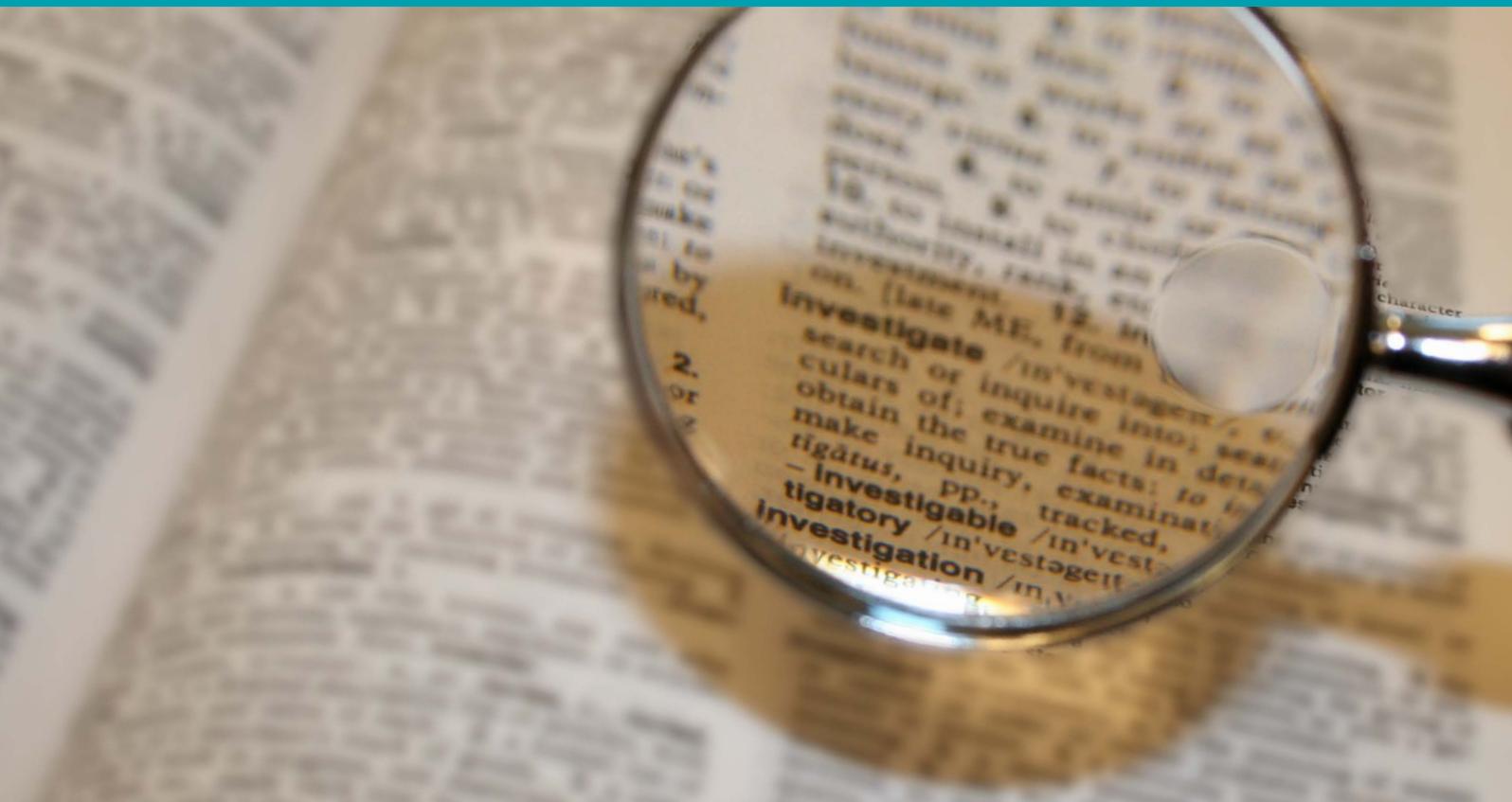


Office of the **State Coroner**



annual report
Dec 2003-Jun 2005

Letter of transmission

26 June 2006

The Honourable Linda Lavarch MP
Attorney-General and Minister for Justice
Level 18 State Law Building
50 Ann Street
Brisbane Qld 4000

Dear Madam Attorney

Section 77 of the *Coroners Act 2003*, provides that at the end of each financial year the State Coroner is to give to the Attorney-General a report for the year on the operation of the Act. In accordance with that provision I enclose that report for the period 01 December 2003 to 30 June 2005.

In accordance with s. 77(2) I attach a CD rom containing a digital copy of the guidelines I have issued pursuant to s14 of the Act. I advise that in the reporting period there were no inquests held into matters referred to in s.77(2)(b) and no directions given under s14 of the Act.

Yours Sincerely



Michael Barnes
State Coroner



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WARNING: Aboriginal and Torres Strait Islander peoples are warned that this document may contain images of deceased persons. Due care has been taken to ensure that the images have been used with the appropriate consent.

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Foreword



The Coroners Act 2003 introduced far reaching changes to most aspects of the investigation of sudden deaths in Queensland that included the creation of the position of State Coroner. I am honoured to be the inaugural appointee to that position. It is a privilege to be given the opportunity to help people in such need as those who are suddenly and unexpectedly bereaved.

This is the first substantive annual report that has been produced under the new regime and it sets out in some detail the course of the implementation of the new system and acknowledges the contributions made by many people and organisations.

I wish to particularly acknowledge the assistance and support I have received from the Deputy State Coroner, Ms Christine Clements and the staff of the Office of State Coroner. I also want to acknowledge the co-operation and assistance I have received from the Queensland Police Service, in particular the willingness of Commissioner

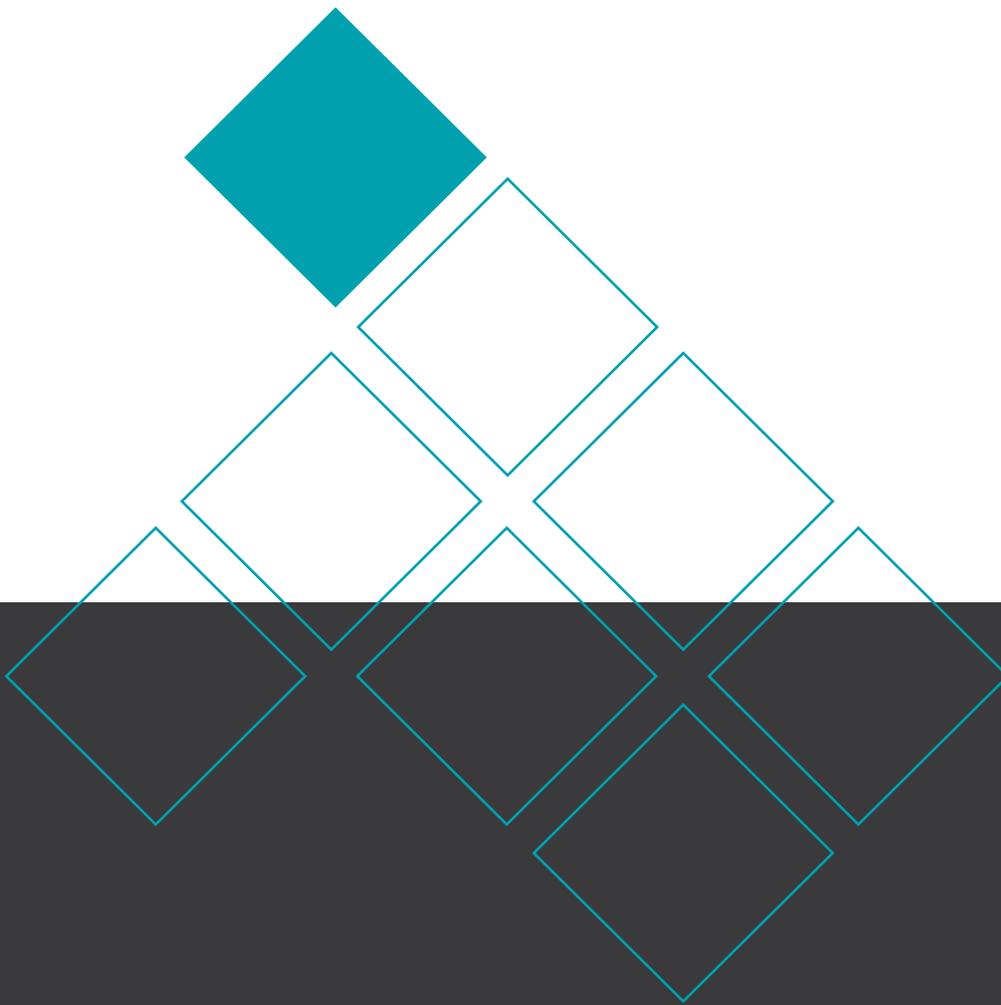
Atkinson and Deputy Commissioner Conder to adequately staff the Coronial Support Unit and the phlegmatic acceptance of officers across the state in adjusting to the new system.

The support and assistance of Queensland Health has also been crucial, in particular the advice given by the Chief Forensic Pathologist, Dr Charles Naylor. The contribution by the staff of Queensland Health Scientific Services has also made my job much easier.

And finally, I wish to acknowledge the patience and collegiality shown to me by the Magistrates of Queensland. Undoubtedly, my constant badgering has at some stage irritated most but very few have ever shown it. I am grateful for their patience.

A handwritten signature in dark ink, appearing to read 'Michael Barnes'. The signature is fluid and cursive, written on a light-colored background.

Michael Barnes
State Coroner Queensland
June 2006



Our role

Introduction

The *Coroners Act 2003* (the Act) represents the most significant reform of the coronial system in Queensland's history. Not only has the Act brought Queensland into line with the rest of the country by creating a modern, centralised and responsive coronial system overseen by a State Coroner but it has, according to one independent expert, created the best coronial system in Australia.¹

The new system gives greater emphasis to the prevention of avoidable deaths,

focuses on the needs of bereaved families and seeks for the first time to bring case management to investigations.

This report gives context to the need for reform, details the most significant changes and describes the strategies used to pursue the legislative goals of the new model. It also provides data reflecting the performance of the new system.

¹ Comment made by Helen Roberts an editor of Halsburys Laws of Australia at 2004 Australasian Coroners Society Conference.

Acknowledgments—the reform process

Since 1990, when the Royal Commission into Aboriginal Deaths in Custody drew attention to the serious inadequacies of the old coronial system, successive state governments have been committed to reform. The determination of the Honourable RG Welford, when Attorney-General and Minister for Justice, to transform policy into practice by the introduction of the *Coroners Act 2003* deserves acknowledgment.

It is also appropriate to acknowledge the contribution of the working party responsible for developing the Act. In particular, the dedicated industry of Ms Leanne Robertson, Principal Legal Consultant, Strategic Policy, Department of Justice and Attorney-General, Associate Professor Charles Naylor, Chief Forensic Pathologist, Queensland Health Scientific Services, Mr Larry Clark, Legislative Projects Unit, Queensland Health who with the support of the former Chief Magistrate Diane Fingleton undertook countless reviews and consultations before arriving at the final draft of what has been acknowledged as the best coroners legislation in Australia.

In November 2000, a consultation draft bill was released for comment. Over 90 submissions were received from advocacy groups, medical colleges and associations, private citizens who had dealings with the coronial system, academics, the funeral and crematoria industry, the State Coroner for Western Australia and the Queensland Law Society. The Victorian State Coroner, Mr Graeme Johnson, provided extensive information and advice.

The consultation draft was sent to the Chief Justice, the Chief Judge of the District Court, the Chief Magistrate, the Brisbane Coroner, Legal Aid Queensland, the Commissioner for

Children and Young People, the (then) Criminal Justice Commission, the Health Rights Commission and the Director of Public Prosecutions for comment.

It was also circulated to relevant government departments including Queensland Health, the Queensland Police Service (QPS), the Department of Families, the Department of Aboriginal and Torres Strait Islander Policy, the Department of Corrective Services, the Department of Emergency Services, the Department of Premier and Cabinet, the Department of Industrial Relations, the Department of Local Government and Planning and Queensland Treasury.

The draft bill was also sent to targeted stakeholders including the Australian Medical Association of Queensland, the Association of Australian-owned Funeral Directors, the Queensland Cemeteries and Crematoria Association, the Australian Funeral Directors Association, the Queensland Funeral Directors Association Limited, the Independent Funeral Directors Association, the Local Government Association of Queensland, the Queensland Nursing Council, the Office of the Health Practitioner Registration Boards, the Aboriginal and Torres Strait Islander Advisory Board, the Deaths in Custody Monitoring Unit at the Queensland Aboriginal and Torres Strait Islander Legal Services Secretariat, the Law Society, the Bar Association and the Queensland Council for Civil Liberties.

The responses provided by these individuals and groups were instrumental in the development of premier legislation.

The need for change

From 1194 when the 'Office of Coroner' was established in medieval England until its importation to the fledgling Queensland colony seven centuries later, the role of the coroner changed dramatically. Originally, the main function of the coroner was to ensure that fines and forfeitures owed to the Crown for wrongful deaths and violent crimes were paid. By the 1850s, the main function was the investigation of sudden and unexpected deaths. Over the next 150 years, while almost all aspects of society in Queensland were transformed, the coronial system remained virtually static.

As the 21st century approached, Queensland had a coronial system that treated family members as mere witnesses with no right to participate in decisions concerning their deceased relatives. There was an absence of any recognition of the differing views among various spiritual and religious groups with regard to the handling of dead bodies. It was a backward looking scheme that focused on attributing blame or apportioning liability rather than the prevention of future deaths.

Investigations were generally undertaken by junior, general duties police officers who gave a very brief initial report of the death to the local coroner, obtained an autopsy order and then ran out the investigation over the succeeding months or even years as they saw fit.

There were no data management systems that could collate even the most basic information and because of the rarity of judicial review of coronial decisions, there was a lack of consistency of practice among coroners. Indeed much of the coroner's role was discharged by clerks of the court who were by virtue of that office also coroners.

And finally, if there were concerns about the way an investigation was being conducted, there was no mechanism to have those concerns addressed.

In summary, it was an antiquated system, under resourced and neglected.

The most significant changes

Family input and support

The Act recognises that family members are more than just potential witnesses. They have a right to have their views considered when issues such as the extent of an autopsy, organ retention or whether an inquest should be held, are determined.

The new system also provides for professional support of the bereaved by qualified counsellors.²

Prevention rather than blame

The primary object of the Act is to '*help to prevent deaths from similar causes happening in the future*'.³ This approach is consistent with the jurisprudence of coronial inquiries which holds that their purpose is not to attribute blame or apportion liability but to discover all the facts surrounding the death that the family and the public have a right to know. The Act therefore abolishes the power of a coroner to commit someone for trial in connection with a death and strengthens the duty of a coroner to make recommendations relating to public health or safety and the administration of justice.

To assist coroners in making effective, evidence based recommendations, Queensland has become a participant in the National Coronial Information System (NCIS) and the Act authorises coroners to hold an inquest into multiple deaths if they appear to have happened in similar circumstances albeit at different times and places.

Accountability and consistency

The State Coroner is responsible for overseeing the coronial system and for issuing guidelines that are to be applied by coroners generally and giving directions to a coroner in specific matters.

The State Coroner also continually liaises with the Queensland Police Service, other investigative agencies, Queensland Health and the funeral industry to address concerns or practical difficulties. Improvements can then be implemented across the State.

Families or interested parties can appeal to the State Coroner if dissatisfied with the decisions of local coroners, giving them access to an administrative review process without the delays or costs of litigation.

The Act, for the first time, establishes a clear line of authority and accountability within the coronial system.

Case management

Under the new system, coroners receive a detailed initial report of the death from the Queensland Police Service enabling them to make considered decisions about the extent of the autopsy and other investigative steps required. As a result, at an early stage they are able to indicate to police or other investigative agencies, any further information needed to determine whether an inquest is warranted and/or to enable findings to be made 'on the papers'.

² See page 39 for a full description of the role of the counsellors

³ s3 (d)

This approach saves significant resources for the Queensland Police Service as they are no longer required to make unnecessary inquiries into those deaths where the cause is obvious and which provide no opportunity for preventative recommendations. Of equal importance is the relief provided to families by having the finalisation of official inquiries into the death of their loved ones expedited.

This case management approach puts coroners back in control of their investigations rather than being the passive recipients of the results of the investigators' reports. It requires coroners to be proactive and consultative. To manage numerous matters in this manner, coroners are dependent upon the department's data base, Queensland Wide Inter-linked Courts (QWIC), being able to provide useful reports with a minimum of delay. This has not always been possible and is a continuing challenge for coroners.

The implementation of the new system

The coronial system is highly interdisciplinary. It requires collaboration between the judiciary, lawyers, police and the medical profession. As the 'Acknowledgments' section above makes clear, many senior practitioners from each of these groups devoted considerable energy and effort to the development of the Act. The next step was to sufficiently engage enough of these professionals to enable the new system to move from policy to law to practice.

The Act was passed into law in April 2003 and proclaimed on 1 December 2003. The inaugural State Coroner, Michael Barnes, was appointed on 1 July 2003 and spent the ensuing five months overseeing the initial implementation of the Act.

Consultation

The process involved consulting with numerous stakeholders such as senior officers from the division of Workplace Health and Safety, senior officers from the Queensland Police Service, lawyers and executive members of the Aboriginal and Torres Strait Islander Legal Service, senior officers from Queensland Health, members of the Women's Legal Service, senior officers from the Office of the Director of Public Prosecutions and numerous others. A list of those consulted in this process is contained in Appendix 1.

Coronial forms

One of the first tasks was to redesign the forms used to report a death to a coroner. The old form consisted of one page and provided only the briefest of information. The new

form is twelve pages with numerous additional supplementary menus that allow the form to be customised for the various categories of reportable deaths. Reporting in this format has enabled coroners to be properly informed of the circumstances of each death immediately the death is reported. It also facilitates data gathering for researchers and allows trend analysis and data aggregation far beyond that previously available. Twenty nine other forms were also designed and gazetted.

