rex Harold

Rex Harold was a 59-year-old indigenous man who died at the Townsville Hospital on 23 July 2009. He had been in custody at the Townsville Correctional Centre since 28 April 2009. Mr Harold had a lengthy mental health history with long periods of inpatient treatment and a significant medical history. He was the subject of a guardianship order at the time of his death. He was transferred to hospital on 19 July 2009 when he was noted to have been unwell for several days.

Mr Harold's death was investigated by the QPS CSIU. The CSIU investigation was informed by seizing all relevant medical and custodial records and statements from relevant clinical personnel. The OSC supplemented this with an independent clinical review by the Queensland Health CFMU of the adequacy of the health treatment provided to Mr Harold both while he was an involuntary mental health patient and while he was in custody. The Deputy State Coroner was satisfied with the investigation.

Autopsy revealed the cause of death to be disseminated carcinoma secondary to right lung carcinoma with chronic obstructive airways disease and coronary atherosclerosis contributing to the death.

The Deputy State Coroner found that:

- Mr Harold died from natural causes
- the combination of Mr Harold's mental and physical health issues over a long period of time and the frequency and length of time during which Mr Harold was either incarcerated or subject to involuntary mental health treatment provided a very complex presentation for treating doctors to consider
- although a lung malignancy was suspected but not diagnosed during an involuntary admission to the Cairns Base Hospital Mental Health Unit in

2007, it was unknown whether an earlier diagnosis of the lung cancer which caused his death could have changed the outcome.

The Deputy State Coroner noted that following review, changes have been initiated across Queensland Health mental health units to improve the care of mental health inpatients with medical co-morbidities. The Deputy State Coroner also noted the implementation of electronic medical records systems across Queensland Health facilities from 2011 but observed that these systems were not mandatory and the regional based health care delivery model may continue to reduce the likelihood of conformity with a single system state-wide. The Deputy State Coroner made no preventative recommendations.

Sen Hung Chen

Sen Hung Chen was a 65-year-old man who died at the PAH Secure Unit on 6 December 2010. At the time of his death, Mr Chen was serving a custodial sentence at the Borallon Correctional Centre (BCC). Three months prior to his death, clinical investigations had revealed terminal cancerous lesions.

Mr Chen's death was investigated by the QPS CSIU. The investigation was informed by seizure of all relevant medical and corrections records, statements from involved medical staff and corrections officers and statements from six prison inmates. The OSC supplemented the CSIU investigation with an independent review of the prison and hospital medical records by the Queensland Health CFMU. The State Coroner was satisfied that the investigation was thorough and conducted professionally.

Autopsy revealed the cause of death to be metastatic adenocarcinoma of unknown origin.

The State Coroner found that:

- Mr Chen died from natural causes
- Mr Chen received adequate medical treatment at BCC and a timely referral was made to the PAH for more extensive testing
- the care provided by the PAH was of a high standard.

The State Coroner considered the reviewing CFMU doctor's concerns about a three week delay for a CT scan to be arranged and a three day delay in the scan results being reported to the treating doctor. The State Coroner accepted that the delay had no impact on the outcome for Mr Chen and further, it was consistent with timings that might be expected by members of the public, with a similar clinical presentation, who are being treated at the PAH. The State Coroner noted that a new radiology reporting system is being implemented at the hospital and will provide for electronic reporting and better access by the radiologist to the patient record.

The State Coroner made no preventative recommendations.

Gerry Maxwell Cooper

Gerry Maxwell Cooper was a 57-year-old Indigenous man who died at the PAH Secure Unit on 12 May 2012. At the time of his death, Mr Cooper had been in the custody of Queensland Corrective Services for 23 years. He had a significant medical history, including chronic renal failure for which he required regular dialysis at the

hospital. Mr Cooper was known to be a difficult patient and frequently refused recommended medical care including dialysis which resulted in complications requiring medical attention. Mr Cooper had been admitted to the hospital 29 days prior to his death after suffering an ischaemic stroke and intermittent confusion as a result of hepatic encephalopathy. He suffered two falls during his final admission, after the second of which on 5 May 2010, following consultation with his family, he was commenced on palliative care and placed on a not for resuscitation order. Mr Cooper was found unresponsive in his room without life signs seven days later.

Mr Cooper's death was investigated concurrently by the QPS CSIU and the QCS Chief Inspector. The investigation was informed by a forensic examination of the scene and statements from various medical and corrections personnel and the other inmate patients in the Secure Unit. The investigating officer noted that Mr Cooper's previously reported concerns about his treatment by corrections staff and the priority of treatment he was offered by the PAH Secure Unit had been investigated by the QCS Ethical Standards Unit and the allegations found to be unsubstantiated. The QCS investigation noted Mr Cooper's general non-compliance with his medical treatment and his poor behaviour towards medical and custodial staff and concluded his frequently expressed concerns had been addressed sufficiently on each occasion. The OSC supplemented these investigations with an independent review of the prison and hospital medical records by the Queensland Health CFMU. The State Coroner was satisfied that the investigations were thorough and conducted professionally.

An external examination, toxicology and review of medical records confirmed the cause of death to be hepatic encephalopathy due to end stage liver failure due to alcoholic cirrhosis.

The State Coroner found:

- Mr Cooper died from natural causes and no other person caused or contributed to his death
- Mr Cooper frequently refused dialysis, hospitalisation, treatment and medications recommended by medical staff
- during his final admission, Mr Cooper often ignored instructions from nursing staff designed to mitigate the risk of him falling
- Mr Cooper had a history of breaches of discipline and threats against medical staff and other prisoners
- the implementation of a Health Management Plan, designed to achieve a common understanding of behavioural expectations and possible consequences of Mr Cooper's behaviour during dialysis treatment, was appropriate and did not adversely impact on the health care provided to Mr Cooper
- the health care provided to Mr Cooper by the PAH, WCC and the AGCC was adequate and appropriate in the circumstances
- there is no evidence that any injury sustained when Mr Cooper fell in hospital contributed to his death and while the fall and subsequent head injury on 2 May 2010 may have contributed to clinical decision making with respect to his further treatment, the process of considering palliation was already underway and would have been implemented at about the same time in any event
- the Queensland Health and QCS investigations into Mr Cooper's complaint that he was being racially discriminated against because non-aboriginal inmate

patients in the Secure Unit had received dialysis before him were satisfactory and Mr Cooper's allegations about the quality of his health care were unsubstantiated.

