QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

AMENDED FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Shiralee Deanne Tilberoo and Vlasta Wylucki**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2020/3901; 2018/975
DELIVERED ON:	18 June 2024
DELIVERED AT:	Brisbane
HEARING DATE(s):	6 March 2023 – 13 March 2023
FINDINGS OF:	Stephanie Gallagher, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, deaths in police watchhouses, family liaison, adequacy of care of prisoners and adequacy of prisoner inspections.

REPRESENTATION:

Counsel Assisting: Ms Sarah Lane

Wylucki and Tilberoo Family: Ms K Bryson instructed by Kilroy & Callaghan Lawyers

The Aboriginal and Torres Strait Islander Legal Service: Ms J Kefford instructed by ATSILS

Nurses Gomersall and Armstrong: Ms S Robb instructed by QNMU Law

Queensland Police Service Officers Wiss, Morris, Tarrant and New. Watch House Officers Marshall, Shaw and Gould: Ms S Ford instructed by Gilshenan & Luton

Queensland Corrective Services: Ms J Franco instructed by Crown Law

Commissioner of Queensland Police: Mr M Nicholson instructed by Queensland Police Service Legal Unit

Metro North Hospital and Health Service (MNHHS): Ms N Mason instructed by MNHHS Legal

Queensland Police Service Senior Sergeant Damien Hayden: Mr P Lyons instructed by FC Lawyers

Watch House Officers Ecimovic, Haigh, Baxter, Singh, Mole, Mohr, Connelly, Pinteritsch, Young, Holst and Toleafoa: Ms S Williams instructed by Gilshenan & Luton

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Introduction

1. Vlasta Wylucki was 50 years old when she died in the Southport Watchhouse (**SPWH**) on 1 March 2018. The cause of her death was determined to be ischaemic heart disease due to coronary atherosclerosis. Although this is a natural cause of death, there were concerns about the care and supervision she received in the SPWH in the days leading to her passing, particularly as she was likely to have been suffering from alcohol withdrawal during her time in custody. There were also questions as to whether she should have been given her heart medications while in custody.

2. Shiralee Deanne Tilberoo, an indigenous woman known to her family as Aunty Sherry, was 49 years old when she died in the Brisbane City Watchhouse (**BCWH**) on 10 September 2020. The cause of her death was determined to be a subarachnoid haemorrhage, due to a ruptured berry aneurysm. Although this is a natural cause of death, there were concerns about the care and supervision she received in the BCWH in the days leading to her passing, particularly as she appeared to remain in watchhouse (**WH**) custody for an unusually long period, and she was suffering from heroin withdrawal during her time in custody. In Ms Tilberoo's case, there was also a period of some 8 hours overnight during which it is likely she had passed away and WH officers did not identify any problems.

3. These matters were dealt with together as both concerned women who died of natural causes in a Queensland Police Service (**QPS**) WH and the issue of proper supervision of inmates by WH officers arose in each case. In each case checks were conducted by WH officers which recorded that there were "no problems detected" when, in fact, the women appeared clearly unwell or their state of wellbeing could not be properly discerned. In addition, both women were experiencing some level of substance withdrawal, and the management of their symptoms, as well as other pre-existing health conditions, was an issue to be considered by the court.

Relevant Operational Procedures

4. Chapter 16 of the QPS Operational Procedures Manual (**OPM**) sets out the obligations of QPS and WH officers in respect of persons in custody. The current version (Issue 98, as at 7 February 2024) is available online.

5. The version in operation at the time of Ms Wylucki's death was Issue 62.1: 12 February 2018. Issue 77: 31 July 2020 was in effect at the time of Ms Tilberoo's passing.

6. The relevant sections of the OPM are set out below. Amendments were made after Ms Wylucki's death to Section 16.13.1, Assessment of prisoners. Amendments were also made after Ms Tilberoo's passing to Section 16.13.3, Prisoner/WH inspection. The amendments made after Ms Tilberoo's passing were made in direct response to the circumstances of her case. The amendments to both of the sections of the OPMs are indicated below by underlining & strikethrough.

7. The purpose of chapter 16 is to:

   (i) reinforce the legal obligations of police officers and watchhouse officers to care for the health and safety of persons in their custody;

(ii) set uniform minimum standards of custodial care throughout the State;
(iii) consolidate policies, orders and procedures for the performance of duties; and
(iv) allow additional station/establishment instruction where necessary.'

16.1. Introduction

8. Section 16.1.1 details that QPS officers and WH officers have a duty of care to those persons in their custody '*which is recognised in both criminal and civil law*':

Section 285 of the Criminal Code imposes duties to provide the necessaries of life. Section 285 imposes the same duty on one having charge of another who is unable by reason of that person's detention to provide themselves with the necessaries of life, as it does on a parent in relation to that parent's child. Therefore, the people to whom necessaries are being provided are the persons who are being detained.

16.4 Responsibilities of officers

9. Section 16.4.4, guarding of persons in custody, provides:

When a police officer or watchhouse officer is required to tend or guard a person in custody responsibility for duty of care of the person in custody rests with that police officer or watchhouse officer. Where more than one police officer or watchhouse officer is required to tend or guard a person in custody the senior police officer or senior watchhouse officer is the responsible officer.

16.8 QPRIME custody, search and property reports

10. Section 16.8.4, maintaining QPRIME custody and search records details:

When a change in status occurs to a person who is recorded on any QPRIME custody and search reports, this change is to be recorded accurately and appropriately in the relevant report. The responsible officer is to ensure that the appropriate QPRIME custody and search report is maintained until the person is:
(i) no longer in the company of an officer for the purpose of being questioned about his or her involvement in the commission of an indictable offence;
(ii) released from custody; or
(iii) transferred into the custody or company of another person or organisation.'….
…
Officers in charge are to ensure regular checks are conducted of QPRIME custody records linked to their unit, at least monthly, to ensure officers at their station, establishment or unit are complying with the requirements of this section.'