State Coroner's guidelines

Another milestone was the development of the State Coroner's Guidelines as required by s.14 of the Act. When framing the guidelines, the State Coroner must have regard to the recommendations of the Royal Commission into Aboriginal Deaths in Custody and deal with the way investigations should be undertaken. They are binding on local coroners and the State Coroner is required to consult with the Chief Magistrate when framing them. They provide local coroners with guidance in all aspects of their role. They can be accessed on line at www.justice.qld.gov.au/courts/coroner/publications.htm.

Presentations to professional groups

It would be wrong to conclude that implementation of the new coronial system is a 'one off' achievement. It is an ongoing process that requires continuing engagement and dialogue with members of the various disciplines and industries who participate in coronial processes.

In recognition of this, the State Coroner and staff of the Office of the State Coroner (OSC) participate in numerous working parties and committees, the more important of which are discussed later in this report. They also present to professional groups about relevant aspects of the coronial system. In the period covered by this report the State Coroner made forty-five such presentations to hospitals, police groups and work place health and safety training conferences. A list of all presentations is contained in Appendix 2.

Court staff training

The Magistrates Courts Coronial Procedures Manual was prepared in response to the introduction of the Act and the release of the State Coroner's Guidelines.

In recognition of the support role played by Magistrates Courts officers throughout the State, a presentation on the new procedures and the associated QWIC database was delivered by the Executive Officer. The presentation/training highlighted the significant changes in the coronial process and complemented the Coronial Procedures Manual.

The presentations were held in the following centres:

Beenleigh	Mackay
Brisbane	Mount Isa
Caboolture	Rockhampton
Cairns	Roma
Gympie	Toowoomba
Hervey Bay	Townsville
Ipswich	Warwick

Deputy Registrars and nominated staff from surrounding regional areas attended and provided positive feedback on the training package.

A range of information sheets was also developed for health professionals, court staff and the general public on the new Act. These information sheets were distributed through Queensland Health, Magistrates Courts and the Queensland Police Service and are able to be accessed on the OSC web site.

The OSC also provided a telephone help desk once the new Act commenced and provided support to regional staff in implementing the new procedures.

Police training

The Queensland Police Service is the lead investigative agency in respect of reportable deaths. Accordingly, it was necessary for operational police to undergo training to ensure they are able to deal professionally with coronial deaths. An updated training program was implemented to coincide with the commencement of the Act.

A coordinated approach to training has been initiated through the OSC involving the Department of Justice and Attorney-General (DJAG), Queensland Police Service and Queensland Health. Presentations are given to groups of police and court staff around the State on a regular basis. The State Coroner is pleased to acknowledge the willingness of the officers of the Queensland Police Service to engage with the new system, to make suggestions for improvement and to have assisted in overcoming the initial 'teething problems'. This has resulted in a seamless transition to the new coronial system.

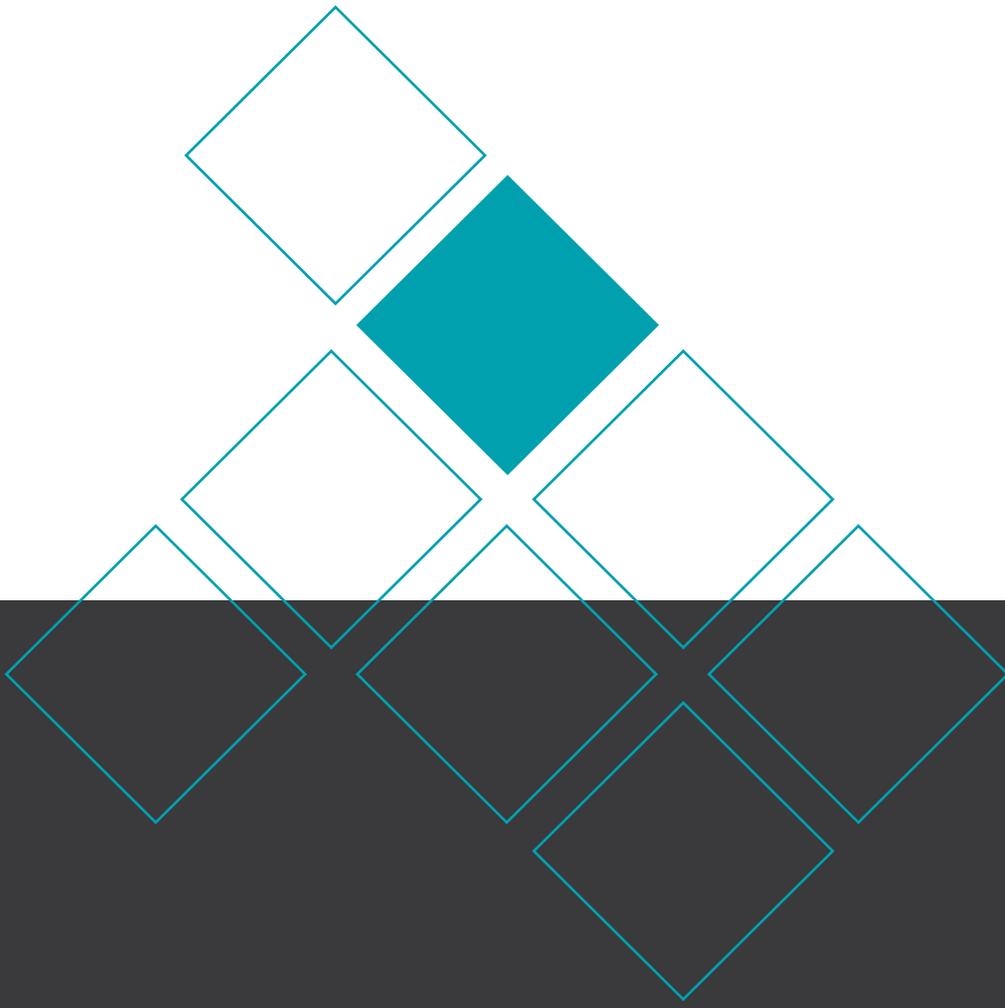
Liaison between the Chief Magistrate and the State Coroner

Coroners are independent judicial officers. The *Magistrates Act 1991* and the *Coroners Act 2003* give the Chief Magistrate and the State Coroner authority over some aspects of the functions of magistrates and coroners. This authority is, of course, exercised through consultation between the Chief Magistrate or the State Coroner and the magistrate/local coroner concerned.

However, to avoid the possibility that directions or guidelines issued by the State Coroner might conflict with arrangements or instructions given by the Chief Magistrate, s76 requires the State Coroner to consult with the Chief Magistrate regarding:

- the resources necessary to ensure the efficient administration of the coronial system;
- the amount of work conducted by magistrates as coroners; and
- any guidelines or practice directions the State Coroner proposes to issue.

That consultation has occurred and has helped ensure the smooth transition to the new coronial system. The Chief Magistrate, to date, has not raised any concerns in relation to any directions or guidelines proposed by the State Coroner. The Chief Magistrate has provided assistance and advice to the State Coroner in the resolution of a number of operational matters.



Our people

The State Coroner—role and responsibility

The State Coroner's role is to oversee and coordinate the coronial system to ensure that it is administered efficiently and that investigations into reportable deaths are conducted appropriately.

The State Coroner discharges these responsibilities by issuing guidelines that have general application or by giving directions in relation to specific matters. He is also involved in providing advice to local coroners on a daily basis and liaising with members of other professions and industries involved in coronial processes.

The State Coroner liaises with the Chief Magistrate to ensure that coronial work does not impose too great a burden on local coroners who also carry a full Magistrate's Court case load.

The State Coroner discharges his monitoring function by reviewing all deaths as they are reported and all completed investigations after local coroners have made findings. Local coroners are judicial officers and it is therefore important that the State Coroner's role does not impinge upon their judicial independence.

Any interested person may request that the coroner investigating a person's death hold an inquest into the death. If the coroner decides not to hold an inquest, the person may apply for a review of that decision by the State Coroner (if the original coroner was not the State Coroner) and, if the decision of the State Coroner is adverse (or if the original decision maker was the State Coroner) the person may apply to the District Court. An interested person dissatisfied with a finding at an inquest may apply to the State Coroner or the District Court to set aside that finding. Both these provisions enhance the rights of citizens in relation to the coronial investigation process.

The State Coroner or the Deputy State Coroner is required to hold inquests into all deaths in custody. The State Coroner also undertakes inquests into some of the more complex deaths that, if dealt with by a local coroner, would take him/her out of general court work to the detriment of the local court diary. To undertake these inquests the State Coroner has, in the reporting period, sat in Brisbane, Bundaberg, Cairns, Cooktown, Doomadgee, Hervey Bay, Mount Isa, Palm Island, Toogoolawah and Townsville.

The Deputy State Coroner—role and responsibility



The Deputy State Coroner, Ms Christine Clements, was appointed on 8 December 2003. For the previous three years, Ms Clements had been the Brisbane Coroner and continues to take primary responsibility for all Brisbane deaths—nearly one thousand each year. Ms Clements is the only other full time coroner.

The Deputy State Coroner is also able to investigate deaths in custody and acts as the State Coroner whenever necessary.

The Deputy State Coroner has undertaken thirty inquests during the reporting period. Some are summarised on page 32.

The Local Coroners—role and responsibility

All magistrates are, by virtue of their position, also coroners. Other than deaths in custody, police report deaths to the coroner nearest to the place of death. The local coroner then takes responsibility for ordering the autopsy and the investigation of the death unless it is transferred to the State Coroner. The local coroner liaises with family members and if appropriate, holds an inquest. Findings are made in all cases.

Some of the notable inquests undertaken by local coroners are summarised on page 35.

Coronial work makes demands that do not mesh easily with the workload and schedule of a busy magistrate. It is one of the tensions of the current system that may need to be resolved by legislative amendment in the future.

The Office of the State Coroner



The OSC was created to support the State Coroner in delivering a more consistent and efficient coronial system across the State. The primary function of this office is to maintain a register of all reportable deaths, support the State's involvement in NCIS⁴ and to provide ongoing legal and administrative support to the State Coroner, Deputy State Coroner and local coroners.

The OSC also plays an important role in administering the Burials Assistance Scheme and the conveyance of human remains through the management of contracts with designated government undertakers throughout the State.

The staff of the OSC has developed processes and procedures to enable families to receive timely information about the purpose of the coronial system, its impact on their need to bury or cremate their deceased loved ones and to have any concerns about the death addressed. The OSC is the focal point of the coronial system and devotes considerable resources to integrating and coordinating the various diverse participants in the system.

There are currently sixteen positions within the OSC that offer legal and administrative support to the State Coroner, Deputy State Coroner, local coroners, Magistrates Courts registry staff and coronial clients throughout the State. A description of the key positions follows.

⁴ See page 44 for discussion of NCIS

The Registrar

The Registrar is the senior administrator of the OSC. This position has line control of all staff and has sufficient financial delegation to operate the office effectively.

Mr Michael Bice, a court registrar and experienced acting magistrate, was the first person appointed permanently to the position of Registrar. He commenced with the OSC on 31 January 2005. This position had previously been occupied through the expressions of interest process which resulted in three people acting as the Registrar in the first eighteen months of the OSC's operation. While it is appropriate to acknowledge the contribution of Gary Finger, Robyn Albury and Damien Mealey to the initial implementation phase and first full year of operation of the new coronial system, the lack of continuity in this key position hindered the development of the OSC.

Mr Bice has represented the State Coroner on a number of working groups and committees such as the Child Death Case Review Committee and coordinated numerous projects such as the renegotiation of the government undertaker's contracts and the development of a business plan for the OSC.

The Registrar is also responsible for ensuring the forms gazetted under the Act comply with appropriate drafting principles.

The Legal Officer

The coronial jurisdiction is subject to a discreet sub-discipline of law in which few lawyers are expert. It is a combination of administrative and criminal law with the focus changing depending upon whether the inquiry is at the investigation phase or has moved to the curial or court phase.

With a background in health investigations gained at the Health Insurance Commission and administrative and health law expertise developed while working in the legal section of Queensland Health, Ms Jo-Anne Dickson is ideally qualified for the position of Senior Lawyer, OSC. Ms Dickson appears in less complex matters as counsel assisting and prepares more complex matters for hearing in which she instructs counsel. Ms Dickson also advises local coroners when required and has worked on a number of committees and working groups. She has been extensively involved in reviewing the Act to identify appropriate amendments. Ms Dickson has also been primarily responsible for advising the State Coroner on applications by researchers for recognition as an approved genuine researcher⁵.

⁵ See page 42 for a full description of genuine researchers

Depositions Clerks

Coronial files are more labour intensive than most other magistrates court files as coroners are responsible for directing investigations into the deaths and for ensuring all issues are appropriately resolved. As a result, depositions clerks have greater responsibility for following up requests for information, collating briefs and arranging hearings. Tasks that would fall to a prosecutor or defence solicitor in a criminal matter are attended to by a coronial depositions clerk who must then attend to all the other duties usually associated with that position. In addition, the State Coroner's depositions clerk is frequently required to travel all over the State to assist with inquests.

The OSC has two depositions clerks.

Executive Officer and Administrative Support Officers

Ms Kristy Harvey is the OSC Executive Officer. She has considerable experience in coronial offices and supervises the administrative support officers who are responsible for preparing autopsy and burial orders, making up files and managing the thousands of files that come through the office each year. The workload of Ms Harvey and her team of administrative support officers is unrelenting and ever growing. Keeping up with these demands will be a continuing challenge for the OSC.

Senior Coronial Information Officer

Numerous people seek access to coronial documents either because they have a direct or financial interest in the death those documents relate to or because they wish to undertake research into issues highlighted by various categories of sudden and unexpected deaths. Coronial documents are excluded from the operation of the *Freedom of Information Act 1992*. Access to these documents is regulated by the *Coroners Act 2003* which limits access with reference to the nature of the documents and the purpose for which they are sought. Obviously, much of the material is highly sensitive but of vital interest to those close to the deceased and those seeking to understand how sudden deaths can be prevented. Balancing the desires of relatives and researchers to gain access to this material with the need to protect the privacy of the deceased and witnesses is a delicate task made more onerous by the increasing number of requests.

Ms Leanne Field is the Senior Coronial Information Officer who attends to these duties. Ms Field also liaises with the Department of Child Safety and the Commissioner for Children and Young People to ensure the obligation of the OSC to provide those agencies with details of child deaths is discharged.

Welfare of the staff of the Office of the State Coroner

Staff of the OSC have constant contact with distressed and bereaved relatives and are frequently exposed to distressing material. Efforts are made to ensure that accidental exposure to death scene photographs and the like does not occur, however, the work performed is unavoidably stressful.

In recognition of this, a counsellor from the John Tonge Centre (JTC) visits the office on a regular basis to talk with staff about their reaction to this environment and to advise them of other professional services available to assist in coping with the effects of working in the OSC.

Deputy Registrars

The Act appoints the clerk of each local Magistrates Court to the position of Deputy Registrar of the Coroners Court.

There are eighty-two clerks of the court throughout the State that manage Magistrates Courts registries and provide administrative assistance to the local coroner in performing his/her functions.

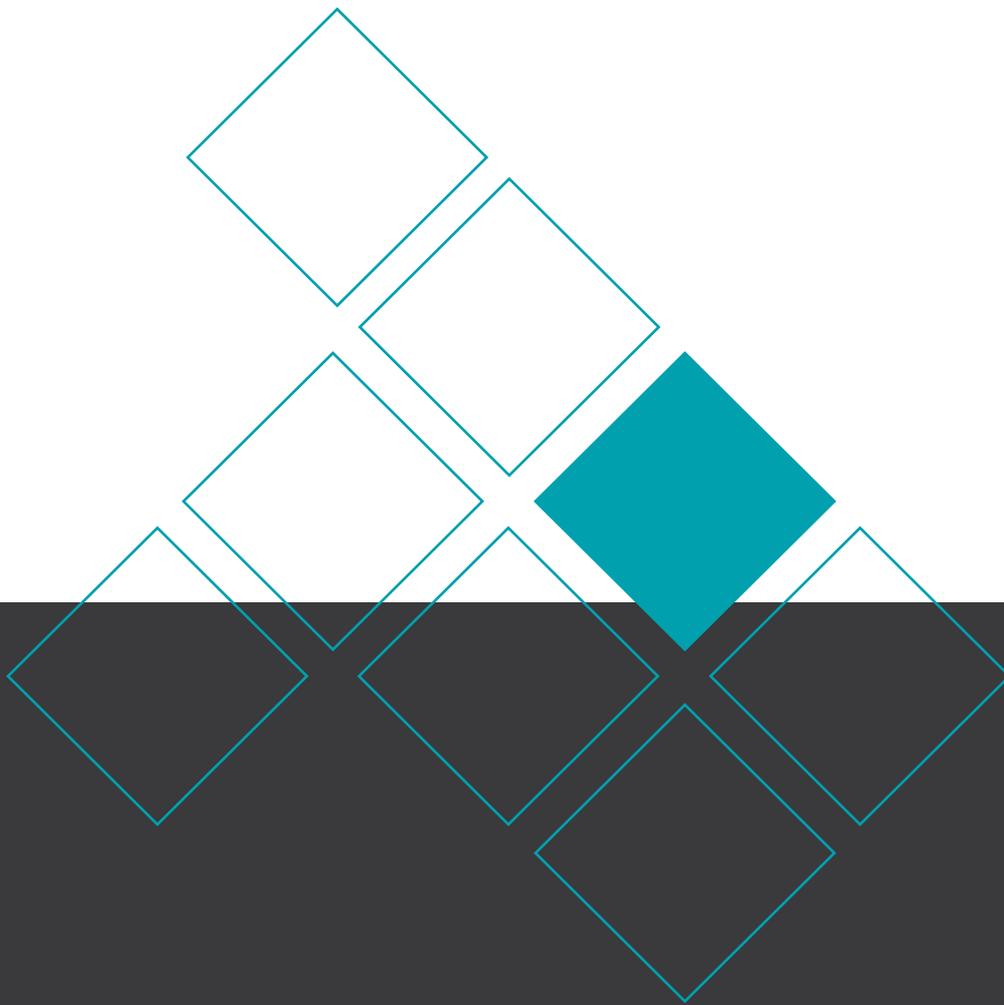
The OSC has developed a Coronial Procedures Manual to assist deputy registrars and their staff in managing the administrative processes associated with providing support to the local coroner. A review of all Magistrates Courts centres in consultation with registries and coroners has resulted in coronial processes being centralised in regional centres where there is a resident coroner. This realignment of coronial processes has led to improvements in response times in the delivery of coronial services.