The inquest considered the issue of in-hospital falls risk management. The State Coroner noted the hospital had since reviewed and amended its falls policy and procedures which he was satisfied largely addressed deficiencies of the policy and procedures in place at the time of Mr Cooper's final admission. The State Coroner made no preventative recommendations.

Hazel Marie Lalara

Hazel Lalara was arrested by police on 28 December 2008 on suspicion of attacking her neighbour with a knife. She was remanded in custody and, when medically assessed, was found to be suffering from psychosis associated with chronic schizophrenia. On 2 January 2009 Ms Lalara was transferred to the High Security In-patient Service (HSIS) at The Park Centre for Mental Health (The Park). There, while awaiting her scheduled return to court in early February 2009, she was treated for her psychosis and for a number of physical medical conditions including peripheral neuropathy.

At 5am on 28 January 2009 a nurse, conducting her third half-hourly check on patients in the HSIS, noted that Ms Lalara had not moved for an hour. As a result a supervising nurse checked on Ms Lalara and found her to be unconscious and exhibiting no signs of life. The medical staff members who responded to the subsequent emergency call were sufficiently confident that Ms Lalara had been deceased for a significant period that no attempt was made to resuscitate her. An autopsy report concluded Ms Lalara had died from dilated cardiomyopathy.

The inquest examined the adequacy of the medical treatment provided to Ms Lalara while she was remanded in custody at The Park and the actions of both the nurse charged with conducting patient checks on the morning of her death and staff who decided that no attempt at resuscitation should be made. The family of Ms Lalara submitted that she had not been given adequate medical care. Statements were obtained from all available medical staff members involved in providing treatment to Ms Lalara. A report on the adequacy of care was sought and obtained from an independent forensic medical practitioner. A toxicologist reviewed the toxicology results from samples taken at autopsy and did not consider there was any link between those results and the cause of death.

The State Coroner found that:

- the medical care provided to Ms Lalara while at The Park was adequate and appropriate
- the death was not caused by any action or inaction by medical staff at The Park and it was not a preventable death
- the decision by the nurse charged with monitoring patients on the morning Ms Lalara was found deceased had acted reasonably. Her decision attributed appropriate weight to the competing needs of ensuring patients were alive and well with the importance of not unnecessarily disturbing them
- the decision not to attempt to resuscitate Ms Lalara was reasonable.

The State Coroner noted that, although it did not affect the outcome in this case, that the medical emergency procedure in the HSIS at The Park was inefficient. He recommended that the clinical director of the HSIS review the procedure to ensure that it, and the available resuscitation equipment, at least equals that in place at other correctional facilities.

Robert John Gerhardt

Robert Gerhardt died at the PAH Secure Unit on 6 May 2011 as a result of advanced lung cancer. He had been a prisoner for more than four years when, in late 2010, he began suffering symptoms now known to be associated with this condition. A chest x-ray taken at PAH in September 2010 revealed a density that was not further investigated by medical staff until November 2010 at which time it was found to be a cancerous growth. In the months between diagnosis and his death Mr Gerhardt received treatment and then palliative care at PAH Secure Unit and WCC.

The inquest examined the adequacy of the health care provided to Mr Gerhardt including the apparent failure to diagnose the cancerous growth in September 2010. A report from an independent medical practitioner tendered at the inquest also raised concern about the provision of pain relief to Mr Gerhardt at WCC while he was receiving palliative care.

The State Coroner found that:

- Mr Gerhardt died from natural causes
- the treatment provided to Mr Gerhard at WCC was adequate despite his apparent inability to access stronger medication than paracetamol at one point (the State Coroner noted that although Mr Gerhardt was refused stronger medication he did not subsequently complain that the paracetamol had been ineffective)
- if the chest x-ray taken at PAH Secure Unit in September 2010 had been correctly interpreted than Mr Gerhardt's condition would likely have been diagnosed at that time
- it is most unlikely, however, that this influenced the outcome given the advanced state of the cancerous growth in September 2010.

The State Coroner considered evidence from a senior practitioner at PAH that the hospital was cognisant of the failure in Mr Gerhardt's case and, under present arrangements, of the propensity for it to occur again. The inquest heard details of planned changes, including the move to a computer based radiology reporting system, that are expected to address the problem.

The State Coroner also examined policy documents from Queensland Health about the provision of pain relief to prisoners and found these to be adequate.

William Alfred Evans

William Evans was 78 years of age when he died at PAH Secure Unit on 8 September 2010. He had been transferred there from AGCC ten days earlier at the conclusion of a lengthy decline in his physical health from the effects of dementia and a metastatic malignancy. The origin of this cancer was unable to be identified despite extensive testing and examination.

A report from an independent medical practitioner which examined the care provided to Mr Evans was tendered at the inquest. That report was complimentary of medical staff at several correctional facilities and of the fellow prisoners involved in providing medical and palliative care to Mr Evans. The report was critical of the lack of facilities available within the correctional system which are specifically designed for the 24-hour care required by prisoners such as Mr Evans.

An autopsy report concluded that Mr Evans had died of acute renal failure as a consequence of "*metastatic malignancy (primary site unknown)*". Accordingly, the State Coroner found that Mr Evans died of natural causes. The inquest heard that subsequent to Mr Evans' death QCS had commissioned the construction of a unit designed specifically to accommodate frail or elderly prisoners or those requiring palliative care. This facility is staffed by special needs nurses 24 hours per day. The State Coroner acknowledged that this would provide a significant improvement in the treating options available for an ageing prison population.

Geoffrey John Hornby

Geoffrey Hornby died at the PAH Secure Unit on 21 March 2010. At the time, and for the preceding 13 years, he was a prisoner in the custody of QCS. He had been hospitalised at the PAH on six occasions while in custody as a result of his Chronic Obstructive Pulmonary Disease (COPD); the condition which led to his death.