16.9 Lodging a prisoner in the WH

11. Section 16.9.4, responsibilities of receiving officer and prescribed police officer accepting a prisoner into a WH, provides:

When a person in custody is taken to a watchhouse, the receiving officer is responsible for ensuring that at the earliest reasonable opportunity:
(i) the prisoner is placed on the relevant QPRIME whiteboard; and
(ii) *an assessment of the prisoner is conducted.*

12. Section 16.9.5, determining the frequency of prisoner inspections, states:

In determining the frequency of prisoner inspections, the police officer or watchhouse officer assessing a prisoner is to consider that:

(i) prisoners are to be inspected regularly at varying intervals (the intervals between inspections is to be no greater than one hour);

(ii) inspections are to be conducted on a basis consistent with the prisoner's risk assessment level;

(iii) a prisoner displaying suicidal tendencies is to be closely monitored until medical attention can be obtained; and

(iv) where a professional healthcare provider has assessed a person as fit to remain in custody, that person must be subject to periodical checks every thirty minutes (minimum) for the initial four hours after the assessment, as per level 3 – Medical (see below). Such medical inspections are to be carried out in accordance with s. 16.13.3: 'Prisoner/watchhouse inspection' of this chapter.

The greater the risk assessed, the more frequently an inspection will be required.

The following time levels of inspection frequency are to be considered the minimum standard times acceptable and are to be recorded in the QPRIME custody suite 'Level of Observation' field:

(i) Level 1: General – sixty minutes or less. This is for normal prisoner inspections;

(ii) Level 2: Intermittent – thirty minutes (where the member conducting the checks is to interact with the prisoner). Typically, this frequency of inspections related to a prisoner with a higher than normal risk, such as contraband, possibly suicidal etc;

(iii) Level 3: Medical – as a minimum thirty minutes for the first four hours, with the results of the three stage assessment (open eyes/respond verbally/move limbs) recorded in the detention log; and

(iv) *Level 4: Constant – constant visual supervision in the case where a person in custody has known significant risk factors (actively attempting self-harm).*'

<u>16.13 Healthcare of persons in custody</u>

13. The introduction makes the following comments:

Members are to be mindful of the need to continually reassess the healthcare needs of persons in custody throughout the duration of such custody.

It is the responsibility of each officer who forms a reasonable degree of suspicion (see definitions of this manual) with regards to the health of a person in custody, either in a watchhouse or not, to contact or cause to be contacted a professional healthcare provider (see also the State Watchhouse Coordinator's 'Statement of Intent' on the Service Intranet.'

14. Section 16.13.1, Assessment of prisoners, notes:

Every person in custody, whether held in a watchhouse or not, is to be assessed and reassessed as appropriate using Appendix 16.1: 'The assessment of persons in police custody' of this chapter.

Where a person is taken to a watchhouse the receiving officer is to complete, at the earliest opportunity, the QPRIME risk assessment regarding:

(i) the person's health; and

(ii) officer observations and prisoner injuries.

If a person is compliant:

(i) a request for a voluntary specimen of their breath for a blood alcohol concentration test for the purpose of a health assessment is to be made. There is no requirement for the person to comply with the request; and

(ii) *where the person indicates they are diabetic, a Service glucometer is to be offered to the person to check their Blood Sugar Level (BSL), (see 'Conducting alcohol and blood sugar level tests on compliant persons in custody' of this section).*

Where a reasonable degree of suspicion (see SMD) exists after any assessment of a person in custody (including outside of a watchhouse), the responsible officer is to seek appropriate professional healthcare assistance or advice.

Where a professional healthcare provider is performing duty at a watchhouse, the responsible officer (see SMD) is to consult with the provider regarding a person's health and medical needs (see 'Professional healthcare provider assessment of persons transported to watchhouses' of this section).

A police or watchhouse officer assessing or reassessing a prisoner is to:

(i) observe the prisoner's physical appearance and demeanour;

(ii) seek from the prisoner, police, watchhouse officers or other persons who have had contact with the prisoner, information that will assist in the management of the prisoner;

(iii) determine the healthcare requirements of the prisoner, including the provision of medication/treatment plans (e.g. medical devices or care) and obtaining medical assistance for minor injuries or illnesses. Prisoner healthcare requirements may be determined by:

- *(a) asking other persons who have had contact with the prisoner;*
- *(b) locating medication etc. in their property;*
- *(c) checking all relevant QPRIME entries;*
- *(d) asking the prisoner questions about their health; and*
- *(e) making observations about their health and behaviour; and*

(iv) determine whether the prisoner is:

- *(a) fit to be held in police custody; or*
- *(b) requires the intervention of a professional healthcare provider.*

This determination is to be made by using Appendix 16.1 of this chapter.

The responsible officer is to immediately assess and re-assess the level of supervision and healthcare requirements for a prisoner where the prisoner:

…

(vii) is believed to be heavily intoxicated or affected by drugs; or

(viii is believed to be alcohol or drug dependent. Where any of the above issues are evident, the responsible officer is to ensure that the prisoner is closely monitored while in their custody.

15. Under this section WH officers are to "take into account any ~~special~~ vulnerability, disability or cultural needs and take appropriate action as suggested in Chapter 6…", including:

…

(c) having the prisoner medically assessed by a professional healthcare provider before accepting custody of the prisoner into the watchhouse.

16. This section specifically covers the taking of appropriate action to prevent illness or death from alcohol or drug intoxication, overdose or withdrawal as follows:

Police officers and watchhouse officers are to be aware that in some cases of severe alcohol or drug dependency or intoxication; withdrawal may result in death if the person does not receive medical treatment.