Three regional coronial training sessions were conducted in the second half of this financial year to provide continuing support to registrars and registry coronial staff in providing assistance to their local coroners.

Accommodation and facilities

On completion of the new Brisbane Magistrates Court Building, officially opened on 16 November 2004, the OSC moved into the first purpose built coroners facility in Queensland. The new premises include two specially designed Coroners Courts, State Coroner and Deputy State Coroner Chambers, an office for the Queensland Police Coronial Support Unit and registry offices and workstations.

The new Coroners Courts are serviced by modern communications technology such as video conferencing and are designed for the future installation of digital recording.



Reportable deaths

Introduction

When the European occupation of Australia extended to Queensland, the English 'Office of Coroner' was transplanted and grafted onto the role of magistrates. Its function was established as the investigation of sudden, unexpected, unnatural or suspicious deaths and some fires.

That role is continued by the Act although there has been some rewording of the categories of deaths that must be reported. Jurisdiction in relation to non fatal fires has been abolished. Generally, any death that is not the result of the natural progression of disease must be reported to a coroner. Medical practitioners must

not issue cause of death certificates in these circumstances as scrutiny by an independent authority is required.

The death must also be connected to Queensland in some way. Usually this requirement is satisfied by the death occurring within the State or the body coming into the State after the death e.g. when a passenger on an airliner dies midway across the Pacific and Brisbane is the first landfall.

'Usual place of residence' also confers jurisdiction on a Queensland coroner and so the deaths of the Queenslanders who died in the Boxing Day tsunami were reported to the State Coroner.

Categories of reportable deaths

Section 7 requires that anyone becoming aware of an apparently reportable death must report it to the police or a coroner. Section 8 contains a list of categories of reportable deaths.

Unidentified bodies

An important function of the coronial system is the identification of a deceased person. This enables relatives to be informed of the death, the Register of Births, Deaths and Marriages to be updated and various legal procedures to be initiated. Unless police inquiries can readily establish the identity of the deceased with sufficient certainty, the death must be reported to a coroner. Various means such as fingerprints, photographs, dental examinations or DNA can then be used to identify the person.

Violent or unnatural

Traffic accidents, drownings, electrocutions, suicides and industrial and domestic accidents are all reported to a coroner under this category. The purpose of the report is to enable a coroner to investigate the circumstances of death to determine whether it should be referred to a prosecuting authority for the laying of charges or whether an inquest is warranted with a view to making recommendations to reduce the likelihood of similar deaths recurring.

Suspicious circumstances

Suspicious deaths are reported to a coroner to enable their circumstances to be further investigated. If, as a result, police consider there is sufficient evidence to prefer criminal charges in connection with the death, the holding of an inquest must be postponed until those charges are resolved.

Not reasonably expected to be the outcome of a health procedure

A death must be reported to a coroner if it '*was not reasonably expected to be the outcome of a health procedure*'. This replaces the requirement of the *Coroners Act 1958* to report deaths that occurred while the deceased was '*under an anaesthetic in the course of a medical, surgical or dental operation*'.

This change was designed to shift the focus from when the death occurred to why the death occurred. It is easy to think of examples in which a death might occur during an operation which would not excite the interest of a coroner whose primary focus is to investigate unnatural, sudden or suspicious deaths. Equally, the fact that the patient survives the operation only to die a day or so later should not preclude a coroner from considering whether substandard care contributed to the death.

Deciding whether a death that occurs in a medical setting should be reported and if so, determining how it should be investigated, poses considerable challenges for a coroner. A submission by the State Coroner to the Public Hospitals Commission of Inquiry described these difficulties in detail and made suggestions as to how they could be addressed. That submission is Appendix 3 to this report.

No cause of death certificate has been issued and is not likely to be issued

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

Deaths in care

'Deaths in care' is a new provision created in recognition of the special responsibilities the State holds towards the most vulnerable members of the community. The provision requires the deaths of specific categories of vulnerable people (namely children in care, the mentally ill and the disabled) be reported to a coroner, irrespective of their cause.

Table 1 indicates deaths in care comprise 1.2 per cent of total reportable deaths in the reporting period.

It is doubtful that the table accurately reflects the total number of deaths in this category. The OSC is concerned that there has been considerable under-reporting of this category, largely attributable to the difficulty in applying the statutory definition.

Due to these complexities, amendments are foreshadowed to this provision.

The OSC would also like to acknowledge the assistance provided by the staff of the Community Visitor Program. The partnership which has developed between these two agencies has been instrumental in increasing the number of deaths reported in this category.

Deaths in custody

This term is defined in s.10 of the Act to include those who, at the time of their death, are actually in custody, trying to escape from custody or trying to avoid being placed into custody.

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

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

Table 1 indicates deaths in custody represent .37 per cent of total reportable deaths during this period.

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

Table 1

Deaths in Care	
01/12/03–30/06/04	31
01/07/04–30/06/05	36
Total	67
Deaths in Custody	
01/12/03–30/06/04	6
01/07/04–30/06/05	11
Total	17

Indigenous burial remains

The Act recognises the sensitivity surrounding indigenous burial remains and places an obligation on the State Coroner to develop guidelines for coroners to ensure that they are appropriately managed.

When dealing with indigenous burial remains, a balance must be struck between the need to ensure the death was not a homicide and the need to avoid the unnecessary disturbance of the remains. As soon as it is established that remains are indigenous burial remains, the coronial investigation must cease and management of the site is transferred to officers from the Cultural Heritage Coordination Unit (CHCU) of the Department of Natural Resources and Mines (DNRM) and representatives of the traditional owners of the land where the remains were found.

The CHCU chaired an inter-agency working party to develop guidelines to assist in managing responses to reports of this nature. The working party comprised members from the OSC, the Queensland Police Service, Queensland Health, the Queensland Museum and the Environmental Protection Agency.

The guidelines, still in draft format, provide a useful guide to agencies in managing indigenous burial remains once located.

Table 2 represents the number of matters investigated by coroners in the reporting period where the remains were confirmed as indigenous burial remains.

Table 2

Indigenous Burial Remains	
01/12/03–30/06/04	1
01/07/04–30/06/05	4
Total	5

Stillbirths

The Act retains the same position as the *Coroners Act 1958* and reflects the common law position that coroners do not have jurisdiction over stillborn children. This is because, as a matter of law, an unborn child is not a legal 'person' unless and until it has an independent existence from its mother. As such, a stillborn child is not a reportable death under the Act.

A coroner has authority to order an autopsy to determine whether a body is that of a stillborn child but once that has been established, a coroner is precluded from further investigation.

Although the OSC has received a large number of inquiries regarding these provisions, only a small number of autopsies have been ordered by coroners to establish whether or not a foetus was stillborn.

Suspected deaths

A suspected death is one in which a person is missing but no body is located—living or dead. Until a death is registered, no claim can be made under a life insurance policy and no sale of jointly owned property can occur. The general principle is that if the missing person has not been seen or heard from by those who might be expected to have seen or heard from him or her and due inquiries have been made that have produced no positive results, the circumstantial evidence may be sufficient to enable a finding of death to be made.

However, the circumstances of these incidents vary greatly and can pose quite challenging issues for coroners. For example, if a person, who is known not to be able to swim, is seen to fall from an ocean liner a long way from shore, it may be concluded, if he has not been found after a week or so, that he is dead. In such a case, a coroner can find accordingly and the death can be registered.

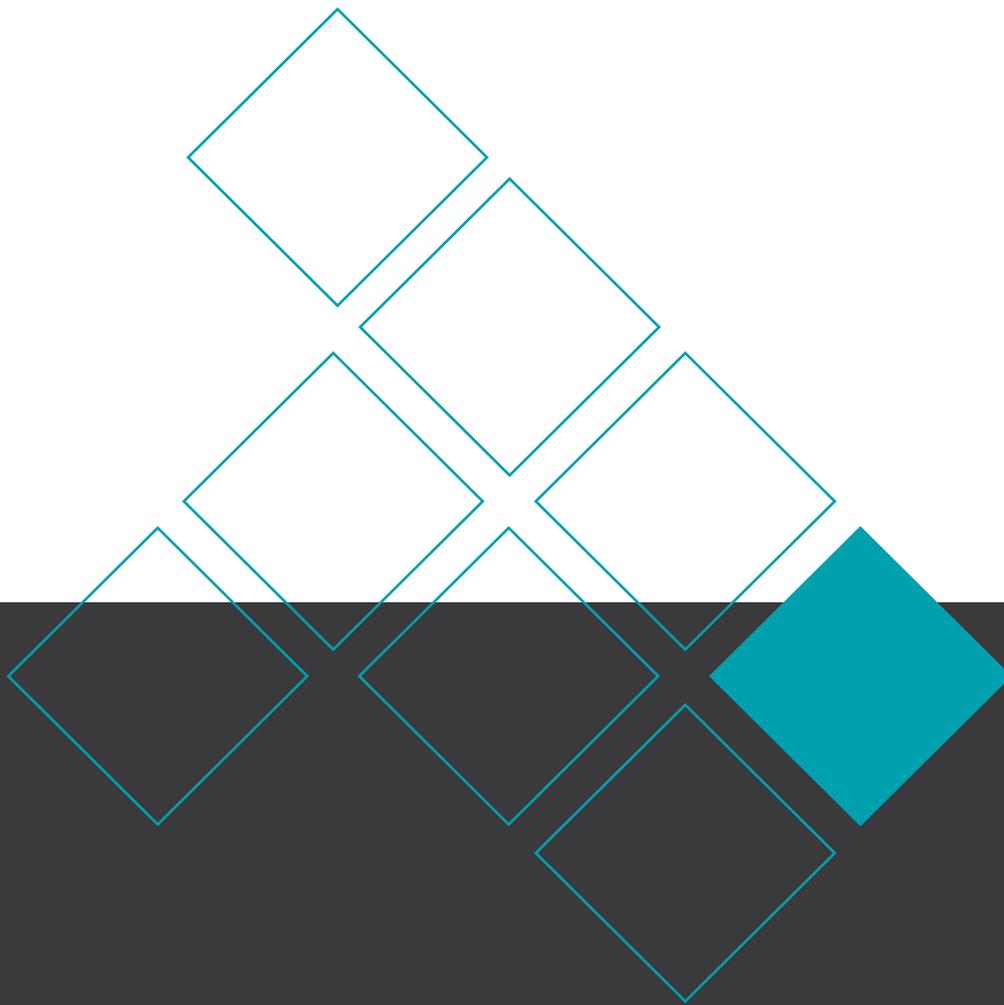
In other cases however, such a conclusion may not be so readily drawn. For example, if there is some basis to suspect that the missing person may have had reason to ‘disappear’ or at least relocate in order to leave behind some unhappiness or trouble, it may be unsafe to conclude that he/she has died. In those cases, the coroner must consider whether all reasonable inquiries have been made and whether it is more likely than not that those inquiries would have disclosed some evidence of the missing person’s continued existence were they not dead.

Checks with the Australian Tax Office, the Department of Social Security, financial institutions, friends, relatives, interstate Registries of Births Deaths and Marriages and immigration authorities can be useful, but a coroner has to be satisfied that the missing person has not assumed another identity and that the negative results to these checks are sufficient to conclude that the person is dead. Of course, if the death is to be registered in Queensland, the coroner also needs evidence that the person died here—a further complication.

The risks posed by these cases were highlighted by a recent incident in New South Wales. The coroner found that the man had drowned when his runabout was found floating, damaged and empty in a coastal waterway. Three years later, the deceased was located, alive and well and charged with insurance fraud.

The Act contains surprisingly few provisions concerning missing persons or suspected deaths. The requirement for police to report missing people to a coroner after twelve months and the right of relatives or the police to request a public inquiry into the disappearance is abolished.

The State Coroner intends recommending to the Attorney-General that aspects of this regime be reviewed.



Coronial investigations

Purpose of coronial investigations

A coronial investigation is undertaken to establish with legal certainty, the identity of the deceased, when and where he or she died, the medical cause of death and the circumstances of the death.

By carefully considering the circumstances of a sudden or unnatural death, coroners with the assistance of relevant experts, also frame recommendations designed to reduce the likelihood of similar deaths occurring in the future.

Scope of the Inquest

Because a coroner must look beyond the immediate medical cause of death to try and identify the relevant contextual factors that contributed to the death, the appropriate breadth or scope of the inquiry may sometimes be difficult to ascertain.

Family members may want a wide ranging inquiry that examines all of the circumstances leading up to the death including how the deceased came to be at the location where he or she died. A government agency may be concerned that a wide ranging inquiry may reflect negatively on staff or intrude unjustifiably in the way the agency discharges its functions. A coroner has to have regard to these concerns and consider how long a proposed inquiry will take and cost.

Anyone dissatisfied with a coroner's ruling on the question of who has sufficient legal interest in the issue, can apply to the Supreme Court pursuant to the provisions of the *Judicial Review Act 1991*.

The court's decisions in these applications indicate that while a coronial inquiry is not a commission of inquiry into all circumstances of the death, the power to investigate should not be unduly prescribed.

No rulings by coroners concerning the scope of an inquest have been successfully challenged since the commencement of the Act.

Autopsies

An examination of the body and its internal organs by a medical practitioner, a post mortem examination or autopsy, has long been an integral part of most coronial investigations. This process is undertaken to assist with the determination of the cause of death and/or to assist in the identification of the body.

However, an internal examination is intrusive, expensive and can risk the spread of infectious diseases.

Under the previous coronial regime, full internal autopsies were ordered in almost all cases. The views of the family of the deceased person were not considered when these examinations were ordered. Outside Brisbane, autopsies were often undertaken by Government Medical Officers (GMOs) who were general practitioners with little or no training in the quite esoteric processes involved in forensic pathology. Each of these aspects has been addressed by the new coronial system.

The 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. Accordingly, the Act requires coroners to consider these concerns when determining the extent of the autopsy ordered. This does not mean that family members can prevent an autopsy being undertaken if a coroner considers it necessary. However, a coroner who wishes to override a family’s concerns must give the family reasons for this which enlivens a right to have the coroner’s decision judicially reviewed.

No such review applications have been lodged since the new Act came into effect. Instead, with the assistance of the coronial counsellors, the concerns of family members have been able to be assuaged in most cases. For example, when the family is advised that the body will be reconstructed after the autopsy and an open coffin at the funeral ceremony will still be possible, their concerns may fade. In other cases when it is explained that a criminal prosecution may be jeopardised if an internal examination is not undertaken, the family sometimes withdraws the objection. In still other cases, coroners have been able to exclude the possibility of any third party involvement in a death by an external examination of the body, drug screens of the blood and a thorough scene investigation and have relied on circumstantial evidence to make their findings.

External examinations utilise the expertise of GMOs in injury analysis to exclude the possibility of third party violence as a contributing cause of death which enables coroners to make findings without the need to have an internal examination undertaken. External examinations are augmented by the screening of blood samples to ascertain whether drugs, illicit or prescription, played any part in the death.

In accordance with the Act, the State Coroner has issued guidelines that assist local coroners in selecting the appropriate doctor for particular categories of cases. The general thrust of the guidelines is to ensure that the extent of the autopsy and the expertise of the doctor undertaking it, match or fit the nature of the death. In many cases, the cause of death is apparent and little is to be served by a full internal autopsy. This approach not only saves resources but also ensures that the distress of family members is not exacerbated by the coronial investigation being unnecessarily protracted.

While precise figures are not available, a sample analysis indicates that during the reporting period, full internal autopsies were conducted in 68% of cases, partial internal autopsies were conducted in 25% of cases and external examinations were undertaken in 7% of cases. See Table 3.

Table 3

Percentage of orders for autopsy issued by type of autopsy to be performed		Number of orders for autopsy issued by type of autopsy to be performed	
Order for external autopsy		Order for external autopsy	
01/12/03–30/06/04	11.7	01/12/03–30/06/04	107
01/07/04–30/06/05	6.3	01/07/04–30/06/05	145
Order for internal autopsy—partial		Order for internal autopsy—partial	
01/12/03–30/06/04	16.3	01/12/03–30/06/04	149
01/07/04–30/06/05	25.2	01/07/04–30/06/05	575
Order for internal autopsy—full		Order for internal autopsy—full	
01/12/03–30/06/04	71.4	01/12/03–30/06/04	653
01/07/04–30/06/05	68.3	01/07/04–30/06/05	1559
Order on cremated remains		Order on cremated remains	
01/12/03–30/06/04	0.5	01/12/03–30/06/04	5
01/07/04–30/06/05	0.2	01/07/04–30/06/05	5
		Total	
		01/12/03–30/06/04	914
		01/07/04–30/06/05	2284

Notes: Data is based on Case Files which only contain a single Order for Autopsy.

Measuring outcomes

In most cases, delaying the finalisation of the coronial investigation will exacerbate the suffering of family members. Therefore, the OSC and local coroners constantly strive to conclude matters as expeditiously as possible.

In many cases however, closure of coronial files is delayed by the police investigation or the involvement of other agencies that also have responsibility to review the circumstances of the death. For example, the Department of Child Safety reviews the deaths of children who have had contact with the Department. The Division of Workplace Health and Safety investigates many industrial accidents. In most cases, it

is appropriate for coronial findings to await the deliberations of these other agencies in order that the coroner can reflect upon not only the issue of causation but also whether any preventative measures should be recommended. In many cases, the specialist agencies are best placed to devise such reforms and the coroner need then only note the changes that have been mooted and if appropriate, add his or her voice to the call for improvement. Of course, if criminal charges are preferred, an inquest can not proceed until those charges have been dealt with.

Table 4a and Table 4b show the finalisation rates achieved during the reporting period.