The inquest considered the adequacy of the medical treatment Mr Hornby received while in custody at both the PAH and WCC. The State Coroner was assisted in his examination of this issue by four independent medical practitioners who provided opinions on different aspects of Mr Hornby's treatment.

The State Coroner found that:

- the cause of Mr Hornby's death was respiratory failure resulting from his COPD
- a decision not to transfer Mr Hornby from the Secure Unit to a general ward was appropriate
- the nursing staff to patient ratio in the Secure Unit was appropriate
- there was no significant delay in the emergency response when a Code Blue was called in relation to Mr Hornby
- the procedures relating to such responses have nonetheless been internally reviewed and changes are likely to minimise any delays in future
- there was a small delay between the recognition that Mr Hornby had gone into cardiac arrest and the institution of CPR but the delay was reasonable and did not contribute to the outcome
- Mr Hornby was afforded adequate and appropriate treatment while accommodated at WCC.

The State Coroner made recommendations aimed at the PAH further improving its procedures and training programs in relation to emergency response within the hospital.

During the reporting period, the State Coroner conducted one inquest into a death in immigration detention. This was the first 'death in custody' inquest

conducted under amendments made in 2009 to expand the scope of death in detention to include detention under a Commonwealth Act.

Meqdad Hussain

Meqdad Hussain, a 19-year-old man from Pakistan was detained by officials from the Department of Immigration and Citizenship (DIAC) when he arrived at Christmas Island in late 2010. In an initial mental health screening he was noted to have several scars on his forearm which he attributed to falling through a panel of glass. In January 2011 Meqdad was transferred to an Immigration Detention Centre (IDC) at Scherger Air Force Base near Weipa. That IDC was operated by a private company, SERCO. DIAC had also contracted a private company, IHMS, to provide physical and mental health care to the detainees. In the weeks after his arrival no concerns were raised about Meqdad's mental state or his interaction with other detainees. On 16 March his application for refugee status was officially declined by DIAC but this had not yet been communicated to Meqdad when he was found hanging from a bed-sheet in his room the following afternoon. Handwritten notes found in the room and later identified as having been written by Meqdad appeared to nominate two other detainees as being responsible for "killing" him.

The State Coroner, counsel assisting and the other participants in the inquest travelled to Weipa and inspected the Scherger IDC. The inquest sat in Weipa, Cairns and Brisbane and heard from present and former SERCO, IHMS and DIAC staff as well as several former detainees who were close to Meqdad. The inquest examined the events leading to Meqdad being detained at Scherger IDC and, ultimately, being found deceased in his room. This occurred in the context of suspicions from the family of the deceased that he had been murdered. The inquest examined the adequacy of the mental health care Meqdad received and considered whether his death was foreseeable. The inquest also considered evidence indicating a SERCO employee had falsely reported a sighting of Meqdad on the day of his death during a scheduled roll call, thus delaying the discovery of Meqdad's body.

An autopsy examination resulted in the forensic pathologist concluded the cause of death was hanging. There were no other signs from this examination or from an extensive forensic examination of the scene of death indicating another person being involved in the death. Medical opinion from the pathologist and other health practitioners was that the scars on Meqdad's arms were likely the result of self-harm and were at least three months old. A small amount of mirtazapine found during toxicological testing raised some concerns as Meqdad had not been prescribed this drug but it was not considered to have any connection to the death.

The State Coroner found that:

- Meqdad Hussain died as a result of his own, intentional, actions and that no other person contributed to his death
- the false sighting of Meqdad by the SERCO employee was unlikely to have affected the outcome and SERCO dealt with the matter through appropriate disciplinary action
- there was insufficient evidence to conclude that the IHMS mental health worker on Christmas Island who accepted Meqdad's (likely false) explanation in relation to the scars on his arm had made an error of judgement by not scheduling his next mental health assessment at an earlier date than she did

- the same IHMS employee failed to accurately identify the scars in documentation relating to Meqdad as possibly being related to self harm which meant it was not brought to the attention of SERCO staff
- there were no observable behaviours that should have led any DIAC, SERCO or IHMS employee to conclude that Meqdad was at risk of self harm or suicide in the period leading to his death.

The State Coroner examined the mental health policies of DIAC and considered the manner in which those policies were being implemented by IHMS. He noted the extremely high number of immigration arrivals on Christmas Island at the time Meqdad arrived in late 2010. He also referred to the extensive review of mental health care for detainees (among other matters) conducted by the Commonwealth and Immigration Ombudsman. The findings of that review were handed down shortly before the State Coroner's findings in this matter and adequately covered any preventative comments or recommendations that might otherwise have been made.

Inquests of Public Interest

Isabella Wren Diefenbach (Rockhampton Coroner, Magistrate Annette Hennessy)

Isabella was a seven-week-old baby who died from head injuries sustained in an accidental fall from her father's arms when his foot fell through a rotten decking board on the front verandah of their rented home in Yeppoon on 29 May 2012.

The inquest examined the circumstances leading to Isabella's death including the extent of the tenants' concerns about the condition of the front verandah and the extent to which these were communicated to the letting agent; the adequacy and timeliness of the response of the letting agent and the property owner to the identification of wood rot in the front verandah and the circumstances in which the decking board failed. These matters raised broader issues regarding the obligations of tenants, lessors and letting agents in respect of the maintenance and repair of residential rental properties.

The Coroner found that:

- Isabella's death was accidental
- her parents had identified the presence of wood rot in the front verandah and reported this to the letting agents on at least four occasions prior to Isabella's death
- the property owner was aware of the identification of wood rot in the front verandah and some repairs had been made prior to the incident. The trade qualified but unlicensed carpenter who carried out the repairs failed to conduct a sufficiently thorough investigation of the condition of the front verandah and could and should have identified the extent to which the board that subsequently failed and those adjacent to it had deteriorated
- the letting agent's agency practices and a lack of training about how to properly inspect a deck for property management purposes combined to prevent the property managers from identifying the potential safety hazard posed by wood rot as an emergency repair and from seeking appropriate and

timely instructions from the property manager for further independent expert inspection of the front verandah
- there were sufficient visual indicators on the underside of the front verandah to cause a person with building qualifications, skills and experience to have significant concerns about the extent of wood decay and termite damage.