The responsible officer must take appropriate action aimed at preventing the likelihood of a prisoner becoming seriously ill or dying in custody as a result of intoxication, an overdose or withdrawal from a dependency on alcohol or drugs. Appropriate action may include:

(i) monitoring the prisoner for signs, symptoms and behaviours consistent with a person suffering from drug or alcohol intoxication, overdose or withdrawal. See Appendix 16.10: 'Drug and alcohol intoxication, overdose and withdrawal' of this chapter;
(ii) being aware that persons in custody may not be truthful, may refuse or be unable to answer the risk assessment questions asked from the QPRIME Risk Assessment tab about their alcohol or drug intake;
(iii) constant direct/personal supervision of the person; and
(iv) ensuring Appendix 16.1 of this chapter is complied with.

Medical advice or attention is to be sought from a professional healthcare provider if a watchhouse prisoner is discovered to be in possession of drug paraphernalia. This is in addition to any criminal investigation to identify how/when the drugs were brought into the watchhouse.

The greater the likelihood that a prisoner or person in custody may be intoxicated, has taken an overdose or is suffering withdrawal from a dependency on alcohol or drugs, the greater the level of supervision and action that is to be taken to prevent the prisoner becoming seriously ill or dying.
ORDER
Wherever a reasonable degree of suspicion exists regarding a prisoner's health, a professional healthcare provider is to be contacted.

17. Section 16.13.3 again confirms that the '*interval between prisoner inspections is to be no greater than one hour*'. Section 16.13.3 also notes that:

- *OIC of stations or establishments are to ensure any reasonable requests made by a watchhouse manager to ensure compliance with this section, including supply of officers to assist watchhouse staff in making checks on prisoners within watchhouse cells or modifications to watchhouse cells, are considered.*
- *OIC of regions are to ensure prisoners held in watchhouses are inspected where practicable by a police officer other than a police officer involved in the administration of the watchhouse (independent inspection officer) on at least one occasion each shift during which the watchhouse operates (at least 3 checks in a 24-hour period for a 24-hour watchhouse) and further as appropriate in the circumstances. The independent inspection officer is to be nominated by the OIC of the region and may include, for example, the RDO, patrol group inspector, DDO, or shift supervisor.*

18. Section 16.13.3 requires that prisoner inspections are to be conducted personally regardless of whether CCTV equipment is installed.

19. Section 16.13.3 sets out the criteria for an officer conducting an inspection as follows:

    (i) where practicable and subject to prisoner numbers, prior to the initial inspection, read the information in the QPRIME Custody Report (Full) Detention Log relating to each prisoner;
    (ii) observe the prisoner's physical appearance or demeanour;
    (iii) ask prisoners who are awake if they are well;
    (iv) pay particular attention to any prisoner apparently intoxicated to ensure intoxication is not masking symptoms of a serious medical condition (see Appendix 16.10: 'Drug and alcohol intoxication, overdose and withdrawal', of this chapter);
    (v) ensure a sleeping prisoner is breathing comfortably and appears well by observing the prisoner's breathing and moving. Breathing is to be observed by the rise and fall of the prisoner's chest. In low light conditions a torch or other method of illumination, is to be used to confirm the rise and fall of the prisoner's chest;
    (vi) wake a sleeping prisoner: ~~when the inspecting officer is unsure or has a reasonable degree of suspicion about the condition of that prisoner~~
        a. when they cannot easily observe the rise and fall of the chest;
        b. if unsure of a prisoner's condition and suspects the prisoner may require medical attention;
    (vii) ensure the security of the cell keys and where reasonably practicable, be in the company of a second officer when entering a cell.

20. Section 16.13.3 further provides that the inspection officer who conducts the inspection makes an entry in the QPRIME custody report for each prisoner detailing:

    (i) the date and time of the commencement of the prisoner inspection;
    (ii) the number of prisoners inspected;
    (iii) a brief comment in relation to each prisoner inspected;
    (iv) relevant details where the current assessment differs from the previous assessment;
    (v) any injuries observed on prisoners; and
    (vi) what action, if any, was taken in relation to the prisoner.

21. Section 16.13.4 details the obligations and responsibilities with respect to providing prisoners with medication. It provides that medication '*may be obtained for a prisoner':*
    (i) by using medication or a prescription in possession of the prisoner after seeking medical advice on the medication being required and verifying its contents;
    (ii) by allowing friends or family to supply medication or a prescription after seeking medical advice on the medication being required and verifying its contents;
    (iii) by prescription from a pharmacy or hospital; or
    (iv) *from a government medical officer (GMO), other doctor or registered nurse.*'

Appendix 16.1 The assessment of persons in police custody

22. Appendix 16.1 provides that:

> *If a prisoner or person in custody answers yes to any of the drug and alcohol questions, or exhibits signs or behaviours suggestive of withdrawal, overdose or intoxication, ensure the person is observed closely and comply with the provisions of the subsection titled: 'Preventing illness or death from alcohol or drug intoxication, overdose or withdrawal' in s. 16.13.1: 'Assessment of prisoners' of this chapter.*

23. Appendix 16.1 requires that if a prisoner or person in custody states they require medication or treatment, the relevant officer is to:

> *a. make enquiries with a FMO/GMO, nominated doctor or hospital to confirm the need for the person to have medication or treatment;*
> *b. where necessary obtain appropriate medication or treatment;*
> *c. determine the time the medication or treatment is next required to be provided; and*
> *d. record the result of these inquiries.*

24. The same appendix also notes, relevantly,:

> *Medical advice or attention is to be sought as soon as possible if the person in custody states they:*
>
> *(i) are suffering from, or appear to be exhibiting the signs and symptoms of drug or alcohol withdrawal, as outlined in Appendix 16.10: 'Drug and alcohol intoxication, overdose and withdrawal' of this chapter;*
> (ii) *are suffering from, or appear to be exhibiting the signs and symptoms of a drug or alcohol overdose, as outlined in Appendix 16.10: 'Drug and alcohol intoxication, overdose and withdrawal' of this chapter*'.