Table 4a

Coronial cases finalised by court location 01/12/03–30/06/04

Court location	Inquest held	No Inquest held	Total	Court location	Inquest held	No Inquest held	Total
Atherton	-	6	6	Landsborough	-	-	-
Ayr	-	1	1	Longreach	-	-	-
Beaudesert	-	-	-	Mackay	-	10	10
Beenleigh	-	6	6	Mareeba	-	4	4
Biloela	-	-	-	Maroochydore	-	-	-
Blackwater	-	-	-	Maryborough	-	4	4
Bowen	-	-	-	Mitchell	-	1	1
Brisbane	-	184	184	Moranbah	-	-	-
Bundaberg	-	26	26	Mossman	-	-	-
Caboolture	1	17	18	Mount Isa	-	16	16
Cairns	-	22	22	Murgon	-	1	1
Caloundra	-	-	-	Nambour	-	-	-
Charleville	1	2	3	Nanango	-	-	-
Charters Towers	-	-	-	Noosa	-	-	-
Childers	1	1	2	Oakey	-	-	-
Chinchilla	-	-	-	Petrie	-	-	-
Cooktown	-	-	-	Proserpine	-	4	4
Cunnamulla	-	-	-	Redcliffe	-	16	16
Dalby	-	4	4	Rockhampton	2	18	20
Emerald	-	-	-	Roma	-	2	2
Gatton	-	-	-	Southport	2	73	75
Gayndah	1	-	1	Stanthorpe	-	-	-
Gladstone	-	12	12	State Coroner	-	2	2
Goondiwindi	-	1	1	Taroom	-	1	1
Gympie	-	9	9	Thursday Island	-	-	-
Hervey Bay	-	3	3	Toogoolawah	-	-	-
Ingham	-	2	2	Toowoomba	-	30	30
Innisfail	-	-	-	Townsville	-	35	35
Ipswich	-	22	22	Warwick	-	3	3
Kingaroy	-	-	-	Weipa	-	-	-
Kowanyama	-	-	-	Yeppoon	-	-	-
				Total	8	538	546

Data Source: QWIC

Table 4b

Coronial cases finalised by court location 01/07/04–30/06/05

Court location	Inquest held	No Inquest held	Total	Court location	Inquest held	No Inquest held	Total
Atherton	-	19	19	Lockhart River	-	-	-
Aurukun	-	1	1	Longreach	-	5	5
Ayr	-	6	6	Mackay	-	87	87
Beenleigh	1	100	101	Mareeba	-	15	15
Blackwater	-	1	1	Maroochydore	-	153	153
Bowen	-	15	15	Maryborough	1	39	40
Brisbane	5	682	687	Mitchell	1	-	1
Bundaberg	-	66	66	Moranbah	-	1	1
Caboolture	-	67	67	Mossman	-	7	7
Cairns	-	100	100	Mount Isa	-	49	49
Caloundra	-	-	-	Murgon	-	-	-
Charleville	5	2	7	Nambour	-	-	-
Charters Towers	-	13	13	Nanango	-	-	-
Childers	1	1	2	Noosa	-	16	16
Chinchilla	-	-	-	Oakey	-	6	6
Coen	-	1	1	Pormpuraaw	-	2	2
Cooktown	-	3	3	Proserpine	-	12	12
Cunnamulla	-	5	5	Redcliffe	-	41	41
Dalby	-	13	13	Richmond	-	1	1
Emerald	-	21	21	Rockhampton	-	73	73
Gayndah	-	6	6	Roma	-	5	5
Gladstone	1	24	25	Southport	6	213	219
Goondiwindi	-	4	4	St.George	-	1	1
Gympie	1	21	22	Stanthorpe	-	11	11
Hervey Bay	4	34	38	State Coroner	-	25	25
Hughenden	-	3	3	Taroom	-	3	3
Ingham	1	15	16	Thursday Island	-	-	-
Innisfail	-	27	27	Toogoolawah	-	2	2
Ipswich	-	120	120	Toowoomba	4	104	108
Kingaroy	-	-	-	Townsville	-	126	126
Kowanyama	-	4	4	Warwick	1	20	21
				Weipa	-	-	-
Total					32	2,391	2,423

Data Source: QWIC

Notable inquiries/inquests

Scott Karajic

In the early hours of 28 February 2003, Scott Karajic and his work mates on Century Resources drilling rig 16 were nearing completion of the coal seam gas well they had been drilling over the preceding four days. After what the crew considered to be a straight forward and uneventful job, total depth had been reached the day before and they were in the process of removing the lengths of drill pipe from the well for the final time before the well would be capped and they would move on to the next well site.

This task had also almost been completed; the drilling bit had been removed from the well and the last length of pipe was being stacked vertically, beside the mast of the drilling rig when suddenly it plunged below the surface of the ground fatally crushing Mr Karajic against another part of the rig.

The inquest established that this occurred as a result of the drilling pipes being inappropriately stacked on old and unsafe matting not designed to bear such loads.

The State Coroner made the following preventative recommendations—riders:

- 1 that the Petroleum and Gas Inspectorate consult with participants in the gas drilling and extraction industry to design an education package that should then be mandated by regulation. This package should address the training needs of rig workers, supervisors and senior drilling company personnel; and
- 2 in the case of rig managers and supervisors, the education package should mandate a tertiary education course as a component of the required qualifications.

Troy Crossman

In April 1999, in the Cairns District Court, Troy Crossman, then 28 years of age, was sentenced to imprisonment for six years and six months after pleading guilty to an offence of robbery with actual violence.

Mr Crossman was admitted to parole in April 2002 but, within a week, he breached a condition of his parole by consuming alcohol and was returned to prison in May 2002. He served time at Wacol and Woodford correctional centres before being transferred to Borallon Correctional Centre (Borallon) in December 2003.

On the night of 17 March 2004, Troy Crossman was found hanging in his cell. He was not able to be revived and was pronounced dead.

The State Coroner was satisfied that the prison authorities responded expeditiously to the advice that someone was hanging and that the first aid given was appropriate. He considered that no action of any officer or other prisoner caused or contributed to the death.

However, this did not mean that the death was not preventable or that the cells at Borallon could not be made safer. The State Coroner considered there was a basis for concern about the way the authorities at Borallon responded to the information about Mr Crossman's risk of self harm and the prevalence of hanging points in the cells.

The State Coroner made several recommendations:

- 1 that the Department of Corrective Services investigate the viability of adding an auditing function to the Integrated Offender Management System (IOMS) to enable the level of compliance with policy concerning the accessing of 'at risk' information to be assessed;
- 2 that the Department of Corrective Services examine the effectiveness and feasibility of introducing a suicide awareness program in all prisons aimed at encouraging prisoners to report observations that might indicate fellow prisoners are at risk of self harm;
- 3 that the Department of Corrective Services develop a more sophisticated and comprehensive system for assessing the level of risk of self harm of individual prisoners and that such a system include the monitoring of the telephone calls of those identified as being at risk; and
- 4 that the Department of Corrective Services immediately cover with mesh any bars accessible to prisoners in cells at Borallon and continue with its program to make suicide resistant all cells in use in the prison system.

Phillip Bruce Partridge

Phillip Bruce Partridge was thirty-seven years of age when he was involved in a siege with police officers at his home at Boonah for approximately thirty-six hours until its conclusion on Wednesday 1 September 2004. When police finally entered Mr Partridge's premises, he was found dead with stab wounds to his abdomen.

The following aspects of the matter supported the conclusion that Mr Partridge intentionally caused his own death:

- the history of bizarre behaviour and schizophrenia;
- the destruction by Mr Partridge of his property;
- his unusual behaviour prior to and during the siege situation;
- the diagnosis by a doctor that during the siege situation Mr Partridge was suffering from a schizophrenic episode;
- evidence that he was alone in his residence surrounded by police when he was found deceased;
- the autopsy evidence indicating injuries consistent with self-inflicted stab wounds; and
- an absence of evidence of any third party involvement.

The State Coroner found that none of the police officers caused or contributed to the death and that nothing could have been done to save Mr Partridge when police finally gained entry to the house. He was of the view that the police involved in this incident rightly determined to attempt to resolve the situation by containing and negotiating with Mr Partridge. However, due to his mental state, this was unable to be achieved and Mr Partridge died from self-inflicted stab wounds to his abdomen.

Hope Vale man

An inquest was conducted by the State Coroner into the death on 28 April 2003 of a Hope Vale Man in an aboriginal community police van.

The deceased spent the afternoon of 28 April 2003 at his home in Hope Vale socialising with friends. As the evening wore on, the deceased became increasingly intoxicated and a violent dispute erupted with his partner resulting in the deceased being arrested by the Hope Vale Aboriginal Community Police.

He was taken back to the community police station and the state police in Cooktown were contacted. It was agreed that the deceased should be brought to Cooktown. The three community police therefore drove to Cooktown with the deceased in the back of the community police van. When they arrived at the Cooktown police station they found him to be deceased.

The State Coroner found that the community police were not to blame for their lack of training that left them ignorant of basic custodial issues.

The State Coroner observed that unless the decade old *Queensland Police Service Review of Policing in Remote Aboriginal and Torres Strait Islander Communities* is fully implemented with the Queensland Police Service budget adequately augmented to enable responsibility for the recruitment, training and management of Aboriginal Community Police to be transferred to the Queensland Police Service, it was likely that similar aboriginal deaths in custody will continue to occur.

Alan Paul Toohey and Andrew Tasman Hill

Shortly after 6.00pm on 24 April 2003, three Far North Queensland bushmen, Allen Toohey, Andrew Hill and William Fowler, set off in a battered and near-broken Toyota tray back utility—a ‘bull catcher’—to try to snare some feral bulls that they anticipated might come out from the scrub at dusk to feed in more open country on Andrew Hill’s huge and remote cattle station.

Half an hour later, two of them were dead, killed not by a bull but by a police vehicle, the driver of which observed them in the un-roadworthy bull catcher on the Peninsular Development Road that transects Hill’s property and gave chase when they failed to comply with his direction to stop.

The State Coroner recommended that the Queensland Police Service should take more decisive action to limit unnecessary police pursuits. He recommended that the Queensland Police Service in conjunction with the Crime and Misconduct Commission design, implement and evaluate a trial, in a suitable geographic region of the State, of a more restrictive police pursuit policy that prohibits police from pursuing drivers suspected of only minor offences. Depending on the results of that trial, consideration should then be given to amending policy and practice state wide.

Alvin Naidu

Alvin Naidu was fifteen years old and had been living with his family members at the time of his death. He was attending the local high school. On 10 November 2004 his family became aware for the first time that he had been absent from school. Mrs Naidu received a phone call from the absenteeism officer, (a teacher aid) at the high school. She recalls being told that her son had not been at school for two weeks. She expressed her surprise and concern over the completely unexpected news.

Alvin came home about 2.30 pm that day, as if returning from school after sport. His mother asked him where he had been and he indicated he had been at school. She challenged him and told him that she had been speaking with the school and she knew that he had not been at school. It was necessary that Mrs Naidu go out at that time in relation to children she cared for. She told her son they would talk when she returned.

Mrs Naidu came home about ten past three that afternoon and discovered her son to be hanging in the garage area. Immediate efforts were made to help Alvin and he was taken to hospital. He was resuscitated but tragically he had suffered such severe hypoxic brain damage that he died.

The Deputy State Coroner made several recommendations:

- 1 that Education Queensland reviews the minimum requirements to communicate with parents of students on each day that a student is absent from school. Education Queensland considers making it compulsory to use soft ware options generating automated SMS messages to parents indicating a student is absent;
- 2 that Education Queensland assists the high school to consider an independent or external audit of its absenteeism/truancy management communication system with parents. The audit should include a focus on whether there is sufficient feedback (both up and down the hierarchical chain within the school) to ensure that each consequential step is being taken in accordance with the school policy; and
- 3 that Education Queensland reviews all Queensland schools' communication requirements with parents concerning the issue of truancy in light of the evidence in this inquest.

Jacinta Kate Robinson

Jacinta Kate Robinson was born on 16 March 1995. She died on 26 September 2002 in the surgical ward of the Royal Children's Hospital in Brisbane. She was seven years old. After her birth, it was discovered that Jacinta had multiple problems. She suffered from spina bifida as well as bowel and bladder incontinence. She had more than thirty procedures performed during her lifetime. She was admitted to the Royal Children's Hospital on 2 September 2002 for a bladder procedure. That surgery proceeded uneventfully and she was discharged on 4 September 2002.

Jacinta became unwell with abdominal pain and vomiting on 12 September 2002. She was admitted to the surgical ward. Diagnostic testing was performed and a diagnosis of a bacterial infection was made requiring a week's intravenous antibiotics. She was discharged again on 20 September 2002. Early the next morning, she woke with severe vomiting and back pain. She was taken back to the emergency department and re-admitted.

After more diagnostic tests Jacinta was diagnosed with a bowel obstruction and a perforation of the ileum, the end section of the small bowel near the colon. On 24 September Jacinta underwent a laparotomy to divide the adhesions and repair the perforation of the ileum. This operation was performed between 4pm and 7.20pm on 24 September.

During this operation the anaesthetist inserted a central venous line into the jugular vein in the right side of the neck. Jacinta had been ill for sometime and was significantly underweight and it was necessary to provide this support.

At about 11.00pm on the evening of 25 September 2002 Jacinta's pulse rate was one hundred and seventy (170), but then dropped back to one hundred and forty (140).

The doctor examined Jacinta and attempted to obtain a blood pressure, also without success. The doctor asked the nurse to activate the medical emergency response team. Resuscitation attempts were made until 2.08am when it was decided that it was not possible to resuscitate Jacinta.

A post mortem autopsy examination was performed by a pathologist on 27 September 2002. He identified the cause of death to be cardiac tamponade caused by the leaking of total parenteral fluid into the pericardial sac as a consequence of the central line therapy.

The Deputy State Coroner made the following recommendations:

- 1 there be a review of training in the Royal Children's Hospital for nurses and general medical staff (as well as intensivists) to raise the awareness of the possible complications of central venous line therapy which includes cardiac tamponade;
- 2 that consideration be given by the hospital and/or Queensland Health to enable nurses and junior medical staff to be funded to attend acute or critical care specialist training courses; and
- 3 that Queensland Health continues consideration of the best approach to delivery of specialist, particularly cardiac, services to children in Queensland, particularly having regard to the circumstances of this death.

Shone Landue, Gary Reid and Stanley Doolan—the Sandgate Boarding House Fire

At about 1.30am on the morning of 19 August 2002 police received a telephone call to attend the scene of a fire at the Sea Breeze Lodge at 30 Second Avenue, Sandgate.

It was a large timber and tin premises occupying a large block of land, best described as a big Queenslander made into a boarding house or guest house. It was raised from the ground approximately five feet.

Notable inquiries/inquests continued

The whole building was destroyed by fire with only the stumps and the chimney remaining. The initial concern had been to locate missing persons, people who had occupied the building but were unaccounted for. It was determined that there were twenty three people residing at the property at the time of the fire. Three residents were not accounted for after the fire.

In their statements, residents described being alerted by the sounds of yelling and broken glass. Some thought there was a fight due to the noise but on leaving their rooms discovered there was a fire. Most exited from the rear of the building, away from the fire at the front of the building. The majority of statements collected from witnesses indicated they were unaware of any procedure to be followed in the event of fire. Some recalled a map in the large common room of the premises indicating exit points. There were conflicting accounts of whether there were fire alarms, but most said fire alarms were not working. Recollections from witnesses were that batteries were sometimes stolen for personal use and that the batteries for the alarm in the kitchen were removed because cooking inevitably set off the alarm. Information was that there was a fire blanket in the kitchen and there were a number of fire extinguishers in the building.

There was no information about whether anyone had tried to use any of the fire extinguishers inside the premises after the blaze had started. The ferocity of the fire was so intense that it was unlikely that individual fire extinguishers would have made any difference.

Police investigations could not establish the cause of the fire.

The fire officer stated there was no problem in accessing the water from the main at the front of the residence but he said the quantity of the water was very, very poor. He explained that the pump provides the pressure but he needed a volume of water that was not available. The mains were, (he thought) eighty or ninety years old and he expected them to be corroded internally.

The fire officer said the water supply was a matter of taking what you can get. Only if access could have been gained to an independent main could the volume of water been increased. The fire officers did tap into another water source which was right down the end of the street towards the esplanade but by that time the house was gone.

The Deputy State Coroner made the following recommendations:

- 1 that Brisbane City Council review its water management practices for replacement of water mains having regard to the capacity of those mains to deliver sufficient volume of water to effectively fight fires;
- 2 that Brisbane City Council review their systems of monitoring premises to ensure that safety related requirements made by it are complied with within the time stipulated, or, if not, that effective follow up procedures are actually taken;
- 3 that Qld Fire Service and the Brisbane City Council conduct formal liaison procedures to ensure that they perform their respective fire safety functions in a way that their effectiveness is maximised and responsibilities of each authority are clearly recognised;

- 4 that Qld Advocacy Incorporated be involved in any co-regulatory approaches between local government, the fire service and boarding house operators and tenants;
- 5 local council authorities and Queensland Fire Service review their procedures relating to any element of discretion with council or fire officers in enforcing compliance with safety and fire standards;
- 6 review of legislation to consider including dwellings with six or less people as also being subject to boarding house licensing provisions;
- 7 investigation of possibility of implementation of an automatic cut off system for gas lines in the event of fire as well as metal enclosures for the meter;
- 8 review of legislation to consider empowering an appropriate authority to conduct spot audits of multiple dwellings in relation to safety issues;
- 9 review of legislation to elevate fire safety requirements above competing interests of privacy or other tenancy based interest where there is a conflict in relation to multiple occupancy dwellings;
- 10 fire protection be reviewed specifically focusing on under floor areas of 'Queenslander' style buildings;
- 11 review and improve communication methods for fire fighters at the scene of a fire so that they can immediately access via radio information about water supply or other issues relevant to fire fighting;
- 12 that appropriate authorities consider commendations for bravery for the witnesses who notified the fire service and any other people including fire and police officers and residents of Sea Breeze Lodge (including the possibility of posthumous awards);
- 13 electrical and fire safety review of premises at 39 Northy Street Windsor where the evidence indicates there may have been unlicensed electrical work performed; and
- 14 the most significant preventative measure to ensure fire safety is a hard wired smoke detection system giving early warning of a fire to residents and giving them the opportunity to escape the premises. It is urged that all levels of government and fire authorities concertedly act to ensure the efficacy of these new provisions to avert the repetition of such a tragedy.