The Coroner made a suite of recommendations aimed at:
- improving industry awareness of, and training provided to property managers about how to conduct a satisfactory inspection of decks, verandahs and stairs for property management purposes and about what constitutes an "emergency repair"
- introducing a regime of mandatory structural inspections of residential rental properties with a deck, verandah or balcony that is greater than ten years old
- improving the accessibility of maintenance and repair information held by lessors and letting agents
- improving the management by letting agents of tenant complaints in respect of residential rental property repair and maintenance issues
- clarifying the responsibilities of letting agents in respect of building, pest or termite inspection reports commissioned on behalf of a lessor
- improving public awareness of the importance of regular and proper maintenance of residential rental properties, including regular inspection of decks; and
- encouraging reconsideration of aspects of the current regulatory regime for real estate agents.

Mia Davies and Preston Paudel (Brisbane Coroner, John Lock)

The Brisbane Coroner held separate inquests into the deaths of two babies from birth complications. The inquests examined the adequacy of the care provided to the babies' mothers, including CTG tracing interpretation, and whether there were any indications that a caesarean section should have been performed (Paudel), or performed earlier (Davies).

The Brisbane Coroner found there were numerous opportunities for each child's well-being to have been ascertained but this did not occur and they were both born with a poor prognosis for survival.

The Brisbane Coroner recommended that:
- the CTG interpretation sticker that had been implemented by Toowoomba Base Hospital (which required hourly interpretation, with the interpretation to be checked by a senior midwife or registrar every second hour) following Preston's death be implemented at all hospitals throughout Queensland
- the Toowoomba Base Hospital implement a policy that the four hourly reviews of high-risk patients be conducted by registrars or consultants
- the Royal Brisbane and Women's Hospital consider the outcomes of the internal mortality review in order to ensure as many of the suggestions for improvement can be implemented
- the Royal Brisbane and Women's Hospital adopt a policy, procedure or practice that at the changeover of shifts between consultants (i.e. at 815 and 1630) that a consultant (either the outgoing or incoming) personally review all

high-risk patients to satisfy themselves of the ongoing management plan and that the management of the patient is appropriate
- noting the Royal Brisbane and Women's Hospital now has a policy that any clinician asked to review a CTG should note their interpretation of the trace on the trace itself and in the medical records and also note the actions to be taken, that the hospital conduct an audit to ensure this is occurring satisfactorily.

Jennifer Ann Boon (Caloundra Coroner, Magistrate Stephanie Tonkin)

Jennifer Boon was a 45-year-old woman who died on 12 July 2009 from injuries she sustained when she was run over by a courtesy bus from which she had just alighted.

The inquest examined the manner of driving of the bus driver and the circumstances in which Mrs Boon came to be run over by the bus.

The Coroner found there was insufficient evidence to establish conclusively whether the collision resulted from momentary inattention or distraction by Mrs Boon. The Coroner was satisfied that the death did not result from careless or negligent conduct by the bus driver.

The Coroner noted that Mrs Boon's death was the only passenger/pedestrian fatality arising from a bus arriving at or leaving from a bus stop in substantially more than 190 million annual bus passenger movements during 2004–2011. The Coroner considered this statistic demonstrated that current safety measures were largely "remarkably effective".

The Coroner made recommendations directed to the Department of Transport and Main Roads designed to build on current safety measures by:
- using the Operator Accreditor process under the *Transport Operations (Passenger Transport) Act 1994* to ensure that passenger vehicle drivers complete all necessary reversing after ensuring unrestricted or adequate visibility to the rear of the vehicle before allowing any passenger to alight from the bus
- encouraging all accredited operators to consider installing reversing cameras on all passenger vehicles capable of being fitted with this equipment
- a public education campaign about the dangers of larger passenger vehicles.

Joshua Jai Plumb (Deputy State Coroner, Christine Clements)

Joshua Plumb was a severely disabled seven-year-old boy who died on 15 December 2012 during an admission to the Ipswich General Hospital. Joshua was found unresponsive with his head wedged between the padded vertical bed rail and the mattress. Despite emergency resuscitation efforts, Joshua was unable to be revived.

The inquest examined the medical cause and circumstances of Joshua's death and the suite of changes implemented by Ipswich General Hospital in response to the death.

The Deputy State Coroner found that:
- Joshua died due to a combination of physical entrapment of his head, which occluded or partly occluded his nose and/or mouth, aspiration induced pneumonia, epilepsy and neurological impairment

- it was not that Joshua's clinical condition was more serious than assessed and was overlooked, but that his underlying special needs placed him at higher risk than was otherwise appreciated
- there were indicators of risk associated with Joshua's movement in the bed that were overlooked and could have triggered consideration of higher levels of observation.

In the absence of any direction from medical personnel about Joshua's requirement for frequent if not continuous supervision, the Deputy State Coroner declined to refer any of the involved nursing staff for disciplinary action.

The Deputy State Coroner noted changes implemented by the Ipswich General Hospital designed to improve the identification and management of the needs of high dependency patients. These measures included:

- immediate cessation of the use of bed bumpers
- allocation of a 'nursing special' to patients if a parent or carer is unable to stay with the child
- establishment of a working party to examine the needs and safety concerns of high dependency patients
- development of a work instruction for the admission, ward placement, bed types, nursing observations, monitoring and documentation for patients admitted to the children's ward
- consideration of modification of the Children's Early Warning Tool for observations of children with special needs
- review bed safety issues with the assistance of the Queensland Health Patient Safety and Clinical Improvement Service – the Deputy State Coroner noted that there is no Australian Standard for hospital beds for paediatric use and no specialised procurement category for paediatric beds, meaning each Queensland Health hospital makes its own purchase arrangements
- issue of a safety alert to all Australian hospitals regarding non-compliance of the Hill-Rom Pty Ltd vertical bed rails with Australian Standards and ongoing work between the Therapeutic Goods Administration and the bed supplier to implement design changes.