Healthcare arrangements in WHs

25. At the time of Ms Wylucki's death, healthcare in the SPWH was provided by nursing staff rostered on day shifts, 8 hours a day, 7 days a week. These nurses were employed by Queensland Health (**QH**) and were Registered Nurses.

26. At the time of Ms Tilberoo's passing, healthcare in the BCWH was provided by nursing staff rostered on day shifts, 8 hours a day, 7 days a week. These nurses were employed by QH at the Clinical Forensic Medical Unit (**CFMU**) and were Registered Nurses. In addition, QH drug and alcohol nurses from the Biala Alcohol and Drug Service visited the BCWH Monday to Friday as the Biala WH Consultation Liaison Service.

27. State-wide, QH mental health nurses from Forensic Mental Health (**FMH**) also visited WHs Monday to Friday. Medical support was provided state-wide to nurses and WH staff by QH doctors at the CFMU. Those doctors were available on-call 24 hours a day, 7 days a week.

Transfer of WH prisoners to correctional facilities

28. Transfers of remanded or sentenced prisoners from WHs to Queensland Corrective Services (**QCS**) custody are managed by QCS Sentence

Management Services (**SMS**). Although some procedures may differ between corrective services facilities, generally a WH will email SMS a daily WH intake list (or prisoner movement sheet) of prisoners considered by QPS to be eligible for intake by QCS. SMS then considers the vacancies in corrective services facilities, and, on the basis of that availability, complies a list of prisoners upon whom pre-admission checks should be conducted to confirm their eligibility. Preference is given to any prisoners listed by the WH as a priority transfer.

29. In the usual course, if a prisoner on a daily intake list is accepted by QCS, they would be transferred to the corrective service facility on the following day. Standard transfers occur during business hours. Requests for priority transfers made other than in the daily intake list are made on a case-by-case basis by WHs and are made by email request to the SMS. Transfers for emergent or medical intakes may occur outside business hours.

30. Section 6(2) of the *Corrective Services Act 2006* provides that a person who is sentenced to a period of imprisonment or is required to be detained for a period of 21 days or less may be detained in the WH for all or part of that period. QCS acts on the basis that WHs should be equipped to care for prisoners for a period of at least 21 days, should a transfer not be effected prior to that time.

Investigation

31. Both deaths were investigated by officers from the QPS Ethical Standards Command (ESC). The investigations considered the circumstances of each death, whether WH policies and procedures had been properly followed by QPS and WH officers, and whether any officer had failed to comply with the relevant policies and procedures.

32. The findings of each investigation are set out below in the discussion in respect of Issue 1 at the inquest.

Autopsy results

Ms Wylucki

33. On 5 March 2018, A/Prof Alex Olumbe conducted a post mortem by way of external and internal examination as well as CT Scans and toxicological testing.

34. Toxicological testing revealed the presence of multiple drugs that had been prescribed to Ms Wylucki in therapeutic and sub-therapeutic levels including diazepam, sertraline and promethazine. No alcohol was detected.

35. A/Prof Olumbe indicated that Ms Wylucki had known and well documented significant natural cardiovascular disease with surgical insertion of a stent and multiple hospitalisations due to ischaemic heart disease. Ms Wylucki also had extensive scarring on her heart (fibrosis) which was indicative of previous non-fatal heart attacks. The post mortem examination confirmed Ms Wylucki's severe coronary atherosclerosis in that her right coronary artery had severe luminal narrowing of more than 75%, her left circumflex coronary artery narrowing of more than 95% and the left anterior descending coronary artery narrowing of up to 70%. A/Prof Olumbe noted that narrowing of the coronary artery by 75% can result in sudden death.

36. A/Prof Olumbe considered that the mechanism of death would have been an irregular heart beat (arrhythmia) however it '*must be admitted, though it is almost impossible to provide objective proof, that the emotional and sometimes physical upset of being arrested and confined may have affected the blood pressure and heart rate sufficiently, by an adrenal response, to have precipitated an acute cardiac crisis in the presence of the severe pre-existing disease i.e ischaemic disease due to coronary atherosclerosis*'.

37. A/Prof Olumbe indicated that there was no injury which would have contributed to Ms Wylucki's death. He determined that Ms Wylucki's cause of death was ischaemic heart disease due to or as a consequence of coronary atherosclerosis (previous angioplasty-stent).

Ms Tilberoo

38. On 11 September 2020 Dr Rebecca Williams conducted an autopsy consisting of an internal and external examination of the body as well as CT scans and toxicological testing.

39. Dr Williams reported that:

> *Post-mortem CT SCANS revealed subarachnoid haemorrhage (bleeding on the surface of the brain), with a distribution suggestive of aneurysmal haemorrhage. Importantly, there were no findings of traumatic injury.*
> *…*
> *INTERNAL POST-MORTEM EXAMINATION also demonstrated subarachnoid haemorrhage. This was due to a ruptured berry aneurysm at the junction of the anterior communicating artery and left anterior cerebral artery of the brain. This is a known cause of sudden unexpected death.*

40. The toxicological test results showed therapeutic amounts of the medications prescribed and administered at the WH, as well as traces of cannabis, methylamphetamine and morphine in amounts which indicated they had been taken sometime prior to entering the WH, and could not have contributed to the death. Alcohol was not detected.

41. Dr Williams concluded that Ms Tilberoo's cause of death was a subarachnoid haemorrhage, due to, or as a consequence of a ruptured berry aneurysm.

Inquest

42. In cases involving a death in custody, an inquest is mandatory pursuant to s27(1)(a)(i) of the *Coroners Act 2003* (**the Act**).

43. An inquest is intended to assist the Coroner to obtain evidence to make the findings required by s45 of the Act. It also provides the public and, most importantly, the family of the deceased, with transparency regarding the circumstances of the death, and an opportunity to obtain information to answer any questions which may have been raised following the death insofar as such matters inform the findings required by s45 of the Act.