Maren Lyndsey Dell

Maren Lyndsey Dell was 23 years old. On 30 May 2003 she took part in a boat cruise to Agincourt Reef where part of her activities was to include a resort dive. A resort dive is an introductory underwater dive using scuba equipment, usually with persons who have not experienced diving before. Basic training is undertaken both in the form of a talk conducted by an instructor using documentary and pictorial prompts and then practical tuition on some essential tasks in a controlled water environment. The dive is then supervised by instructors and conducted over a set course.

Ms Dell signed a medical questionnaire and clearance. There is no suggestion that she was other than a healthy young woman. Her mother and brother also intended to dive and signed the same documents. Her mother was not given a clearance to dive by the company as a result of answers she gave in her medical questionnaire.

She and her brother were in the company of a senior dive instructor and a new dive instructor. Both instructors were suitably qualified to conduct recreational diving.

Towards the end of the dive Ms Dell had difficulty in clearing her mask. The evidence is clear that she panicked, tore off her mask and then ascended quickly to the surface from about nine metres. She was seen breathing out during ascent. Both instructors were in close proximity to her.

At the surface she was initially responsive to a question put to her and probably conscious but shortly after lapsed into unconsciousness. The company had oxygen equipment and an automatic electric defibrillator, all of which were used. A crew member performed cardiac compression.

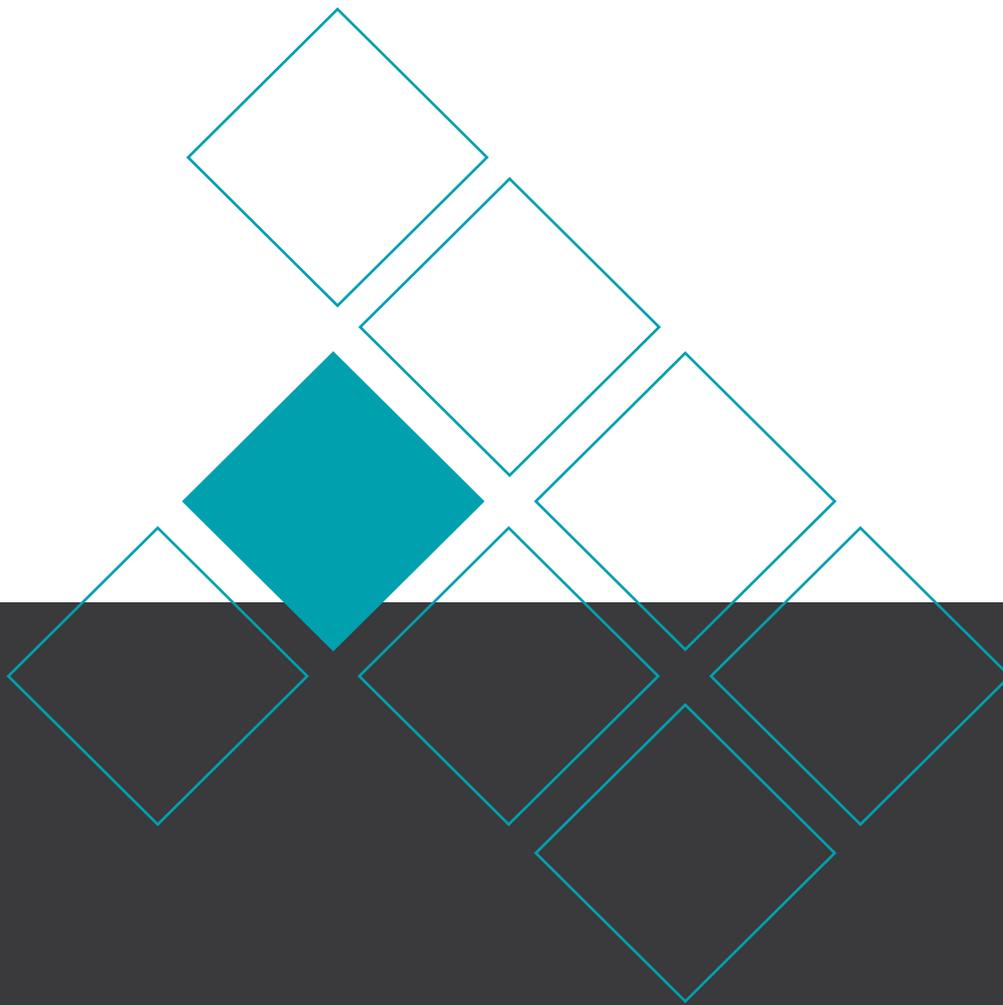
A medical practitioner visiting from the United States of America assisted. He attached an intravenous drip and gave her two doses of epinephrine to stimulate the heart. All of this was to no avail, and she remained unconscious and with no pulse. A rescue helicopter had by this time been called and arrived. An ECG machine confirmed there was no electrical activity from the deceased and CPR was discontinued. The efforts at reviving Ms Dell took place over a period of approximately one hour.

The Queensland Police Service conducted a thorough investigation. Statements from all relevant witnesses were taken. The diving equipment was scientifically examined and found to be in good working order. The compressed air in the tank was suitable. The actions of staff were prompt and showed proper rescue procedures were in place and were carried out.

The concerns of the family principally related to whether proper safety instructions and training for the dive were given and as to whether Ms Dell was given adequate supervision.

The coroner recommended the Recreational Diving Industry, in conjunction with the Division of Workplace Health and Safety, do as follows:

- 1 review the training materials and programs used for the training of resort divers to ensure they meet best practice standards;
- 2 that included in such training materials clear advice be given to novice and/or resort divers of the dangers associated with diving generally, and specifically, but not limited to, the dangers of a rapid ascent from any depth; and
- 3 review the training programs of instructors to ensure they are aware of the factors which can cause panic in a diver and are able to better recognise those factors when exhibited by potential divers and to enable them to make decisions minimising a risk of injury or death to that person. Those decisions may include more training and instruction for the novice diver, or prohibiting the dive or cutting short a dive.



Coronial investigators

Coronial Support Unit

The Queensland Police Service has implemented the Coronial Support Unit (CSU) under the Superintendent, Forensic Services Branch. This Unit comprises the police unit at the JTC, Disaster Victim Identification Squad (DVIS) and staff attached to the OSC.

This unit coordinates all police coronial functions associated with bodies lodged at the JTC by liaising with coroners, investigators, forensic pathologists, mortuary staff and counsellors.

The DVIS is responsible for the identification of deceased persons in terrorist (Bali Bombings), disaster (Asian Tsunami) and mass casualty (Lockhart River Aircrash) incidents.

Staff attached to the OSC undertakes administrative, investigative and liaison duties between the OSC, the Queensland Police Service, DJAG and other departments, agencies and persons involved in the coronial process.

Forensic pathology



Forensic Pathology, Queensland Health Scientific Services (QHSS) is responsible for the provision of the coronial autopsy service and coronial counselling services, predominantly in the south-eastern region of Queensland.

Between July 2004 and July 2005, 1623 deceased persons were admitted to the mortuary at the John Tonge Centre—an average of 124 per month. The number of deceased persons proceeding to autopsy following a coroner's order was 1427 (88%). In the remaining 196 (12%) deaths, a doctor was prepared to issue a Cause of Death certificate (Form 9) so that these deaths ultimately did not require reporting under the Act.

Prior to 2003, the number of outstanding reports had been at times as high as 508. This was partly the result of an inability to fill vacant positions due to a global shortage of forensic pathologists. However, in September 2003, all the forensic pathologist vacancies were filled and for the first time, QHSS was able to become involved in the Forensic Pathology Registrar Training Program. This, together with the introduction of new automation in the laboratory and the filling of other key positions, has resulted in significant decreases in the number of outstanding cases. This trend has been maintained beyond July 2005 and the number of outstanding reports is now consistently less than 140 per month.

Coronial Counsellors



Understandably, many of the people who have contact with the coronial system are extremely distressed and fragile. In many cases, they want practical information about the coronial process and how they can find out more about the circumstances and cause of the death. Much of this information is contained in a brochure that is given to family members by the police officers who attend the scene of the death but not surprisingly, in some instances, information in this form is not well assimilated. Research has consistently shown that, perhaps counter intuitively,

many relatives want detailed information about the death. Equally, to operate effectively, the coronial system often needs information that only intimates of the deceased can provide. Obviously it is vitally important to provide and seek this information in a way that will not exacerbate the suffering of the surviving relatives or friends. The expertise needed to facilitate these sensitive and important functions is provided by the four social workers of the Coronial Counselling Service based at QHSS. These dedicated professionals provide the following services:

General information about the coronial jurisdiction

No one can reverse the death but the way those involved in the coronial system interact with the family of the deceased who will often have had no prior experience with the State's official response to sudden death, can alleviate or exacerbate the suffering. The complexities of the coronial system and the role of the police can be confusing and intimidating to bereaved families. The counsellors attempt to 'de-mystify' the system by clearly explaining the functions and objectives of the different organisations involved as well as the scope and limits of a coronial inquiry.

Identification viewing

The counsellors assist police with arranging and undertaking the visual identification of deceased by family members or friends. This involves working closely with mortuary staff to ensure that the body of the deceased person is presented as respectfully as possible. The counsellors also work directly with the family describing clearly the appearance of the deceased prior to the identification so as to minimise the risk of trauma for the bereaved.

Bereavement viewing

While many families choose to conduct a viewing at the funeral home, issues of cost and time restrictions can sometimes mean that the only opportunity to see the deceased prior to burial or cremation is at the JTC. The counsellors help arrange the viewings with the family and mortuary staff and meet with the relatives to support them through the process.

Information about autopsy procedures and results

A vital part of the counselling role is to keep relatives informed about medical findings and to answer any questions about the autopsy process. This involves the ability to be both sensitive to the needs of the family and to give what is often uncompromisingly distressing information in a way which is accurate, timely and appropriate. Of course family members want to know, and indeed have a right to know, the cause of death but in those rare cases where police suspect homicide it can be vital to the investigation that this information is not released until other investigative steps have been completed. In these cases, the counsellors work with the detectives to ensure the rights of family members are accorded without compromising the criminal investigation.

Objections to internal autopsy

The Act requires coroners to take into account any concerns family members may have about a proposed internal examination of the deceased's body. When police record that family have such concerns, counsellors liaise with the family. This can involve clarifying with the family the nature of their concerns, providing the coroner with an accurate account of the objection and liaising with medical staff about the type of autopsy needed to provide the coroner with necessary information. If the coroner decides it is essential to proceed with an internal examination despite the family's concerns, the counsellors advise the family members of that decision and their right to have it judicially reviewed by the Supreme Court.

Organ retention

The Act requires that when a coroner has authorised a whole organ to be retained after autopsy for further testing, family members are to be advised of this before the body is released for burial. This enables the family to consider postponing the burial until the organ can be returned. Counsellors liaise with coroners, court staff, pathologists/GMOs and families in relation to proposals to retain organs to ensure that the family is informed of the retention and the reasons for it. The counsellors are also able to ensure that the coroner is advised of any concerns the family have in relation to the proposed retention.

Clinical counselling

On an on-going or single session basis, grief counselling is provided to any relative of a deceased person whose body has been taken to the JTC depending on the needs and wishes of the client.

Support when viewing files, photographs or suicide notes

Families deal with the trauma of bereavement in a variety of ways. In an endeavour to learn as much as they can about the cause and circumstances of the death, some family members wish to view coronial files and reports, photographs of the death scene and suicide notes. Obviously, much of this information can be very confronting and potentially traumatic. It would be irresponsible to simply expose family members to this material without support. The counsellors go through this process with families, ensuring they are properly prepared and safely debriefed while at the same time meeting the wishes of the family as far as possible.

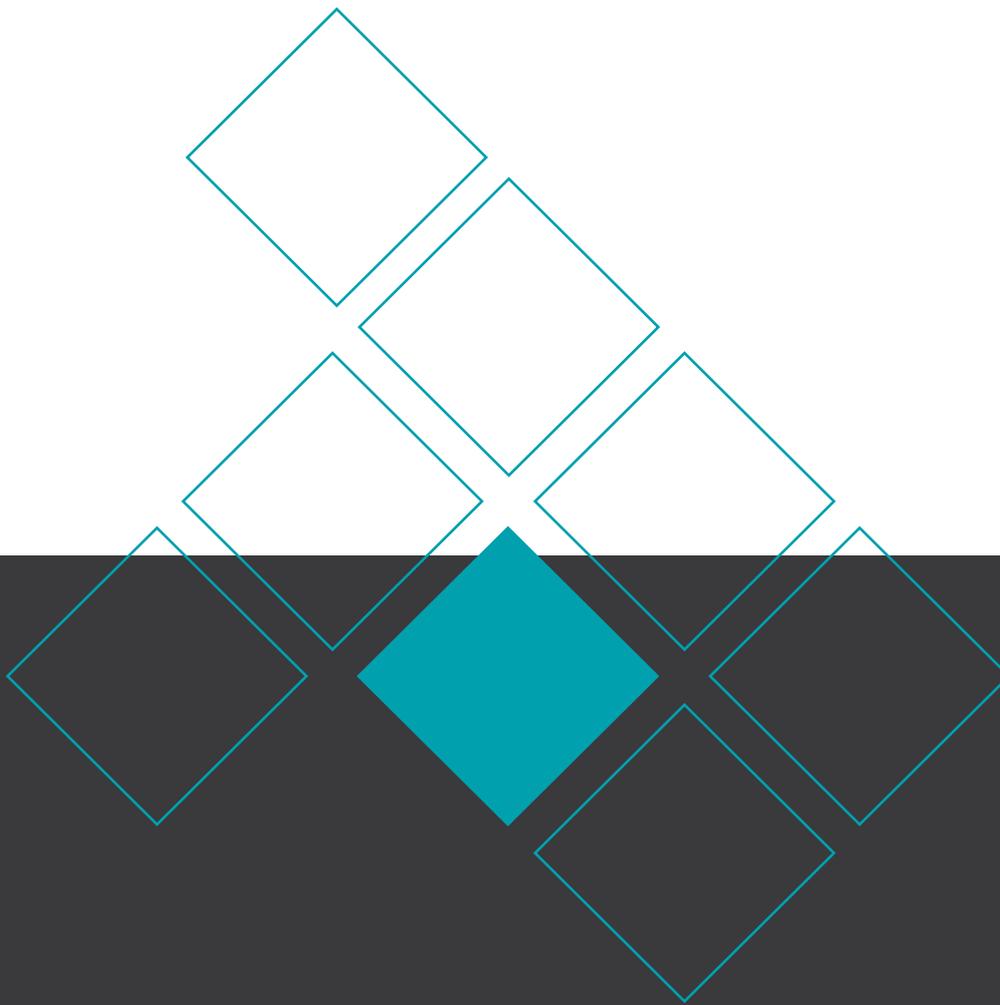
Support at inquests

Inquests can occur many months or even years after the death. They often involve graphic accounts of the circumstances of the death and can therefore be very stressful for family members who usually want to be present in court. At the request of families or court staff, counsellors will attend before and during the inquest to provide emotional support for family members.

Specialist referral

A small percentage of family members, either as a result of underlying emotional or psychological fragility or as a reactive response, suffer grief of a greater magnitude than the 'normal' bereavement experience. The counsellors are trained to recognise these conditions and can provide a referral to specialist mental health practitioners or crisis counselling where necessary.

The counsellors telephone the relatives of all deceased persons whose bodies are lodged at the JTC to offer them counselling and to respond to any of their questions. Some of the other services described above are activated by the investigating coroner requesting the assistance of the counsellors. Some of these services can, at present, only be provided to families in the south east corner of the State. On page 54 the plans for the expansion of these services are discussed.



Research, prevention and improvement

Genuine researchers

The Act introduced a comprehensive regime for researchers to access coronial documents. This regime reflects the policy that the scholarly investigation of sudden deaths is vitally important to improving the safety of our communities. The coronial system is an important source of information for researchers and the analyses of researchers are essential in assisting the coronial system to prevent future deaths.

All applications for access to 'investigation documents' for research must be determined by the State Coroner. The State Coroner may only consent to the release of an investigation document if he is satisfied that:

- 1 the person is a 'genuine researcher' in accordance with the definition in the Act; and
- 2 the document is reasonably necessary for the research.

A number of individuals and organisations have been declared 'genuine researchers' since the Act commenced. The researchers cover a broad spectrum including: suicide prevention, mining accidents, transport accidents, pool drownings, diving deaths, maternal and peri-natal deaths, peri-operative deaths, road safety, etc.

The documents researchers frequently seek to access are Form 1's (initial report of death to a coroner by a police officer), police or other investigation reports, autopsy and toxicology reports, witness statements and coroner's findings. Table 5 lists the genuine researchers approved in the reportable period.

Table 5

Queensland Maternal and Perinatal Quality Council (QMPQC)—Queensland Health

Undertake confidential reviews of maternal, perinatal, paediatric and peri-operative mortality and apply clinical classification to each case. They are then summarised and the data is de-identified which is then presented in the annual reports of the council.

Queensland Paediatric Quality Council (QPQC)—Queensland Health

Undertake confidential reviews of maternal, perinatal, paediatric and peri-operative mortality and apply clinical classification to each case. They are then summarised and the data is de-identified which is then presented in the annual reports of the council.

Committee to Enquire into Peri-operative Deaths (CEPD)—Queensland Health

Undertake confidential reviews of maternal, perinatal, paediatric and peri-operative mortality and apply clinical classification to each case. They are then summarised and the data is de-identified which is then presented in the annual reports of the council.

Queensland Injury Surveillance Unit (QISU)

QISU's core activity is to analyse injury data collected from hospital emergency departments with a view to identifying injury risks in the community and promoting safer communities.