The Deputy State Coroner made recommendations aimed at:

- improving nurse training to address team nursing issues
- ongoing resourcing of the Patient Safety and Clinical Improvement Service to improve patient safety
- ensuring Queensland Health completes the review of bed and bed bumper safety related issues, particularly in relation to children with special needs
- the state-wide reconsideration of the use of bed bumpers.

Stanley Charles ANDERSON (Gympie Coroner, Magistrate Maxine Baldwin)

Stanley Charles Anderson was an 86-year-old nursing home resident who died on 12 April 2009 from injuries sustained when he fell while being transferred from a trolley bath to a comfort chair in his room.

The inquest examined how the fall occurred and whether the level of care provided and/or the hoist and sling design contributed to the accident.

The Coroner found:

- Mr Anderson fell from a sling attached to a hoist used to transfer him from a trolley bath to a comfort chair
- Mr Anderson became unstable in the hoist and slipped forward out of the sling legs
- the nursing home had no system in place for consistent review of the appropriate sling size and how it should be used for each resident

The Coroner recommended:

- the nursing home review training for use of the hoist and lifting and developed guidelines for how to determine the appropriate level of adjustment to maximise stability
- the development of a guideline for the sling configuration in different cases
- professional input to ensure correct sizing and use of slings for individual residents
- a system be established to review hoist and sling incidents and liaise with the manufacturer about possible design improvements.

Elizabeth and Isabella Cardwell and Gregory Sanderson (Brisbane Coroner, John Lock)

Elizabeth Cardwell, her eight-week-old daughter, Isabella, and Elizabeth's partner were killed in a single motor vehicle accident near Kilcoy on 6 December 2011. Isabella was harnessed in a rear-facing child restraint at the time of accident. The restraint was second hand and Isabella was wrapped in a blanket with the seat belt harness secured over the top of her.

An inquest was held to raise awareness of the dangers of excessive speeding, and of the dangers of wrapping an infant in a blanket before placing in a child restraint. The inquest heard evidence from Kidsafe Qld to the effect that public awareness about how to ensure a child is placed correctly in the restraint was very low. The inquest also examined the current Australian Standard AS/NZS 1754 with respect to child restraints. The Brisbane Coroner recommended changes to the standard designed to ensure that:

- child restraints be engineered such that provision shall be made for the instruction booklet to remain permanently with the child restraint
- for child restraints for infants up to six months old, a warning be included with words to the effect of 'fit the harness firmly to the child. Do not wrap the child in a blanket when placing in restraint.'

Judith McNaught (Rockhampton Coroner, Magistrate Annette Hennessy)

Judith McNaught was a 69 year old woman who died on 6 June 2010 in the Rockhampton Base Hospital from post-operative complications of a laparascopic cholecystectomy performed at the hospital on 1 June 2010.

The inquest examined issues including the indications for the initial surgery and whether it was performed appropriately, the appropriateness of a decision to transfer

Mrs McNaught from the surgical unit to a rehabilitation unit for post-operative care and the adequacy of the post-operative care provided to her.

The Coroner found:

- the initial surgery was clinically indicated
- there was no basis to make a finding that the surgeon's failure to place a suction drain in the gallbladder bed during the surgery was an incorrect clinical judgement
- Mrs McNaught was inappropriately transferred to the rehabilitation unit as a surgical outlie patient on 2 June 2010 – the Coroner commented that an acute post-operative surgical patient should not be transferred to a lower dependency unit unless the patient has recovered sufficiently to be cared for appropriately in the lower dependency unit
- there were deficiencies in the nursing care provided to Mrs McNaught in the rehabilitation unit
- there were serious deficiencies in the medical record keeping which led to a lack of adequate communication between the treating team and this impacted adversely on the treatment provided to Mrs McNaught
- miscommunication as to the status of triple antibiotics ordered by the surgeon at the time Mrs McNaught was handed over to the operating theatre on 3 June was quite critical in light of the impact delay in administering all three of the antibiotics was likely to have on her chances of survival
- the root cause analysis (RCA) undertaken in response to Mrs McNaught's death interviewed virtually none of the treating doctors or nurses who cared for her and for this reason, represented a "completely lost opportunity" – the Coroner considered this to be a significant failure, particularly in light of the RCA team's reliance on medical records that were deficient and inaccurate.

The Coroner recommended that:

- the Rockhampton Base Hospital seriously consider the allocation of resources for dedicated discharge planners in its major acute wards, with additional resources allocated for nursing care in those wards to replace the nurses performing discharge planning duties where possible
- the hospital seriously consider whether the patient outlie system is necessary and appropriate for acute and post-surgical patients at all, and in the event it is considered necessary for these patients, that the hospital conduct a complete review of the patient outlie system using input from key frontline personnel to make certain that all precautions are taken to ensure patient safety, including patient reviews before transfer, the appropriate and complete handover of patients to receiving wards, detailed nursing care plans for the patient and consultation with treating doctors before the transfer as well as the supervisor of the sending and receiving wards before the transfer is effected, and regular reviews of the patient and the appropriateness of the patient remaining in the receiving ward
- the conduct of RCA at the Rockhampton Base Hospital ensure all relevant care providers be interviewed in the RCA process.

Cynthia Thoresen (Deputy State Coroner, Christine Clements)

Mrs Thoresen was an 88-year-old woman who died while an inpatient at the Royal Brisbane and Women's Hospital on 3 January 2009. She had been living with her daughter and other extended family. The daughter had received a carer's payment from Centrelink for Mrs Thoresen since 2004. Mrs Thoresen had not seen a doctor since August 2003. She presented to hospital by ambulance two weeks prior to her death in a state of moderate to severe malnourishment. Autopsy confirmed a displaced fracture of the right femur which was aged to be at least three weeks. There were large bruises and pressure sores over much of her body. Cause of death was determined as pulmonary thromboembolism, arising from the fractured right femur.

The inquest examined the circumstances leading up to Mrs Thoresen's death and to highlight gaps in the current criminal law with respect to elderly neglect. The Deputy State Coroner found that Mrs Thoresen had not received adequate care while living with her family.