44. In accordance with section 45(2) of the Act, the Coroner is required, if possible, to make the following findings at the conclusion of this inquest:

- the identity of the deceased;
- how they died;
- when they died;
- where they died; and
- what caused their death.

45. The evidence which was given at this inquest is sufficient for me to be able to make each of the required findings.

46. It was agreed at the pre-inquest conference in these matters that, in addition to the findings required by s45 of the Act, the following issues were to be explored and determined at the inquest:

    For Ms Wylucki and Ms Tilberoo

    a. The adequacy of checks conducted by WH staff whilst the deceased was in custody;

    b. The adequacy of the provision of clinical treatment in the WH;

    c. The appropriateness of current QPS policies and procedures relating to the supervision of prisoners in WHs; and

    For Ms Tilberoo only

    d. The appropriateness of the communication and liaison with Ms Tilberoo's next of kin and family following her death including appropriate death notification and management of coronial investigations for deaths of indigenous persons in custody.

Evidence

Ms Wylucki

Personal circumstances

47. Vlasta Wylucki was born on 4 April 1967 in Croatia. Her family moved to Canberra when she was two years old. She grew up with two sisters, Karolina and Cynthia.

48. Ms Wylucki married Robin Wylucki approximately 25 years prior to her death and they moved to Hervey Bay about three years later. They bought a farm and animals, which Ms Wylucki was passionate about. The marriage produced two daughters, Laura and Devinah. Ms Wylucki worked in a variety of positions including in the public service in Canberra and assisted her husband in his business in security. About ten years prior to her death, Ms Wylucki studied nursing and then worked as a nurse in Maryborough Hospital.

49. Ms Wylucki's sister, Karolina, and her mother, Zdenka, say that Ms Wylucki and Robin separated approximately five years prior to her death. Ms Wylucki was working as a nurse at the time and struggled to manage the farm on her own as well as raising her daughters, who were then teenagers. Her family said that she had to sell the farm and the animals she loved, and that she started to drink and "go downhill". Ms Wylucki had a number of heart attacks and had a stent inserted.

She had to retire from nursing because of her heart problems. In 2015, she presented to hospital after cutting her wrist.

50. It was around this time that, Zdenka and Karolina convinced Ms Wylucki to move in with them at the Gold Coast. They could then assist Ms Wylucki with her health care. Ms Wylucki was drinking 3 to 4 bottles of wine a day at that stage, and when she was not drinking, she was detoxing. She was sick a lot of the time, and, at times, would have to be forced to eat.

51. Ms Wylucki began having altercations with her family as a result of her drinking. In January 2016. Ms Wylucki was the aggrieved in a domestic violence protection order (**DVO**) naming her daughter, Laura, as the respondent. In March 2016, QPS took out another order in which Ms Wylucki was the aggrieved and Laura's partner the respondent. Ms Wylucki reported that he had assaulted Laura and then threatened to kill Ms Wylucki and her family.

52. On 26 July 2016, Ms Wylucki presented to her GP at Pacific Pines Medical Centre for a mental health care plan. Valium was prescribed, and she was referred to Suzanne Riggs, a psychologist, and Dr John Bou-Samra, a cardiologist.

53. On 7 August 2016, Ms Wylucki presented to the Gold Coast University Hospital (**GCUH**) with chest pain. The diagnosis was heart failure and angina. Ms Wylucki self-discharged, against medical advice, later that day and before further investigations could be undertaken. The following day, 8 August 2016, Ms Wylucki was re-admitted to GCUH with chest heaviness with no associated symptoms. Ms Wylucki was diagnosed with coronary artery vasospasm, her medications were changed, and she was discharged after two days of being pain free and having no further cardiac events.

54. On 16 August 2016, psychologist Suzanne Riggs wrote to Ms Wylucki's GP stating that she had seen Ms Wylucki once but that Ms Wylucki had cancelled her next two scheduled appointments. Ms Riggs noted that Ms Wylucki's dependency on alcohol appeared to be very high (although she was not formally assessed) and, much like other clients with drug or alcohol issues, she was not good at making a commitment to attend appointments.

55. On 19 August 2016, Dr John Bou-Samra wrote to Ms Wylucki's GP. Dr Bou-Samra indicated Ms Wylucki's chest pain commenced in January 2015 and RBWH had performed an angiogram which did not show coronary blockage. Ms Wylucki had re-presented a month later and undergone a stent insertion. Since that time, Ms Wylucki had re-presented to hospital about six times but no further investigation had been undertaken. Dr Bou-Samra considered that recent drug changes made during an admission at Logan Hospital had caused hypotension. He noted that the lack of follow up from hospitals was unusual given Ms Wylucki advised that on four of the admissions her troponin was elevated. He also requested another angiogram. After adjusting her medication and conducting a stress echocardiogram in September, Dr Bou-Samra considered that the results of the investigations indicated strongly against there being any significant fixed coronary obstruction but did not exclude coronary artery spasm. Dr Bou-Samra considered Ms Wylucki was '*currently reasonably well*' and he would see her again '*if need be*'.

56. On 29 November 2016, Ms Wylucki was taken to GCUH on an Emergency Examination Order following self-cutting. Ms Wylucki indicated that she had been

feeling depressed, distressed and unable to cope during the past week or two due to financial stress which included having depleted the entirety of her superannuation account, an outstanding mortgage and an $8,000 credit card debt. She was agitated and upset and had commenced drinking. She then cut her calf five times. Her family were trying to apply a bandage however this agitated Ms Wylucki and QPS were called. QPS reported that Ms Wylucki was suicidal. On assessment at GCUH, Ms Wylucki was considered to have no loss of energy or motivation or pervasively low mood however she reported being stressed. Ms Wylucki also denied self-harm and suicidal ideation. Ms Wylucki was diagnosed with an adjustment disorder and her medications changed. The discharge summary recorded that Ms Wylucki would be followed up by the Acute Care Team (**ACT**) for three or four weeks. Ms Wylucki's GP was recommended to link Ms Wylucki with an outpatient alcohol and other drugs service and assistance in linking up with financial advisors.