Australian Institute of Suicide Research and Prevention (AISRAP)

AISRAP core activity is to promote, conduct and support comprehensive inter-sectoral programs of research activities for the prevention of suicide behaviours in Qld. The primary aim of ASIRAP is the prevention of suicide. The organisation maintains the Qld Suicide Register (QSR) which enables statistical identification of predictors relating to suicide which can then be used to develop and inform government policies and initiatives to reduce the incidence of suicide in our community.

Centre of National Research on Disability and Research Medicine (CONROD/QTR)

CONROD/QTR collects data about the cause and treatment of injuries from large accident and emergency departments and regional hospitals. Research is directed towards

all aspects of the continuum including prevention, acute treatment, rehabilitation and social and vocational management of disabling conditions. They consider not just the prevalence of death but the prevalence of harm and assist to identify how people whose deaths we investigate may have been saved.

Minerals Industry Safety and Health Centre (MISHC)

MISHC undertake research to identify root causes of fatalities and serious injuries in the Queensland Mining Industry and attempt to identify improvements that the Qld Mining Industry can make to reduce the incidence of fatalities.

Dr D. Walker

Dr Walker's research is to investigate fatal accidents occurring in the underwater activities in an attempt to identify the 'avoidable factors' in the sequence of these events and expects that the results of his research will be utilised to improve preventative measures in the diving industry such as enhancing training and improving dive procedure protocols and equipment.

Australian Transport Safety Bureau (ATSB)

ATSB coordinates the formulation of the National Road Safety Strategy, undertakes detailed road safety research, collects and analyses road crash data, provides public information and gives research backing to the road transport activities of the Department of Transport.

Centre for Accident Research and Road Safety-Queensland (CARRS-Q)

This project is one of the prevention strategies that will be developed as part of CARRS-Q Rural and Remote Road Safety Study and is currently undertaking a major study of the economic, medical and social costs of road crashes in North Queensland.

Australian Research Council (ARC)

Review of literature and review of closed coronial matters to determine what factors were essential to the decision pertaining to the way coroners order autopsies. To assist with the development of guidelines that identify the characteristics of any death that are crucial to the autopsy decision and to assist coroners to make these decisions.

The National Coronial Information System

The National Coronial Information System (NCIS) is the world's first collection of national coronial information. Data concerning every death reported to an Australian coroner since July 2000 is stored within the system, providing valuable hazard identification and death prevention tools for coroners and research agencies.

Section 93 of the Act authorises the Minister to enter into an arrangement with such an entity for information obtained under that Act to be included in the entity's data base. This has been done in relation to NCIS and as a result Queensland data is available from 1st January 2001.

The NCIS was primarily designed for use by Australian coroners to allow the coroner to review similar cases both inside and outside their jurisdiction which may assist in the investigation of deaths within the community. In this way possible systemic hazards may be identified and addressed. Prior to the establishment of this data base, coroners had to rely on memory or word of mouth to find earlier cases relevant to matters they were dealing with.

The NCIS is an initiative of the Australasian Coroners Society and is based at and operated by the Victorian Institute of Forensic Medicine in Melbourne. Required changes to the governance and management of the NCIS resulted in the Victorian Institute of Forensic Medicine assuming responsibility for the management of the NCIS in 2005 from the Monash University National Centre for Coronial Information (MUNCCI).

Each of the states and territories around Australia has a licence agreement with the Victorian Institute of Forensic Medicine which permits the transfer of coronial information for storage and dissemination via the NCIS.

The transfer of information to the NCIS is performed in accordance with State and Federal Privacy Legislation.

Training

Data entry for all Queensland cases is performed at the OSC onto local case management systems by administration officers. The administration officers use the information contained within the coronial files as the basis for coding the data entry. NCIS Coder training has been given priority over the last twelve months due to the backlog of cases which has been experienced Australia wide.

The OSC has taken steps to ensure that any backlogs are identified and rectified in a timely manner and also to ensure that improvement processes are implemented and maintained.

NCIS Expert

NCIS is a powerful but somewhat complicated data base and like most such tools, unless used frequently searching can be difficult. This has been addressed by the creation of a 'NCIS Expert' within the OSC to assist all coroners around the State in searching the data base in order to benefit from our involvement with the database.

A strategy has been put in place by designating two data entry officers. It is envisaged that this will address the backlog issues for Queensland and also increase the accuracy of the data entry as the inputting of this information is vital to the ongoing success and practical use of this system. Other measures regarding the contribution of quality data inputting could take the form of further coder training and/or increased staff resources. Table 6 shows the total number of cases created and cases closed for the reporting period.

The creation of nominated NCIS Experts enables all coroners/magistrates around Queensland to contact an NCIS Expert and request the expert to conduct specific searches of the NCIS. Training sessions were provided to the nominated key coronial office staff by the NCIS project team and as a result, it is envisaged that the usage figures as outlined in Table 7 will increase substantially for the financial year 2005/2006.

Usage of National Coroners Information System

Table 6

Total number of open/closed cases per financial year	
01/12/03–1/07/04	
Cases created	1079
Cases closed	1052
01/07/04–30/06/05	
Cases created	2540
Cases closed	2538

Table 7

Usage figures for coroners/experts per financial year	
01/12/03–1/07/04	
Position	State Coroner
Count of use	2
01/07/04 – 30/06/05	
Position	nil
Count of use	nil

Presentations and awareness sessions were also provided to select coroners and magistrates on the benefits of using the NCIS and how to access the data. This awareness will also increase the usage for the financial year 2005/2006.

Research collaboration

Australian Research Council Grant with Queensland University of Technology and Queensland Health

A significant change introduced by the new coronial system involves a move away from the automatic ordering of full internal autopsies. The Act requires a coroner to stipulate whether an internal, partial internal or external only autopsy is undertaken and to specify the doctor who should undertake the autopsy. The coroner is also obliged to have regard to any concerns the family of the deceased may have about the extent of the autopsy proposed.

Internal autopsies offend the beliefs of numerous religions on the basis they are an unnecessary interference with the body. Family members also sometimes object on the basis that a relative has 'already suffered enough' or that the idea of an autopsy is tantamount to desecration of the body.

The need to avoid unnecessary internal autopsies is buttressed by financial considerations. Each autopsy costs about \$5,000 and as there is a world wide shortage of forensic pathologists, there is usually some delay in obtaining the results of internal autopsies.

The State Coroner has therefore issued guidelines directing that internal autopsies should only be undertaken when there is a forensic necessity. It is difficult however to obtain consistency in the resort to internal autopsies without some more specific guidelines.

A literature search failed to find any that have been developed in other jurisdictions. The State Coroner, together with the Chief Forensic Pathologist and a criminologist from the Queensland University of Technology, successfully applied for an Australian Research Council grant in the amount of \$65,000 to research and develop such guidelines. That process is ongoing and it is hoped to produce and publish guidelines before the end of 2007.

Australian Research Council Grant with the Australian Institute of Suicide Research and Prevention (AISRAP)

AISRAP is a world leader in its field. One of the mysteries of suicide is why successful intervention by medical practitioners seems so sporadic. The State Coroner has therefore joined with researchers from AISRAP, Queensland Health, Lifeline, the Commonwealth Department of Veteran Affairs and others to explore this issue. This research is funded to the extent of \$315,000 over three years. It aims to identify those aspects of a therapeutic medical relationship that successfully reduce the likelihood of suicide.

Prevention collaboration

Suicide prevention and research

Australian Institute of Suicide Research and Prevention (AISRAP)

Griffith University has been involved in suicide prevention and research with the Queensland Police Service since 1994 through AISRAP. With the implementation of the new coronial process, the State Coroner, Queensland Police Service and AISRAP formulated a new procedure for gathering and collating information from the families of those who suicide. As from 1 January 2005, police officers investigating apparent suicides facilitate the provision of contact details of family members to AISRAP to enable follow up interviews as part of their research program. To ensure privacy issues are adequately addressed and legislative compliance adhered to, this procedure is conducted with the written consent of the family member.

The new process has been embraced by the Queensland Police Service and proven to be very successful. Police resources are no longer used to conduct lengthy interviews as interviews are now conducted by trained researchers at a later, more appropriate time for family members.

Suicide Expert Advisory Group

As part of its Suicide Prevention Strategy, the Queensland Government has set up a number of advisory groups to participate in various programs clustered under the strategy. The State Coroner was appointed a member of the community expert group which provided assistance to the steering committee. The group meets four times a year to review and critique the activities of the other groups which participate in the various programs.

The State Coroner also presented at a conference organised to further knowledge and understanding in the area of suicide prevention.

Older drivers

Two inquests were convened by the Deputy State Coroner specifically concerning the issues arising from motor vehicle accidents where the driver was elderly (over seventy five). Coronial comments were made to prompt a review of the licensing system for older drivers to include a practical test and to consider an independent review.

Mental health sentinel event review

In February 2004 the Director-General of Queensland Health established a committee to undertake the Queensland Review of Fatal Mental Health Sentinel Events. The task of the Review was to investigate deaths involving people with serious mental illness that occurred in a two year period (1 January 2002 to 31 December 2003) and to determine if there were systemic issues in mental health services that needed to be addressed.

'Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events' was submitted to the Director-General in March 2005. The Report highlights many significant issues facing mental health services including the increasing level of acuity of mental health patients with high levels of co-morbid drug and alcohol abuse and low numbers of skilled staff particularly in inpatient units and in high growth, low socio-economic districts.

The Report outlines sixty recommendations and nine key recommendations. Implementation of the nine key recommendations was approved by the Queensland Health Board of Management in June 2005 and is expected to continue until December 2009.

Ombudsman review of riders

Coroners frequently make preventative recommendations, referred to under the *Coroners Act 1958* as riders. Under that Act there was no mechanism for monitoring the responses to riders. The Queensland Ombudsman came to the view that opportunities for improvement in public sector administration were being lost as a result. Accordingly, his office has been undertaking a study examining which riders have been implemented, which have not and why not. This report is expected soon.

The State Coroner has met with the Queensland Ombudsman in connection with this project the results of which are expected to be beneficial to the coronial system.

The new Act provides more comprehensive provisions to ensure that coroners' recommendations are brought to the attention of the relevant government Minister and agency.

Child Death Case Review Committee

As part of the Crime and Misconduct Commission's 'Blueprint' to reform the child welfare/safety system, the Child Death Case Review Committee was created under the auspices of

the Commission for Children and Young People and Child Guardian. The Committee is chaired by the Commissioner for Children and Young People and is comprised of persons with expertise in paediatrics, investigations, psychiatry and child protection. The State Coroner was appointed a member of the inaugural committee.

The Committee considers child death case reviews undertaken by external consultants appointed by the Department of Child Safety. The focus of the work of the Committee is to critique the delivery of child protection services to children who have had contact with the Department of Child Safety or its predecessors. The review reports are provided to coroners investigating the deaths in question.

Police Education Advisory Committee (PEAC)

The Police Education Advisory Committee (PEAC) is chaired by a retired Supreme Court Judge and constituted by people with expertise in criminology, indigenous affairs and education and training. It reports to the Commissioner of Police. The role of the PEAC is to advise the Commissioner on the training needs of police officers. In particular, those issues brought to the attention of PEAC which suggest some lack or gap in the training of officers. The State Coroner has been a member of PEAC since 2003. It has provided a useful forum in which he can raise concerns about suboptimal police conduct identified during coronial investigations.

Efficiency and effectiveness

Transportation of autopsy specimens

Until recently, the Queensland Police Service maintained responsibility for transporting coroner's autopsy specimens from their local mortuaries to Queensland Health situated at the JTC for analysis. This process not only costs the Queensland Police Service hundreds of thousands of dollars each year but it also meant operational police were diverted from their primary purpose to become 'delivery drivers'.

The Queensland Police Service, Queensland Health, the DJAG, the State Coroner, and the Chief Government Medical Officer were involved in negotiations to have Queensland Health take responsibility for transporting coroners' autopsy specimens in non-suspicious deaths to the JTC.

Queensland Health subsequently agreed to accept responsibility for transporting coroners' autopsy specimens in non-suspicious deaths to the JTC. This has enabled the adoption of an effective specimen tracking system (AUSLAB) and supports continuity of specimens.

Significantly, the DJAG agreed to finance the packaging and transport of coroners' autopsy specimens from across the State, thereby relieving the Queensland Police Service of this commitment.

Queensland Health in conjunction with the Queensland Police Service proposes to incrementally implement this new specimen transport system on a site-by-site basis. The system has already been commenced in Cairns and is anticipated to be implemented state-wide by June 2006.

Investigations

With the implementation of the new coronial legislation, procedures for investigating and reporting on reportable deaths were reviewed. Coroners now take a more active role in the direction of the coronial investigation. Coroners now provide early advice by way of a facsimile to the relevant police District Officer regarding their requirements for investigation. This process has resulted in the reduction of timeframes in the finalisation of most reportable deaths, more efficient investigative processes and improved coordination between Queensland Police Service, Queensland Health and coroners.

Virtual autopsy—post mortem radiology

Partly in response to the sensitivities many people feel in relation to internal autopsies and partly in an effort to make better use of developing technology, there is increasing interest in the use of various technological scanning instruments in post mortem examinations. CT scans, MRI, ultrasound and plain x-rays are all examples of technology that can provide information that, in some cases, would not be available without surgically opening the body. In other cases these technologies can provide more information than is available by traditional internal autopsies.

Scientists in the United Kingdom, Switzerland and the United States are leading the development of a more innovative application of these technologies to death investigation. These developments are now being more seriously considered in Australia.

Issues of access to the technology and cost will need to be addressed but it seems likely that in the future far greater reliance will be made on these techniques.

The State Coroner and the Chief Forensic Pathologist therefore benefited by attending a conference which explored developments in this approach to post mortem investigation.

Transportation of human remains—body bag trial

The Queensland Police Service is responsible for engaging government contracted undertakers to transport the bodies of deceased persons, sometimes over long distances, for lodgement at mortuaries for subsequent autopsy examination. As a result, a trial for police was introduced in the Redcliffe, Deception Bay, Caboolture and Brisbane Island police divisions whereby the deceased person is placed in a sealed and specifically tagged body bag for transportation to the JTC in Brisbane. This procedure alleviates the need for police to escort the body to the JTC mortuary.

The Queensland Police Service is undertaking an extensive evaluation of this project with the view to further extending this process in suitable areas across the State.

Service Level Agreement between OSC and QHSS

One of the main purposes of the Service Level Agreement (SLA) between the OSC and QHSS is 'to minimise bereaved families' distress and facilitate investigations by coroners and police'.

It was envisaged that this could be achieved, in part, by establishing mutually agreed turnaround times for completion of autopsy reports.

It is outlined in one of the guiding principles in the SLA that autopsy reports will be completed within the agreed time frames or within two weeks of receiving the last test result in 90% of cases. These time frames vary according to the complexity of the case as follows:

'External only' cases

No internal examination
2 weeks *

Simple cases

Heart attacks, motor vehicle accidents, drug overdoses
4 weeks *

Complex cases

Most homicides, suspicious deaths, deaths in care or custody, complex s8(3)(d) cases
8 weeks *

SUID cases

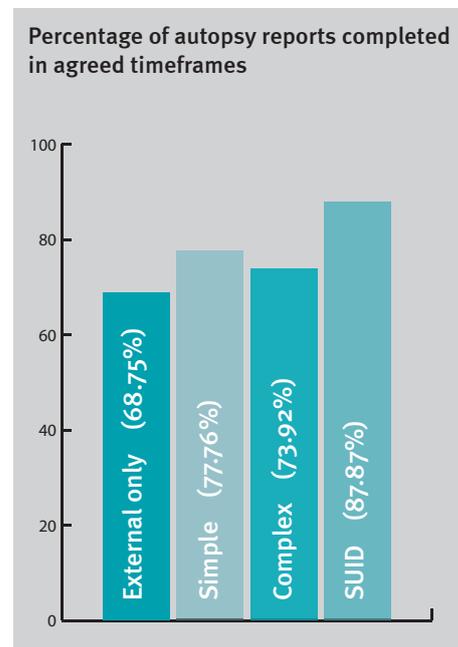
All sudden unexpected infant deaths (SUID) under 2 years old
12 weeks *

** (or within two weeks of receiving last test result)*

Although the current SLA was not officially endorsed until April 2005, Forensic Pathology, QHSS began collecting data to calculate these turnaround times in October 2004 using the information management system, AUSLAB. Data from October 2004 to June 2005 has been analysed to gauge the achievements of Forensic Pathology in relation to the projected turnaround times during this period. See Table 8.

It is believed that setting a target of 90%, which may be high in comparison to benchmarks set by other organisations, serves as a goal to work towards each year. Forensic Pathology achieved an overall average of 77.07% which is consistent with reported results for other organisations (*cf.* 71.09%—Victorian Institute of Forensic Medicine Annual Report 2004) and provides motivation for identifying business enhancements during the next twelve months. It is hoped that the expansion of the AUSLAB system throughout regional Queensland will increase the capture of information on all coronial autopsies and will enhance future statistical analysis.

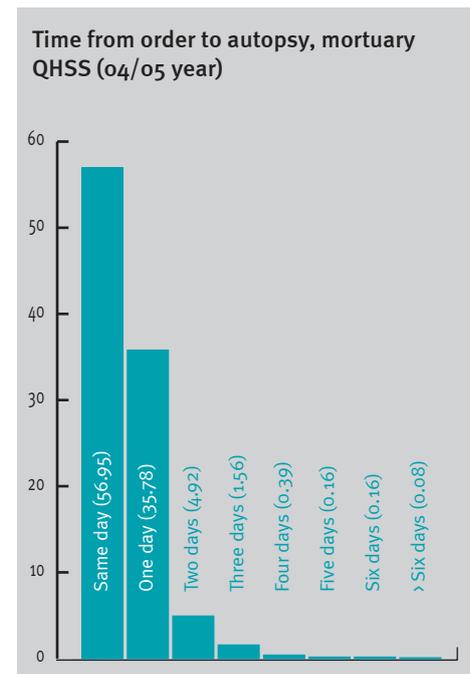
Table 8



Autopsy rates

As discussed earlier in this report, the new Act gives family members a right to have their views considered by the coroner who is determining what type of autopsy will be undertaken. Prior to the introduction of the Act there was concern that this might lead to an unacceptable delay in the undertaking of autopsies as the family, the coroners and the counsellors went back and forth trying to resolve any concerns. As Table 9 shows, these anticipated delays have not eventuated. Thanks to the industry and application of the staff of the JTC mortuary and the counsellors, autopsies have been undertaken very expeditiously in the vast majority of cases. For example, for the financial year ending 30 June 2005, 96% of autopsies were performed within 3 days of lodgement and 93 % of all autopsies were performed on the day of receipt of the order or the next day.