The Deputy State Coroner suggested to Centrelink that a recipient of the carer's benefit should be required to submit an annual independent medical review of the person being cared for. This measure may assist in preventing such an appalling decline in wellbeing of another vulnerable elderly person. The Deputy State Coroner also referred her findings to the Attorney-General to consider referring the issue of review of legislation to the Queensland Law Reform Commission.

Michael James Isles (State Coroner, Michael Barnes)

Michael Isles, a 58-year-old Senior Sergeant of police from Ayr, disappeared on 23 September 2009 while on duty. In August 2008 he had been stood down pending the outcome of a Crime and Misconduct Commission investigation which ultimately cleared him of any wrongdoing. That experience affected his mental health, though he appeared to approach his return to work in September 2009 positively. On his third day back at work Senior Sergeant Isles failed to attend a training session in Townsville. A search of his home revealed a note to his family and a missing shotgun. Five days after his disappearance Senior Sergeant Isles' car was found in bushland more than 70km from his home. Extensive searches failed to reveal any sign of him.

The inquest examined the evidence relating to Senior Sergeant Isles' mental state at the time of his disappearance. This included the circumstances of his being stood down as Officer in Charge of Ayr police station in August 2008. The inquest considered whether the QPS had provided adequate support for Senior Sergeant Isles while he was being investigated. It also examined the adequacy of the search and the various possible explanations for his disappearance.

The State Coroner, while noting the high standard of proof required for a finding of suicide, nonetheless found that Senior Sergeant Isles intentionally took his own life. The State Coroner also found that:

- the treatment of Senior Sergeant Isles by senior police when he was stood down from his position in August 2008 was compassionate and appropriate
- the treatment provided to Senior Sergeant Isles by his doctors and psychotherapist was appropriate
- the facts did not illustrate any systemic problem with the QPS system of review and support for officers on long term sick leave

- the search for Senior Sergeant Isles was extensive and thorough
- there is no substance to several alleged sightings of Senior Sergeant Isles subsequent to 23 September 2009
- the evidence from a survival expert who had inspected the terrain where Senior Sergeant Isles' vehicle was found provides an adequate explanation for why a body may not have been found during the search and, likely, will never be found.

The State Coroner noted that a minor problem with QPS procedure relating to the provision of medical certificates when police officers return to work from extended sick leave had been rectified prior to the inquest.

Kenneth Roland Owens & Daniel Arthur Stiller (State Coroner, Michael Barnes)

Kenneth Owens and Daniel Stiller died within six months of each other as a result of separate traffic crashes on the Bruce Highway. In each case the collision was associated with the escort of wide loads from southern to central Queensland. The State Coroner heard both inquests concurrently given the overlap of safety issues arising from each death.

Kenneth Owens was driving southbound on the Bruce Highway just south of Maryborough shortly before daybreak on 17 May 2011. Approaching him from the opposite direction was a prime mover hauling a semi-trailer carrying a miners hut. The width of the hut caused it to protrude into the southbound lane. The well lit prime mover followed several hundred metres behind a pilot vehicle (with flashing lights) and a police vehicle using its full emergency lighting. When it reached the semi-trailer Mr Owens' vehicle struck the front right corner of the miners hut, killing him instantly.

The State Coroner found that:

- the configuration and lighting on the escort and the load complied with all legislative requirements
- the police officer charged with inspecting the load conducted a thorough check and completed all relevant paperwork
- the driver of the prime mover transported the load in as safe a manner as possible given its size
- there was no evidence of speed, alcohol or fatigue being causative factors in the collision
- it is difficult to discern the reason for Mr Owens failing to take evasive action from an object that other drivers had no difficulty in seeing and avoiding
- an unusual feature of the fog lines near the point of collision (in that they angled towards the centre of the road) may have played a role in Mr Owens driving so close to the centre line
- it is likely that the extremities of the load were rendered less obvious because the load was being carried at night.

Sergeant Daniel Stiller was an experienced traffic officer and police motorcyclist who, in that capacity, was escorting a wide load northbound on the Bruce Highway on the morning of 1 December 2010. He approached a line of four vehicles travelling in the opposite direction on a two-lane section of road. As those vehicles slowed, the

fourth in line, a prime mover hauling a semi-trailer, jack-knifed. It careered into the path of Sergeant Stiller and the resulting collision killed him instantly.

The State Coroner found that:

- as he approached the line of four vehicles Sergeant Stiller was riding over the centre line in the southbound lane
- as he approached the line of four vehicles Sergeant Stiller was involved in a (hands free) mobile telephone conversation
- the pilot vehicle in front of Sergeant Stiller likely communicated a message to the four southbound vehicles that, if they continued at pace they could reach a three lane section of road 1km to the south and safely pass the wide load there
- it is likely that Sergeant Stiller did not hear this message and continued issuing directions to oncoming traffic to pull over immediately
- the sight of Sergeant Stiller emerging from a dip in the road and travelling towards him in the same lane caused the driver of the first oncoming vehicle to brake suddenly. This resulted in the need for the following vehicles to brake sharply which ultimately led to the jack-knife
- the fourth southbound vehicle had an empty trailer leaving it vulnerable on the wet road to jack-knifing
- the driver of the fourth vehicle had failed to notice the pilot vehicle and did not slow sufficiently as the vehicles in front approached the wide load
- despite allegations to the contrary, the driver of the fourth vehicle had not engaged (and had certainly not relied upon) his auxiliary brakes but had applied his mechanical brakes.

The State Coroner heard evidence from a range of experts in movement of wide loads in southern and central Queensland. The inquest heard detail of the large increase in such movements in recent years and of forecasts for continued increases. The State Coroner made recommendations to the following effect:

- permits should not be issued for oversize loads if other forms of transport are available
- the Heavy Vehicle Operations Program Office (HVOPO) should review the basis on which it determines whether a load is “indivisible”. This criterion should be applied with more rigor
- night movements of wide loads should be limited to metropolitan areas and dual carriageways
- the HVOPO should review the use of motorcycles in wide load escort duty given their reduced visibility and the increased risk of death or injury in the case of a collision
- the National Heavy Vehicle Regulator should have regard to the evidence in these inquests when developing regulations or guidelines for the management of wide loads by escorts
- wide loads should be accompanied by more explicit signage
- any new regime of signs should be accompanied by a public awareness campaign.