57. In reviews with the ACT in December 2016, Ms Wylucki reported that she was detoxing and planning to sell her home in Hervey Bay to deal with her financial issues. She had applied for a disability support pension but this was not supported by her cardiologist, which upset Ms Wylucki. It was recorded that Ms Wylucki was possibly experiencing panic attacks which she could be mistaking for angina, and that, in addition to her alcohol dependence, she had developed a dependence on Valium.

58. On 18 April 2017, QPS was called to the family residence after Ms Wylucki, who was intoxicated, threatened to kill Karolina. QPS applied for and obtained a DVO naming Ms Wylucki as the respondent, Karolina as the aggrieved and Zdenka as a named person. One of the conditions of the order was that Ms Wylucki was not to go within 100m of Karolina or Zdenka but, Ms Wylucki remained living with them as she needed their support. Karolina or Ms Wylucki called the QPS 3 times over the next two months to deal with situations in which Ms Wylucki became aggressive towards her mother and sister when she was intoxicated. These incidents resulted in Ms Wylucki breaching the terms of her DVO as she continued to live with Karolina and Zdenka.

59. On 17 July 2017, Ms Wylucki was detained briefly at the Pacific Pines Police Beat after being found drink driving. Two days later, she was arrested and taken to the SPWH for drink driving and driving without a licence. She was released the same day. On 27 July 2017, Ms Wylucki attended Nerang Police Station in relation to the DVO breaches. She was arrested and taken to the SPWH. She remained in custody until 4 August 2017, when she was sentenced in the Southport Magistrates Court to 12 months probation. No conviction was recorded.

60. After that period, Ms Wylucki continued to see her GP reasonably regularly, but often missed other specialist appointments. On 13 September 2017, her GP noted she had applied to be assessed for the Logan House Residential Rehabilitation Program.

61. On 21 September 2017, QPS was called when Ms Wylucki threatened Karolina and Zdenka with a knife. Ms Wylucki was arrested and taken to the SPWH. She was released from custody on 26 September 2017. On 15 November 2017, Ms Wylucki was sentenced to 2 years probation for the traffic offences and offences arising from the DVO breaches in July and September 2017.

62. On 19 December 2017, Karolina called QPS as Ms Wylucki was drunk and verbally abusive. When QPS attended, Ms Wylucki had no recollection of the incident. She was arrested again on a DVO breach and associated offences and taken to the SPWH. She remained in custody until she was sentenced on 22 December 2017 to 14 days imprisonment suspended for 6 months. That evening, after her release from custody, she was reported walking along the Gold Coast Highway intoxicated. A taxi driver picked her up and took her to the police station, and Ms Wylucki told the QPS that she had been raped by a man who had given her alcohol that afternoon. She did not wish to make a formal complaint. QPS charged Ms Wylucki with an offence of being intoxicated in a public place, and she was taken to the WH.

63. On 27 December 2017, Ms Wylucki's GP recorded that Ms Wylucki was going to Logan House tomorrow. On 31 January 2018, Ms Wylucki's GP recorded that Ms Wylucki had been discharged from the 'rehab centre' due to her ongoing chest pains. A referral was made to Dr Ben Hunt, a cardiologist. On 12 February 2018, Ms Wylucki's GP recorded that Ms Wylucki had an appointment with a cardiologist on 20 March 2018.

64. On 15 February 2018, Ms Wylucki attended court for the public intoxication offence. No conviction was recorded and she was not further punished.

65. Karolina told ESC investigators that Ms Wylucki was compliant with taking her medications when she was not drinking, but that she didn't take them when she was drinking. Karolina also advised them that whenever Ms Wylucki stopped drinking, she would start to suffer from angina so they would go to the doctors for a check-up. According to Karolina, Ms Wylucki would be advised that her heart was normal so she would recommence drinking. Ms Wylucki did not complain of heart issues when she was drinking.

66. In the weeks leading up to her death, Ms Wylucki's daily routine consisted of waking up and having a coffee. By 9:00am, she would ask Karolina take her to the bottle shop to buy alcohol. If Karolina refused, Ms Wylucki would catch a taxi. If Karolina or Zdenka tried to speak to Ms Wylucki about her drinking, she would become verbally and physically aggressive towards them and she threatened to kill Karolina.

SPWH Custody: 28 February – 1 March 2018

67. Ms Wylucki entered QPS custody at the SPWH at 17:51 on 28 February 2018 for the contravention of a DVO as Ms Wylucki, whilst highly intoxicated, demanded that Karolina go to the shops to buy her cigarettes. Karolina refused to go. Ms Wylucki became upset and threatened Karolina and swore at Zdenka.

68. At 17:59 that evening Ms Wylucki was placed in cell 19 with prisoner Bianca Hircoe.

69. At 6:02 the following morning, Senior Constable Marjan Borosak did a round of the cells to see if prisoners wanted a shower, Ms Wylucki could not be roused. WH officers commenced CPR and the Queensland Ambulance Service (**QAS**) was called. Despite efforts to resuscitate her, she could not be resuscitated, and Ms Wylucki was declared deceased at 6:38 am on 1 March 2018.

Ms Tilberoo

Personal circumstances

70. Ms Tilberoo was born on 12 February 1971 in Rockhampton, Qld. She was the 11th of 12 children that Ms Tilberoo's mother raised. They lived next to her father's extended family in Woorabinda. Ms Tilberoo's mother never drank alcohol and raised all the children in the church at Woorabinda.

71. When Ms Tilberoo was nine, the family moved to Brisbane. Ms Tilberoo went to Grade 7 at Kelvin Grove Primary but was not really interested in school. She started sniffing petrol and glue that year, as well as taking heroin. When the year was over, she was on the streets during the day, but would come home every night.