Table 9



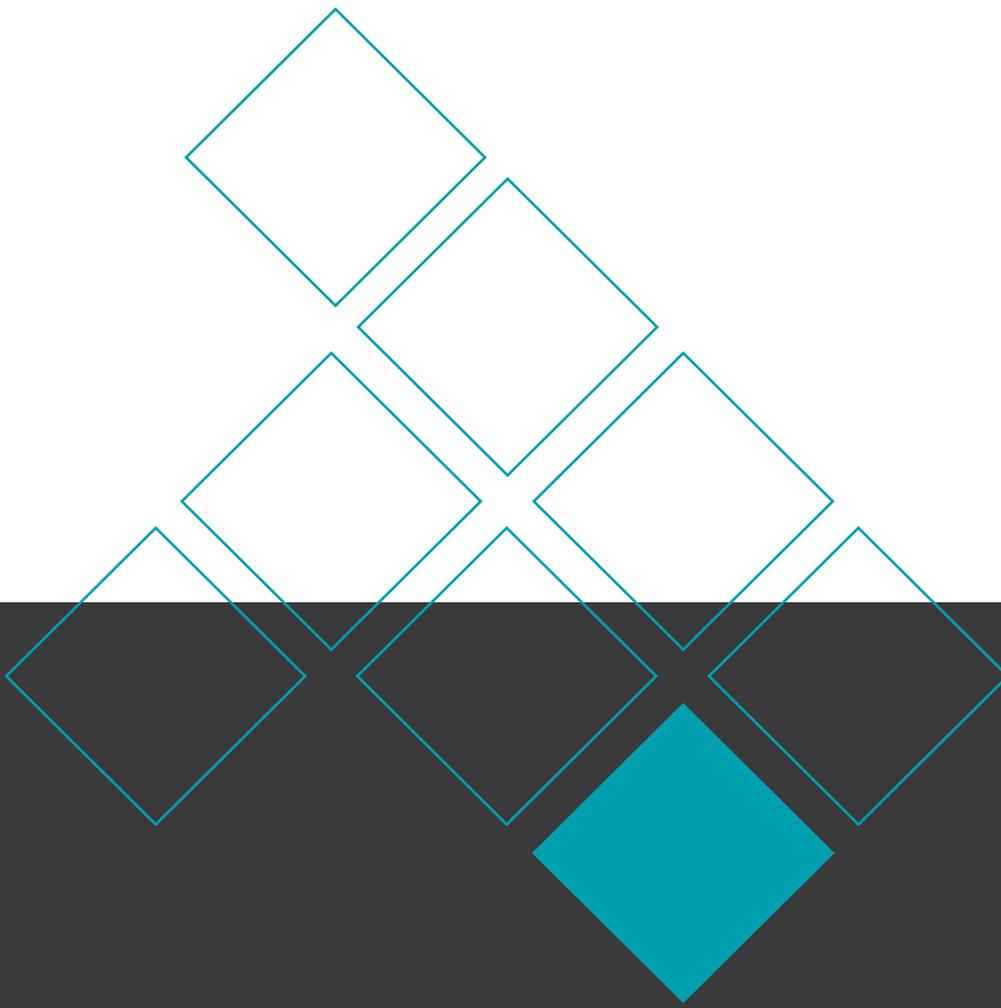
Toxicology and forensic biology rates

In recent years increases in staffing, improved instrumentation and more efficient work practices have seen significant reductions in the turnaround times and the size of the backlog of post mortem toxicology cases.

The year 2004-2005 saw forensic toxicology consolidate the improvements made. The turnaround times have remained approximately 55 days throughout the year. This is in agreement with the Coronial Service Level Agreement of 85% of cases being completed within 8-10 weeks. It also should be pointed out that this figure was maintained despite a slight increase in the number of cases received. This increase in sample numbers is part of an increasing trend that has been observed for a number of years.

The past year also saw a significant reduction in the number of cases greater than three months old, decreasing from over one hundred cases down to ten. This downward trend is also present for cases greater than two months old. These two parameters can be viewed as a measure of the backlog and their reduction indicates how the forensic toxicology backlog has been reduced.

Another area where forensic toxicology has made a significant contribution is in the provision of accelerated testing. Here a 24-hour turnaround service is available for targeted drug analysis thereby giving pathologists rapid toxicology information which can then be used to determine whether a full or partial internal post mortem examination is necessary.



Challenges for the future

Introduction

As this report demonstrates, a new coronial system introduced by the *Coroners Act 2003* has had a relatively smooth implementation; there have been no major or ongoing problems and on most indicia, there have been significant improvements in the way sudden or unexpected deaths have been investigated and processed by the system.

There are of course, challenges confronting continuing improvement in the jurisdiction. Some of those challenges are commented as follows.

Part-time coroners

The State Coroner and the Deputy State Coroner are the only full time coroners in Queensland. All magistrates by virtue of their office are coroners, however, most spend only a very small proportion of their time exercising that function. This makes it difficult for those coroners to develop sufficient expertise to keep pace with developments in the field.

It is also difficult for magistrates to respond as quickly and as frequently as is optimal in the new more responsive coronial setting. Under the previous system, the Clerk of the Court issued the autopsy order and the police conducted a routine investigation. Nothing was required of the coroner until the final police report was received and considered. Under the system introduced by the Act, magistrate/coroners must issue autopsy orders after having considered any objections family members may have and having established the availability of an appropriately qualified medical practitioner to undertake the autopsy.

Not infrequently, further inquiries will need to be made and concerns responded to before this first step can be completed. Similarly, if under the new system, the pathologist wishes to retain an organ, the family's views need to be considered and the coroner needs to be persuaded that this is necessary for the purposes of the investigation. As magistrate/coroners spend most of their time in court, even getting an opportunity to consider these issues can be problematic.

These problems could best be addressed by the appointment of more full-time coroners.

Extension of counselling services state-wide

Coronial counsellors based at the JTC provide a very valuable service to the families of deceased persons and the coroners based in the south-east corner. Details of their work are set out on page 39. A limited service is also available over the telephone but this is more difficult. In remote regions, local social workers employed by hospitals are frequently called upon to perform some of these services with varying degrees of success. A significant increase in the number of counsellors at the JTC, sufficient to provide a state-wide service, is eagerly anticipated.

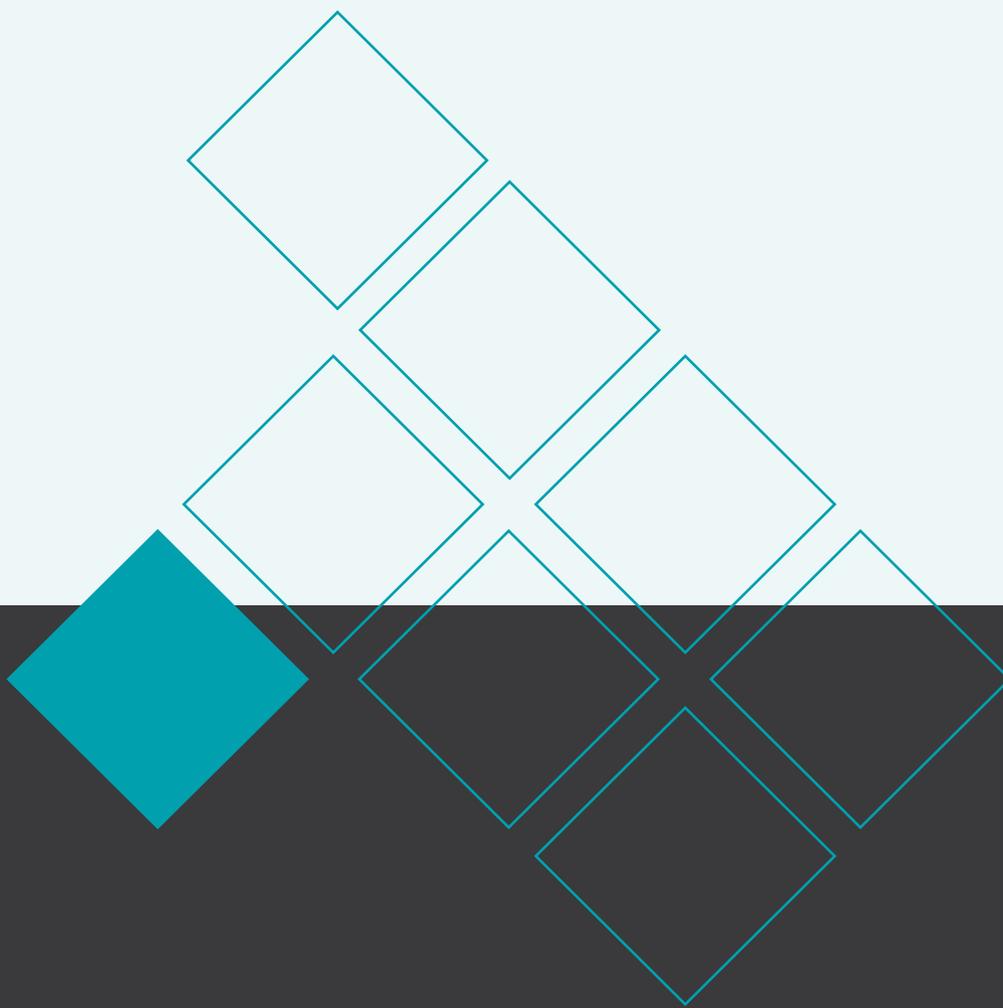
Data retrieval trend analysis

As has hopefully been made clear by earlier parts of this report, the prevention of fatalities is a major focus of the new coronial system. To a large extent this depends upon an ability to retrieve information about previous investigations and to analyse death trends in order to make assessments of the need for investigations. Currently the only database readily available for that purpose is QWIC. This system is not designed for this purpose and cannot cope with many of the demands placed upon it by coroners.

Coroners also have access to the NCIS but this database does not contain up to the minute information and has a number of other limitations. The development of a database/case management system that could specifically handle all Queensland cases is urgently needed.

Investigation and medical deaths

Coronial systems around the western world depend for their effectiveness on the willingness of medical practitioners to report deaths of patients that could have been avoided. Regrettably, broad experience demonstrates not all medical practitioners can be relied upon to do this. Even if the deaths are reported, coroners who are legally trained are not well placed to undertake the investigation of these matters. In many of the other settings in which coronial deaths occur – aircraft accidents, marine accidents, traffic accidents – there is a specialist investigative agency that makes inquiries and reports to the coroner. No such agency is available to assist with the investigation of medical adverse events resulting in death. It is hoped that the foreshadowed Health Quality and Complaints Commission may discharge this function.



Appendices

Appendix 1: Those consulted regarding draft guidelines and the new coronial system

Queensland Police Service

Commissioner Robert Atkinson
Deputy Commissioner Richard Conder
Assistant Commissioner Peter Swindells,
State Crime Operations Command
Assistant Commissioner John Banham,
Operations Support Command
Detective Inspector Michael Condon,
Homicide Squad
Superintendent Paul Stewart, Forensics
State Co-ordinator, Disaster Victim
Identification Squad, Senior
Sergeant Ken Rach

Officer in Charge, Cultural Advisory
Unit, Inspector John Fox
Chief Superintendent Kerry Dunne,
State Traffic Support Branch
Officer in Charge, Arson Investigation
Unit, Detective Sergeant Bob
Campbell
Queensland Police Service Solicitor,
Colin Strofield

Queensland Health

Director General, Dr Robert Stable
Chief Health Officer, Dr Gerry Fitzgerald
Dr Steve Buckland, General Manager,
Health Services
Dr Peter Lewis-Hughes, State Manager
Pathology Scientific Services
Dr Charles Naylor, Chief Forensic
Pathologist
Dorothy Vicenzino, Risk Management
Co-ordinator
Jane Carlisle, Project Officer, Coronial
Data Project
Tina Cooper, Manager, Queenslanders
Donate
Dr Peter Holt, Government Medical
Officer, Thursday Island
Dr Don Buchanan, Manager,
Government Medical Officer Services
Dr Alun Richards, Manager, Drugs of
Dependence Unit
Dr Brian Bell, Medical Superintendent,
Gold Coast Hospital

Women's Legal Service

Zoe Rathus, Co-ordinator
Pam Godsell, Social Worker

**Gold Coast Domestic Violence
Prevention Centre**

Betty Taylor, Co-ordinator

Division of Workplace Health and Safety

Judy Bertram, General Manager
Peter Lamont, Assistant General
Manager
Colin Roundtree, Director, Legal and
Prosecution Services

**Office of the Director of Public
Prosecutions and Crown law**

Paul Rutledge, Deputy Director of Public
Prosecutions
Conrad Lohe, Crown Solicitor
Bill Isdale, Executive Legal Consultant
John Tate, Executive Legal Consultant

**Department of Natural Resources
and Mines—Safety and Health Mines
Inspectorate**

David Mackie, Deputy Chief Inspector
Mines (Tech), Mining Policy and
Coordination
Peter Dent, Executive Director, Safety
and Health Division

Miscellaneous

Professor Nicholas Bellamy, Qld Trauma
Registry
Dr Rob Pitt, Director, Qld Injury
Surveillance Unit
SIDS and Kids Queensland
Gavin Bird, Schizophrenia Fellowship
Professor Diego De Leo, Director,
Australian Institute of Suicide
Research and Prevention
Michael Rolands, Cultural Heritage
Branch, Environmental Protection
Agency
Ian Boardman, Public Advocate
Des Tanner, Registrar of Births, Deaths
and Marriages
Rob Graham and Alan Stray, Australian
Transport Safety Bureau

Appendix 2: Presentations

Qld Law Society—Member benefit teleconference, July 2003, *The Impact of the New Coroners Act on Practitioners*.

Queensland Legal Studies—Teachers State Conference, August 2003, keynote address, *The Role of the State Coroner*.

Corruption Prevention Network—launch, September 2003, *The Impact of Public Sector Ethics on Public Administration*.

Brisbane Incident Management Co-ordination Group—September 2003, *The Contribution of the Coronial System to Reduced Traffic Incident Deaths*.

Qld Police Service—Management Development Programme, September and November 2003, *Leadership, Management and Supervision*.

Department of Natural Resources and Mining—Safety and Health overview meeting, September 2003, *Improving the Integration of Coronial and Safety Investigations in Mining, Gas and Petroleum Incidents*.

Nambour Hospital Staff Conference—September 2003, *The Role of the Coroner in Medical Deaths*.

Queensland Health Medical Superintendents Annual Conference—September 2003, *The Role of the Coroner in Medical Deaths*.

Australasian Coroners Society Annual Conference—October 2003, *The Fundamental Review in England and Wales, Comparisons with the Qld Experience*.

Central Queensland Law Association Annual Conference—November 2003, *A Death in a Workplace – a Hypothetical*.

Medico-Legal Society of Queensland—November 2003, *Life After Death—A Coroner's Christmas*.

The Qld Paediatric Quality Council and the Qld Maternal and Perinatal Quality Council—November meeting, *The Coroners Contribution to Quality Assurance in the Examination of Infant Deaths*.

Logan Hospital Law and Ethic Day—February 2004, *The Role of the Coroner in Hospital Deaths*.

Princess Alexandra Hospital—In service training day, February 2004, *The Role of the Coroner in Hospital Deaths*.

Queensland Police Service Juvenile Aid Bureau O/Cs conference—February 2004, *The Investigation of SUIDS*.

Queensland Police Service Disaster Victim Identification Squad training course—March 2004, *The Role of the State Coroner in Disaster Victim Identification*.

Queensland Annual Magistrates Conference—March 2004, *The New Coronial System—the Experience So Far*.

The Palliative Care Network Brisbane Forum—March 2004, *The Role of the Coroner in End of Life Management*.

The Royal Australian College of Medical Administrators—April 2004, *The Coroners Act 2003 – What's Working and What's Not?*

The Australian College of Health Service Executives—April 2004, *Implications of the Coroners Act 2003 for Health Service Providers*.

Gold Coast Hospital—May 2003, *The Coroners Act 2003, Medical Practitioners Responsibilities and Obligations*.