Cold case inquests

Cherry Tree Creek: Vicky Arnold and Julie-Anne Leahy

Murphy's Creek: Lorraine Wilson and Wendy Evans

(State Coroner, Michael Barnes)

The State Coroner conducted inquests into four 'cold case' deaths arising from two separate incidents. In each case the inquests took place pursuant to a direction from the Attorney-General.

In relation to the deaths of Vicki Arnold and Julie-Anne Leahy, the direction came as a result of widespread and long-standing public disquiet about the findings of two previous coronial inquests. Those inquests had found that Ms Arnold had killed her friend Ms Leahy before killing herself, leading to both women being found deceased in the front seat of Ms Leahy's vehicle in bushland at Cherry Tree Creek, near Atherton in north Queensland. They were found on 9 August 1991, two weeks after their deaths. The second of the two earlier inquests had come to this finding despite having access to a detailed investigative review conducted by two retired senior police officers which had concluded that the evidence supported an open finding.

The State Coroner found numerous serious failings in the initial police investigation. He concluded that the two deceased women had died of intentionally inflicted gunshot wounds to the head fired by a third person. He nominated the person most likely to have murdered the two women and decided that there was sufficient evidence to commit that person to stand trial for murder.

The passage of time meant that many of the investigative failings evident in this matter had already been addressed by changes in technology or police procedure. The State Coroner found a major problem with the investigation arose from the first response police officers jumping to a conclusion about the cause of the deaths. It was assumed at an early stage from the scene in which the bodies were found that there had been a 'murder-suicide'. This affected all subsequent investigations and led to compounding failures. The State Coroner highlighted the need for detectives to suspend judgement where at all possible and for police training modules to outline the dangers in failing to do so.

The deaths of Lorraine Wilson and Wendy Evans in 1974 continued to cause public concern almost 40 years later due to their brutal nature and the fact no one had ever been charged in relation them. These two young nurses disappeared on 6 October 1974 after leaving Brisbane with the intention of hitch-hiking to Dubbo. Their skeletal remains were found in bush near Murphy's Creek on 25 June 1976. In 1985 a Coroner found the women had been murdered 'by a person or persons unknown'.

Following a lengthy inquest the State Coroner concluded that the two women were undoubtedly murdered by more than one person. The inquest heard evidence of a group of young men in the Toowoomba area during the mid 1970's known to have engaged in the assault and sexual assault of young women. The State Coroner found it unlikely Ms Wilson and Ms Evans had been sexually assaulted but that both had been killed as a result of intentionally inflicted head wounds. He confirmed an alleged

sighting of the women attempting to escape their abductors near Toowoomba in 1974 as reliable.

The State Coroner found that the identities of those responsible for the deaths of Ms Wilson and Ms Evans could not be established with sufficient certainty to commit any person for trial, with one exception. That individual is now deceased.

Inquests into the deaths of Patient A, Mia Davies, Joshua Plumb, Preston Paudel, and Judith McNaught – coronial comment about root cause analysis.

There was repeated coronial comment in a number of inquests into health care related deaths about the adequacy of RCA. RCA is a quality improvement technique that examines the contributory factors that led to an adverse health outcome. It is a systemic analysis of what happened and why and is designed to make recommendations to prevent it from happening again, rather than to apportion blame or determine liability or investigate an individual clinician's professional competence.

The coroner's findings in each of these inquests made comment about the adequacy of the RCA undertaken in respect of each death. The coroner expressed a concern about the fact that these processes did not interview involved members of the treating team or feed back to them about the review outcomes.

The Brisbane Coroner repeatedly recommended that wherever possible an RCA process be conducted so that relevant members of a treating team, if they wish to participate, are provided an opportunity to be interviewed and are provided with feedback as to the outcome of the RCA, and further that this should include, where possible, staff no longer at the relevant hospital.

The Rockhampton Coroner noted previous coronial recommendations on this issue and reinforced the desirability of the members of the treating team involved in an adverse health outcome being given an opportunity to give information to an RCA team, as this participation can only assist in the early identification of issues which may need to be addressed to prevent further adverse outcomes. She observed this participation becomes particularly important when the RCA team is otherwise relying on medical records that are deficient or inaccurate.

Higher courts decisions relating to the coronial jurisdiction

In *Nona v Barnes and the Attorney-General for Queensland* [2012] QCA 346, relatives of a deceased person sought reasons for the State Coroner's refusal to refer the matter to the DPP. The Court of Appeal considered the nature of a coroner's decision to refer a matter to the DPP under s. 48 of the Coroners Act. The Court held that (a) a coroner's uncommunicated state of mind - the holding of a suspicion, or the absence of such a suspicion - could not properly be described as a 'finding', a 'determination' or a 'decision' for the purpose of the *Judicial Review Act 1991*; (b) a decision to refer a matter to the DPP did not 'confer, alter or otherwise affect legal rights or obligations, and in that sense … derive from the enactment'; and (c) in any event, a decision to refer a matter to the DPP was one in which any entitlement to reasons was excluded by s. 31 of the Judicial Review Act. In doing so, the Court

confirmed the decision of Justice McMurdo in *Nona & Ahmat v Barnes* [2011] QSC 35.

The Coroners Act does not expressly empower a coroner to make a decision about who is entitled to control the disposal of a deceased person's body once it is released. To date, the suggestion a coroner may have an implied power to do so because he or she is obliged to order release of the body for burial as soon as reasonably practicable, has not been tested in Queensland, though this was questioned but not resolved by the Supreme Court in the 2012 matter of *Kontavainis-Hay v Hutton & Welch*[2]. In that matter, Justice Douglas indicated a preliminary view that the decision was a matter for the Supreme Court, not the coroner.

Justice Douglas ordered the person entitled to Letters of Administration should be entitled to possession of the body. He therefore ordered that the applicant should be entitled to the order she sought.