72. Ms Tilberoo's family said that her mother was raised under the era of the Aboriginal Protection Act, and that the trauma from those years "filtered down the generations" and affected Ms Tilberoo and her siblings. Ms Tilberoo didn't have the tools and the mechanisms to overcome this trauma – she loved her family but the streets just kept on calling her back. Ms Tilberoo's family told QPS that:

> *They were under the Act, before the 1967 referendum, so that all came into play. They'd sit around table and talk about it, how their language was taken off them, how their cultural practices were taken off them, living at Woorabinda, these Aboriginal communities were concentration camps, you woke by the bell and you slept by the bell, you toileted by the bell. You weren't allowed outside of your house or your yard at darkness. You can marry that one, you can't marry that one. It's a battle that they still fight to get their people empowered.*[1]

73. Ms Tilberoo had three children, Edward Simpson in 1989, Jason Fisher, in 1992, and Heather Tilberoo, in 1994. Ms Tilberoo suffered from post-natal depression after Edward's birth and was not able to care for her children. The children's fathers and Ms Tilberoo's sister, Davina Tilberoo, cared for the children, and Ms Tilberoo would visit them on and off. Davina always told the three kids "She's your mother and don't you dare despise her for not raising you, youse got the love from us, and the thing is she's got her own demons to fight, she don't need your crap too". Ms Tilberoo's children loved her and understood the challenges faced by their mother.

74. At the time of her passing, Ms Tilberoo had nine grandchildren, and she was looking forward to Jason having another child and Heather having her first. The family said that Ms Tilberoo was always very quiet and reticent, but very giving. She was also cantankerous and stubborn, she could be cheeky and a fiery little thing. Her family didn't judge her and are devastated by her passing.

75. Ms Tilberoo had a significant criminal history and had spent a great deal of time in and out of prison. When she got out of jail, she would be motivated to get off heroin, go to the doctor and get healthy. In 2017, she was treated for hyperthyroidism and had investigations conducted in respect of degenerative changes to the joints in her big toes. She told doctors that she was a daily smoker but that she had not drunk alcohol since she was in her 30s.

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[1] ESC Report, p 102.

BCWH Custody: 6 September – 10 September 2020

76. On Sunday 6 September 2020 at around 03:20 QPS officers came across Ms Tilberoo 'loitering' in an alleyway off Astor Terrace in Spring Hill. She initially gave the officers a false name but, when she was given a requirement to identify herself correctly, she did so. The QPS officers noted that she had four outstanding warrants. The warrants related to 56 offences including offences of failure to appear, enter dwelling and commit an indictable offence, fraud, receiving tainted property, stealing and drug offences. Ms Tilberoo was arrested. A search of her bag and her person was conducted before she was taken to the BCWH.

77. At 06:22 on 10 September 2020, Ms Tilberoo was called a number of times to come and get her medication but she did not respond. WH Officer (**WO**) Michael Ecimovic took her breakfast into her cell. He found her cold to touch and her limbs were stiff. QAS was called but determined that Ms Tilberoo could not be resuscitated as she was clearly deceased. She was pronounced deceased at 06:30 by QAS officers.

Issues

Issue 1 – The adequacy of checks conducted by watch house staff

Ms Wylucki

78. Ms Wylucki entered QPS custody for the final time at the SPWH at 17:51 on 28 February 2018. Sergeant Lyle Wiss was the afternoon shift supervisor at the SPWH and says that, during the handover from the arresting officers, they were advised that Ms Wylucki had consumed alcohol. He recalled that Ms Wylucki was not handcuffed when she arrived at SPWH. She was nice, quiet, calm and not dishevelled. She did not present as being intoxicated.

79. Sgt Wiss told ESC investigators that he refused Ms Wylucki bail on the basis that her criminal history was entirely for DV offences, she was on probation and a suspended sentence for breaching DVOs and she was therefore facing a term of imprisonment. Additionally, if he gave Ms Wylucki bail, she was likely to go to Zdenka and Karolina's house, which was the location where the breaches had occurred. Sgt Wiss gave that evidence at inquest. Sgt Wiss also gave evidence at inquest that Ms Wylucki had been placed in Cell 19, as there was an available spot in that cell.

80. At 17:52 WO Daniel Marshall was the "booking-in" officer. He recorded that Ms Wylucki was categorised as a general, level one observation prisoner requiring checks every 60 minutes. He explained during his evidence at inquest that he considered that Ms Wylucki required 'general obs' because of "[h]ow she presented, her compliance. She didn't seem ill at all. She – there was no slurred speech or anything like that. She presented very well and it was just like booking anyone else in".[2] At 17:55, WO Marshall recorded that a PPRA search[3] of Ms Wylucki had occurred.

[2] Transcript, Day 1, T44L3.
[3] A search of Ms Wylucki's person conducted in accordance with the relevant provisions of the *Police Powers and Responsibilities Act* 2000.

81. WO Marshall, as the "booking-in" officer, asked Ms Wylucki health questions. Ms Wylucki advised him that she had a heart condition and had consumed two bottles of wine. WO Marshall recalled that Ms Wylucki appeared to be in good spirits, she was steady on her feet and at one point she stood on one foot to take her other shoe off. Ms Wylucki was joking with the staff when she was asked if she had a belly button and said she was too old for that. WO Marshall gave evidence at the inquest that that Ms Wylucki was not nearly as intoxicated on this occasion as she had been on previous attendances, that "she presented really well. She was in high spirits. She didn't appear overly intoxicated".[4] WO Marshall gave evidence that he did not breathalyse Ms Wylucki because he did not have the authority to do so. The decision about whether or not to perform a breath test was made by the shift supervisor, Sgt Wiss. Sgt Wiss gave evidence that he did not breathalyse Ms Wylucki as she did not appear to be intoxicated. Sgt Wiss advised QPS Ethical Standards investigators that he would only breathalyse incoming prisoners if they appeared to be heavily intoxicated or certain alcoholics who are on a 'list' as, if they are under a certain amount of alcohol intoxication, they need to be taken to hospital on the basis that they are detoxing from alcohol.