Royal Brisbane and Women's Hospital Emergency Surgery Team—May 2004, *Medical Deaths and the New Coroners System—What to Report, When and to Whom.*

Redland District Hospital—May 2004, *The Coroners Act 2003—the Impact on Hospital Practice.*

Queensland Health Residential Aged Care Workshop—May 2004, *The Coroners Act 2003—the Implications for Aged Care Practitioners.*

Division of Work Place Health and Safety, Advanced Investigators Training Workshop—May 2004, *The Coroners Act 2003—the Impact on WH&S Investigations.*

Queensland Police Service Watch-house Managers Annual Conference—June 2004, *The Impact of the Coroners Act 2003 on Custodial Death Investigations.*

Mater Hospital Continuing Education Centre—July 2004, *Autopsies, Post Mortems and More.*

Logan Hospital Grand Rounds—July 2004, *Coroner's Cases—How to Identify Them and What to Do with Them.*

Legal Aid Office Q—August 2003, *The Coroners Act 2003—Implications for Legal Practitioners.*

Mt Olivet Hospital—September 2004, *Medical Adverse Events and Coroners Cases.*

Wesley Hospital—September 2004, *Coroner's Cases—How to Identify Them and What to Do with Them.*

Royal Brisbane Hospital Grand Rounds—September 2004, *How to Identify Them and What to Do with Them.*

QUT Master of Laws program—October 2004, *The New Coronial System in Queensland.*

Child Death Review Workshop—October 2004, *The New Queensland Coronial System.*

Holy Spirit Northside—October 2004, *Coroners Cases—How to Identify Them and What to Do about It.*

Brisbane Airport Emergency Committee—November 2004, *The Role of the State Coroner in an Air Disaster.*

Mater Hospital—February 2005, *Coroners Cases—How to Identify Them and What to Do About It.*

Child Death Case Review Committee—February 2005, *The Role of the Coroner in Child Deaths.*

Dept of Emergency Services Control and Command course—March 2005, *The Role of the State Coroner in Major Incidents.*

Ipswich Base Hospital—April 2005, *Coroners Cases—How to Identify Them and What to Do About It.*

Clinical Forensic Medicine Unit—April 2005, *What's Expected of Expert Witnesses—The Perspective of the Judiciary.*

Division of Work Place Health and Safety, Advanced Investigators Training Workshop—May 2005, *The Coroners Act 2003—the Impact on WH&S Investigations.*

Queensland Health—ABI Mental Health and Extended Services Reference Group—May 2005, *Coroners Cases—How to Identify Them and What To Do About It.*

Australian Institute of Management, Qld Criminal Justice Chapter—June 2005, *Matrix Management in an Inter-Disciplinary Setting—The Qld Coronial System.*

Medico—Legal Society of Qld, Annual Conference—June 2005, *Punishing Practitioners to Protect Patients, Does It Make Sense?*

Caboolture Public Hospital—July 2005, *Coroners Cases—How to Identify Them and What To Do About It.*

Department of Emergency Services, Command and Control Conference—August 2005, *The Role of the Coroner in a Mass Fatality Disaster.*

Crime Statistics Network Seminar Presentation—April 2005.

Gold Coast Institute of TAFE, Pre and Post Enrolled Nurses—April & June 2005.

Redcliffe Hospital—March 2004.

QHSS Legal and Admin Law Unit, Professional Development Session—April 2004.

Queensland Health, Longreach Health Service District, Managers—June 2004.

Queensland Health, Longreach Health Service District, Doctors—June 2004.

Queensland Police Service, Longreach—June 2004.

Guild of Air Pilots and Air Navigators—September 2004.

Peri-Operative Nurses Assoc of Qld, Annual Conference—September 2004.

Peri-Operative Nurses Study Day Presentation—October 2004.

Bethesda Nursing Home—October 2004.

Hostel Owners and Managers Forum—November 2004.

QEII Hospital—December 2004.

Nursing and the Law Conference—December 2004.

Presentations to combined groups of Magistrates, Doctors and Police were also held at the following locations:

Beenleigh Magistrates Court

Bowen Magistrates Court

Bundaberg Magistrates Court

Cairns Magistrates Court

Ipswich Magistrates Court

Mackay Magistrates Court

Maroochydore Magistrates Court

Rockhampton Magistrates Court

Toowoomba Magistrates Court

Townsville Magistrates Court

Appendix 3: Queensland Public Hospitals Commission of Inquiry

Submission of Michael Barnes, State Coroner

Introduction

This submission contains my views on the appropriateness of the definition which determines whether hospital deaths are reported to a coroner and observations about how such deaths are dealt with by coroners. It also contains suggestions about how those processes might be improved.⁶

Although there is some overlap, the challenges encountered by coroners in responding to deaths that occur in a medical setting or are contributed to by suboptimal medical care can be grouped into two categories, namely, issues concerning the reporting of such deaths and the difficulties of investigating them.

Reporting problems

The *Coroners Act 2003* by s8(3)(d) requires a death to be reported to a coroner if it *'was not reasonably expected to be the outcome of a health procedure'*. This replaces the requirement of the *Coroners Act 1958* to report deaths that occurred while the deceased was *'under an anaesthetic in the course of a medical, surgical or dental operation'*.

Presumably, the change was designed to shift the focus from when the death occurred to why the death occurred. It is easy to think of examples in which a death might occur during an operation which would not excite the interest of a coroner whose primary focus is to investigate unnatural, sudden or suspicious deaths; equally the fact that the patient survives the operation only to die a day or so later should not preclude a coroner from considering whether substandard care contributed to the death. However, the change of wording, designed to cause the involvement of coroners in cases which suggest that something might have gone wrong, brings with it other problems.

For example, whose expectation is it that triggers the obligation to report? When discussing the subsection with doctors, I have suggested the test is whether a medical practitioner familiar with the condition of the patient before the procedure that led to the death would feel obliged to warn the patient and his/her family that there was a real and substantial risk of death rather than just the ordinary risk that accompanies, say, every general anaesthetic. The difficulty is determining when the possibility of death becomes so great that it can be said to be a reasonable expectation. I am aware that some hospitals employ risk assessment systems that enable them to express the risk of a fatal outcome in terms of a percentage. I do not consider that approach conclusive for determining whether a death is reportable.

⁶ This submission deals only with the circumstances that apply to deaths covered by the *Coroners Act 2003* which applies to deaths which occur or are reported after 30 November 2003. I recognise that some of the deaths being examined by this Inquiry and many of the deaths still being dealt with by coroners occurred before that date.

Another problem is establishing with sufficient certainty that the health procedure has caused the death rather than the underlying condition that made it necessary.

In respect of both of these issues, in some clear cut cases these questions are easily answered; for example, if a patient presents with a ruptured aortic aneurysm the chances of emergency surgery saving him or her are very slight. Accordingly, during such an operation death would not be '*not reasonably expected*'. Rather, it would be foreseen that it was unlikely that the patient would be able to be saved and that death was a likely outcome. However, as death is certain if the procedure is not undertaken, it usually will be.

Alternatively, it could also be reasonably concluded that the procedure did not cause the death but rather it was caused by the aneurysm. On both accounts the death would therefore not be reportable. On the other hand, if during a colonoscopy the bowel is perforated and the patient dies of peritonitis, there would be a low expectation of death prior to the procedure being undertaken and little doubt that it was caused by the health procedure. The death is therefore reportable because it satisfies both elements of the definition.

However, while these examples may be fairly easy to categorise, in other cases the delineation may be less obvious. Expectation and causal contribution are not matters that can be easily quantified or calibrated; they are to

a large extent subjective and best assessed in a qualitative and relative manner. So that in cases that are less obvious or unambiguous, a different assessment may result depending upon who undertakes it.

Suggestions that elective surgery that results in death should always be reported because death would never reasonably be an expected outcome, in my view, over simplify the issue. For example, a neonate with congenital heart malformation might not be at risk of immediate death but his life expectancy may be no more than a few years and the intervening quality of life poor. Surgical intervention in some of these cases has better chances of success if undertaken as soon as possible. It is high risk but whether a death in these circumstances is required to be reported depends on an assessment of how likely was a fatal outcome.

From one perspective, the person best placed to make that assessment is the person who knows the most about the patient's condition leading up to the death. However, he/she is usually also the person whose performance will be scrutinised if a coroner investigates the death and he/she might therefore not be seen as sufficiently impartial to make an independent judgment on these issues.

This potential or apparent conflict of interest is not limited to post operative deaths however. General practitioners treating patients in their surgeries or the patients' homes frequently issue cause of death certificates in accordance with the obligation placed on them by s30 of the *Births, Deaths and Marriages Registration Act 2003* in circumstances where there is no independent check of whether misdiagnosis or inappropriate treatment by the certifying doctor has caused or contributed to the death. It was the abuse of this arrangement that allowed the mass murder committed by Dr Shipman to remain undetected by the English authorities and led to the *Luce Report* commenting that "there is no reliable mechanism to check that deaths which should be investigated by the coroner are reported to him".⁷

That report recommended that all deaths be subject to a second certification by a doctor who has not been involved in the treatment of the deceased⁸ and the creation of a new post in the coroner's office, filled by a doctor, who would audit death certificates relating to deaths not reported to a coroner to ensure the criteria for reporting deaths were being observed.⁹

The Public Inquiry set up to look into how Dr Shipman's murder of 215 of his patients had gone undetected for over 20 years went further and recommended that all deaths be reported to a

coroner and that there be both medical coroners and judicial coroners. These recommendations were made in recognition of the difficulty, at the time of death, of effectively separating unexpected deaths that warranted some investigation from expected deaths that do not need any scrutiny.¹⁰

As would be expected, I have been working with stakeholders to review the operations of the relatively recently proclaimed *Coroners Act 2003*. In the course of that process the chief forensic pathologist from Queensland Health Scientific Services made contact with numerous medical superintendents and surgeons and sought their views on whether the wording of s8(3)(d) could be improved. No suggestions were forthcoming. I consider it appropriately describes the deaths that should be reported.

In summary, the challenges raised by deaths that occur in a medical setting, so far as their reporting to a coroner is concerned, are determining whether a death is reportable and ensuring that those which do meet the criteria are reported.

⁷ The Home Office, 2003, 'Death certification and investigation in England, Wales and Northern Ireland', The report of the fundamental review, p42

⁸ *ibid*, p51

⁹ *ibid*, p43

¹⁰ The Shipman Inquiry, 3rd report, 'Death certification and the investigation of deaths by coroners', chapter 19

I have sought to address these issues by taking every opportunity to discuss them with medical practitioners and encouraging them to call me or their local coroner if they are in any doubt.¹¹ This approach is buttressed by s26(5) of the Act which provides that a doctor must not issue a cause of death certificate if *'the death appears to the doctor to be reportable unless a coroner advises the doctor that the death is not a reportable death'* and s7 of the Act that makes it a criminal offence not to report those deaths which come within the definition. Notwithstanding, I not infrequently become aware that some hospital doctors do not understand or do not comply with their obligation to report.¹² There is a widespread belief among state and territory coroners and forensic pathologists that these deaths are significantly under reported.

I am not aware of any systematic checking or auditing of compliance with the reporting obligations. As a bare minimum, I consider that post operative deaths should be at least reviewed by a doctor more senior than those involved in the procedure that preceded the death so that some independence can be introduced into the assessment of whether the death should be reported. That would, however, provide no reassurance in relation to deaths which occur in the home and are certified by the deceased person's regular treating general practitioner.

Difficulties in investigating medical deaths

Once a death is reported to a coroner on the basis that it was not an expected outcome of a health procedure, the coroner needs to determine the extent and manner of the investigation of the death.

Which matters warrant investigation?

The Coroners Act in s12(2)(b) recognises that not all reportable deaths need to be extensively investigated. That section enables a coroner to authorise a doctor to issue a cause of death certificate even though the death comes within one of the categories of reportable deaths set out in s8.

Some uncontroversial examples of the appropriateness of such a course are set out below:

- a. A deceased person is found naked in his home with copious blood about his person and possessions. It is reported as a suspicious death but family members and the treating GP subsequently notify the reporting police officer that the person suffered from a severe peptic ulcer. That condition (and a number of others) can result in sudden death and the vomiting of a large volume of blood. An inspection of the residence reveals no signs of forced entry or other interference. The coroner authorises the GP to issue a cause of death certificate showing a bleeding peptic ulcer as the cause of death; and

¹¹ Since my appointment I have made 25 presentations to medical audiences explaining their obligation to report deaths. Those presentations always conclude with my mobile phone number and the advice that I am available to discuss these issues 24 hours a day, seven day a week.

¹² For example, funeral directors occasionally refer to me cause of death certificates indicating that the death has been preceded by trauma and when making presentations to hospitals questions from the audience cite examples of deaths that should have been reported but were not.

- b. An elderly woman living at home falls out of bed and fractures the neck of her femur. She undergoes surgery to enable it to be pinned. Two weeks later while recuperating in hospital, she dies of pneumonia brought on as a result of the immobility and underlying chronic obstructive airways disease. The death is reportable because it can be traced to the trauma of the fall but little is to be gained by conducting an autopsy and investigating the death. The coroner authorises the medical registrar in the hospital to issue the certificate listing the pneumonia, the chronic obstructive airways disease and the fractured neck of femur as the descending causes of death.

The provision may also have application in a preoperative setting when the death is an unexpected outcome of a health procedure. For example, an elderly person with chronic heart disease undergoes surgery for a coronary artery bypass and to replace a leaking mitral valve. The surgical team explain to the patient and his family that the operation is highly risky. The patient dies. The death is reportable because it was not reasonably expected but nor was it completely unexpected and there is no basis on which to suspect that any substandard medical practice caused the death.

A special Form 1A has been created for completion by a doctor who seeks the authorisation of a coroner to issue a cause of death certificate in relation to a reportable death. It requires the doctor to provide information about the circumstances of the death and to submit a draft cause of death certificate for the consideration of the coroner.

However, the difficulty for the coroner considering such a request is that he/she is reliant on the advice of the treating team that nothing untoward occurred and that no aspects of the death warrant investigation. I seek to augment that advice by discussing questionable cases with one of the forensic pathologists from the John Tonge Centre who are always very obliging. I routinely also discuss the proposed course of action with the family of the deceased to ensure that they are comfortable with the proposal not to investigate the death.

In my view, the local coroners and I need access to a dedicated medical officer to review medical charts and the Forms 1A to assist in determining whether a cause of death certificate should be issued without further investigation of the death.

How should medical deaths be investigated by a coroner?

Once a death that has occurred in a medical setting has been identified as warranting a coronial investigation, the next challenge for a coroner is to determine how that should be undertaken and by whom.

Most coronial investigations are undertaken by police officers who have a reasonable level of expertise in investigating matters such as suicides, motor vehicle accidents, homicides and many other matters that frequently come before a coroner. When a death occurs in a more unusual setting that might require an understanding of that esoteric context, specialised investigative bodies undertake the investigation and report to the coroner. For example, inspectors from the Department of Natural Resources and Mines undertake the investigation of mining deaths and officers from Maritime Safety Queensland investigate boating accidents. Aircraft accidents are investigated by officers from the Australian Transport Safety Bureau.

There is no doubt that the investigations of deaths that occur in a medical setting are particularly complex and challenging, yet there is no specialist body that regularly investigates such matters on behalf of coroners. These investigations are left to police officers who have to struggle with two main problems. First, they have little or no expertise in isolating the issues that

need to be examined and so even identifying the appropriate people to be interviewed and then deciding what to ask them can be difficult. Second, hospitals frequently fail to co-operate with police investigations. From across the State I continue to receive complaints from police and local coroners that doctors and nurses will not provide statements despite repeated requests; indeed on occasions police even have to resort to search warrants to obtain medical files. Hospital administrators seem unable or unwilling to help address the problem.

In the past, the medical profession was very reluctant to discuss with patients or their families unexpected negative outcomes of medical procedures for fear of litigation. That reluctance has diminished as medical institutions have recognised their ethical obligation to share information about these incidents with those most affected and realised that full disclosure is more likely to reduce litigation rather than contribute to more and/or bigger civil damages claims.

Most, but not all, hospitals have mortality and morbidity committees that examine adverse events that lead to death or an unexpectedly poor outcome. The processes by which these committees operate and the extent to which they disseminate their findings is varied but they demonstrate that clinicians realise that they are best placed to unpack these troubling events. However, they provide little assistance to coroners as the proceedings of such committees are usually cloaked in secrecy and anonymity which make their deliberations difficult to access.

In my view, similar expertise needs to be made available to coroners so that the families of patients who die can be properly informed about the death, the public can be assured that these death investigations are reviewed by a tribunal independent from the institution in which the death occurred, and the results of the investigation can be appropriately disseminated so that preventive strategies highlighted by the death become more widely known.

Currently, as a result of an arrangement I have put in place with the former Chief Health Officer (CHO), coroners who need to access independent expert medical opinions can approach the CHO to have him/her nominate such an expert. However, those experts can only be provided with medical records and the self serving statements clinicians may have provided as there is no system in place for these witnesses to be effectively interviewed.

On occasions I have received reports of investigations undertaken by senior clinicians appointed to act as investigators under the *Health Services Act 1991*. I have found them to be very useful. I understand the Department's 'sentinel events policy' envisages an investigation being undertaken in relation to all hospital deaths. Consequently, at the conclusion of an inquest I recently undertook, I recommended that the CHO, with my assistance, develop a policy and process for the independent and expert investigation of all deaths that are not reasonably expected to be an outcome of a health procedure. I also recommended that the reports of such investigations should be made available to the coroner and the family of the patient as soon as possible.¹³

The Victorian State Coroner has a more sophisticated system for dealing with such deaths. They are all initially reviewed by a multi-disciplinary team of clinicians who advise coroners whether a death warrants investigation. In the event that he/she accepts the advice of this Clinical Liaison Team that it does need investigation, the team then advises what investigative steps are appropriate and what independent experts might need to provide an opinion in the matter. This information is fed to the police officers undertaking the investigation.

¹³ Findings of the inquest into the death of Katherine Sabadina, @ <http://www.justice.qld.gov.au/courts/coroner/findings.htm>

Conclusions

In my view, no changes are needed to the relevant definition of reportable death because the current wording sufficiently describes those deaths which warrant external scrutiny before registration.

I consider there needs to be ongoing training provided to all doctors to ensure they remain cognisant of their obligation to report.

I recommend that a senior clinician not involved in the treatment of the deceased be required to review each hospital death to determine whether the death should be reported.

I consider there should be some systematic auditing of the compliance with the reporting obligation.

Coroners need better access to independent medical opinion to assist them determine whether deaths that are referred to them by hospitals are reportable and/or warrant investigation. They also need similar assistance to help them effectively investigate these deaths. There needs to be at least one dedicated medically trained person available to assist with these issues.

I recommend that Queensland Health put in place a policy to ensure an investigation is undertaken in relation to each death that occurs in a facility operated by them and that a report of that investigation be provided to the coroner and the family of the deceased.



Michael Barnes
State Coroner

14 October 2005

Appendix 4

Operating Expenses		
	1/12/03–30/6/04	1/7/04–30/6/05
Employee related expenses	\$328,159	\$717,269
Supplies and Services	\$156,427	\$265,695
Burials and Cremations	\$398,633	\$660,471
Conveyance of human remains	\$508,437	\$1,005,216
Post Mortem fees	\$305,209	\$544,622
Counsel fees	\$327,946	\$173,007
Travel	\$25,529	\$61,075
Conferences		\$1,045
Total	\$2,050,340	\$3,428,400

Source: F.R.A.S.