[2] (Unreported, Supreme Court of Queensland, Douglas J, 12 November 2012)

Appendix 1: Number of Coronial cases Lodged and Finalised in the 2012-13 financial year and the number cases pending as at 30 June 2013

Court Location	Number of Deaths reported to the Coroner	Number of Coronial Cases finalised			Number of Coronial Cases pending			
		Inquest held	No inquest held	Total	Less than or equal to 12 months old	Greater than 12 and less than or equal to 24 months old	Greater than 24 months old	Total
Brisbane	**2708**	47	2512	**2559**	776	142	106	**1024**
Bundaberg	**35**	1	62	**63**	0	0	0	**0**
Cairns	**596**	6	695	**701**	279	94	39	**412**
Caloundra	**7**	2	28	**30**	0	0	0	**0**
Charleville	**5**	0	15	**15**	0	0	0	**0**
Dalby	**2**	0	18	**18**	0	0	0	**0**
Emerald	**6**	0	21	**21**	0	0	0	**0**
Gladstone	**10**	0	27	**27**	0	0	0	**0**
Gympie	**9**	1	24	**25**	0	0	3	**3**
Hervey Bay	**14**	0	36	**36**	0	0	0	**0**
Ipswich	**22**	1	88	**89**	0	0	2	**2**
Kingaroy	**1**	0	8	**8**	0	0	0	**0**
Mackay	**526**	0	425	**425**	171	34	23	**228**
Maroochydore	**55**	0	93	**93**	0	0	0	**0**
Maryborough	**9**	0	25	**25**	2	2		**4**
Murgon	**0**	1	1	**2**	0	0	0	**0**
Rockhampton	**33**	4	74	**78**	0	0	0	**0**
Southport	**700**	3	719	**722**	292	66	38	**396**
Warwick	**24**	0	62	**62**	0	0	0	**0**
Total	**4762**	**66**	**4933**	**4999**	**1520**	**338**	**211**	**2069**

Appendix 2: Register of approved genuine researchers 2012–13

Person/position	***Organisation***
Chairperson	Queensland Maternal and Peri-natal Quality Council - Queensland Health
Chairperson	Queensland Paediatric Quality Council - Queensland Health
Chairperson	Committee to Enquire into Peri-operative Deaths - Queensland Health
Director (Rob Pitt)	Queensland Injury Surveillance Unit
Director (Prof Diego De Leo)	Australian Institute for Suicide Research and Prevention
Director (Prof Nicholas Bellamy)	Centre of National Research on Disability and Research Medicine
Director (Assoc Prof David Cliff)	Minerals Industry Safety and Health Centre
Dr Douglas Walker	Not applicable
Deputy Team Leader Safety and Education Branch	Australia Transport Safety Bureau
Director (Prof Mary Sheehan)	Centre for Accident Research and Road Safety – Queensland
Dr Charles Naylor Chief Forensic Pathologist	Queensland Health Forensic and Scientific Services (QHFSS) funded by Australian Research Council (ARC)
Dr Belinda Carpenter Criminologist	QUT School of Justice Studies funded by ARC
Dr Glenda Adkins Criminologist	QUT School of Justice Studies funded by ARC
Director (Assoc Prof Robert Hoskins)	Clinical Forensic Medicine Unit – Queensland Health
Dr Ben Reeves	Paediatric Registrar Mackay Base Hospital
Dr Beng Beng Ong	QHFSS
Dr Nathan Milne	QHFSS
Dr Peter O'Connor / Ms Natalie Shymko / Mr Chris Mylka	National Marine Safety Committee
Dr Nathan Milne	QHFSS
Dr Beng Beng Ong	QHFSS
Manager (Strategy & Planning)	Maritime Safety Queensland
Dr Luke Jardine	Royal Brisbane & Women's Hospital
Dr Yvonne Zurynski	Australian Paediatric Surveillance Unit -The Children's Hospital at Westmead

Director of Neonatology - Dr John Whitehall & Dr Yoga Kandasamy	Department of Neonatology - Townsville Health Service District
Professor Ian Thomas - Director of CESARE	Centre for Environmental Safety and Risk Engineering
Dr Margot Legosz	Crime & Misconduct Commission
National Manager for Research & Health Promotion (Dr Richard Charles Franklin)	Royal Life Saving
Lance Glare (Manager BCQD Building Legislation & Standards Branch)	Building Codes Queensland Division
Michelle Johnston masters student	School of Pharmacy, University of Queensland
Dr Damian Clarke	Paediatric Neurology Department Mater & Royal Children's Hospital
Professor Grzebieta, Hussein Jama & Rena Friswell	NSW Injury Risk Management Research Centre
Director - John Lippmann OAM	Divers Alert Network Asia Pacific (DAN AP)
Dr Michelle Hayes	Department of Communities
Associate Professor Alexander Forrest	QHFSS
Professor Tim Prenzler, Doctor Louise Porter, Kirsty Martin & Alice Hutchings	ARC Centre of Excellence in Policing & Security
Professor Christopher Semsarian	Centenary Institute - Molecular Cardiology Group
Ms Donna McGregor, Dr Laura Gregory, Mr Matt Meredith, Miss Nicolene Lottering	QUT / QHFSS
Mark Stephenson - Team Leader / Glen Buchanan - Snr. Chemist	QHFSS
Julian Farrell - Research Officer	Agri- Science Queensland
Professor Belinda Carpenter & Associate Professor Gordon Tait	QUT
Adjunct Professor Peter Ellis, Associate Professor Alexander Stewart & Professor Craig Valli	QHFSS, Griffith University and Edith Cowan University
Keith Loft	QUT / QHFSS
John Drayton, Senior Counsellor	QHFSS
A/Professor Alex Forrest & Professor Peter Ellis & Dr Nathan Milne & Brittany Wong	QHFSS
Director	Department of Veterans' Affairs - Family Studies
Ms Donna McGregor, Dr Laura Gregory, Mr Matt Meredith, Miss Nicolene Lottering & Miss Kaitlyn Gilmour	QUT / QHFSS
Sean Hogan & Professor Richie Poulton	DMHDRU, Dunedin School of Medicine - University of Otago - NZ

Adjunct A/Prof. George Rechnitzer, Adjunct A/Prof Andrew McIntosh and Mr Declan Patton	Transport & Road Safety - University of New South Wales
Dr Susan Ballantyne	Director, Drugs of Dependence Unit