82. Ms Wylucki was placed in cell 19 at 17:59 on 28 February 2018 with prisoner Bianca Hircoe. Cell 19 was a single occupancy cell, and had one bed, which Ms Hircoe was occupying. Ms Wylucki was asked to put her mattresses on the floor behind the toilet partition. The layout of this cell meant that the toilet was near the door, so Ms Wylucki was on the other side of the partition from the door and, if she lay flat, only her feet extended past the partition and were visible from the cell door. If Ms Wylucki's feet were not extended, she was not visible through the door of the cell.

83. Sgt Wiss explained to the court the process by which cell checks are conducted. He gave evidence that, in the SPWH, an audible alarm goes off every 50 minutes to remind officers to conduct the physical cell checks. Each cell check is entered into the QPRIME Custody report for each prisoner by the WH officer conducting the check. The WH officer can record whether it was a physical check, which involved entering the cell, or whether it was a check by looking into the cell or by looking at the CCTV of the cell. CCTV footage of each cell was shown on a single screen, which was supposed to be monitored at all times. While the CCTV screen was to be constantly monitored, CCTV check of each cell, conducted by the officer monitoring the screens in the control room, was to be recorded each half hour. The WH officer was also to record whether any problems were noted, or complaints made, by the prisoner during the checks. If a prisoner was asleep, the WH officer was to look for breathing and/or movement to determine that the prisoner was alive.

84. The SPWH CCTV showed that Ms Wylucki appeared to be sleeping from around 20:00. A physical cell check was conducted by WO Benjamin Shaw at 20:07. At 20:58, WO Mathew Gould, accompanied by Inspector Gary Brown, the Regional Duty Officer on shift, conducted a physical cell check. At 22:00, Constable Bradley New conducted a physical cell check. CCTV showed that Ms Wylucki's feet would have been visible during these physical checks.

85. At 22:41, Const. New conducted a physical check. He left and then returned with WO Kylie Hanna, who unlocked and entered the cell. Const. New told ESC officers during the investigation that he couldn't see any movement in Ms

[4] Transcript, Day 1, T42L10.

Wylucki's feet, so he went to get and other officer so they could open the cell. WO Hanna unlocked the cell. She entered far enough to see Ms Wylucki around the partition and waved at her. WO Hanna told investigators that Ms Wylucki woke up and WO Hanna said 'Oh is that you Ms Wylucki'. Ms Wylucki smiled. WO Hanna apologised for waking Ms Wylucki and advised her to go back to sleep.

86. At 23:41 Const. New conducted a physical check but did not enter the cell. CCTV showed that Ms Wylucki's left calf and foot would have been visible at this time. At 00:20 and 01:11, WO Hanna conducted physical checks during which Ms Wylucki's legs were drawn up and no part of her would have been visible from the doorway. At 02:00, WO Greg Tarrant conducted a physical check during which only Ms Wylucki's toes would have been visible.

87. CCTV showed that at 02:04 Ms Wylucki got up to use the toilet. She lay back down briefly afterwards but started coughing and sat up at the end of her bed. At 02:11, she leaned off the end of the bed and vomited. Ms Wylucki cleaned up the vomit with tissues and lay back down at 02:15. By the next CCTV check, entered at 02:22, Ms Wylucki appeared to be sleeping.

88. CCTV showed that by 02:25 Ms Wylucki was sitting up again. She had been restless and kept sitting up and lying back down. She started coughing and appeared to be feeling sick again and/or having trouble beathing. At 02:40 she vomited at the end of her bed. Ms Hircoe told investigators that that she awoke to Ms Wylucki spitting into a tissue and Ms Wylucki was sitting up at the end of her mattress. According to Ms Hircoe, Ms Wylucki said, "I am really sick. Yeah I am really sick". Ms Hircoe asked if Ms Wylucki was ok and went back to sleep. The CCTV showed that Ms Wylucki put tissues on top of the vomit and lay back down at 02:48. At 02:52, Const. New conducted a physical cell check and Ms Wylucki cannot be seen during this check. The situation is the same during the physical check conducted by Acting Sergeant Daniel Morris at 03:43.

89. From 04:14, CCTV showed that Ms Wylucki was restless and appeared to be feeling sick. She sat up and lay down again a number of times. At 4:21, during the CCTV check entered by WO Zane Tripp, Ms Wylucki was sitting with her back to the partition, sighing and sniffing. At 04:26, Ms Wylucki leaned over the end of her mattress, but it was not clear in the CCTV whether she vomited again. She sat up and lay down again repeatedly until the next physical cell check at 04:33. The CCTV showed that Ms Wylucki heard the door to the pod open and turned towards the cell door. Const. New was conducting this check and shone his torch into the cell for 1 second. He did not otherwise interact with Ms Wylucki.

90. CCTV showed that at 04:44 Ms Wylucki was leaning over the end of her mattress breathing heavily and vomiting. At 04:50 she was breathing heavily, was in the process of lying down and then dropped, flat and turned onto her stomach. Ms Wylucki made loud moaning noises, followed by loud, deep breathing and more moaning. Ms Hircoe stirred but did not appear to wake. At 04:52 Ms Wylucki's breathing ceased. Choking or snorting sounds could be heard around 04:53, and then the loud heavy breathing resumed at 04:54. At 04:55 Ms Hircoe asked "are you ok", but no answer could be heard from Ms Wylucki. At 04:56 Ms Wylucki's breathing stopped and there was no further sound or movement from her. At 04:57, Ms Hircoe got up and walked past Ms Wylucki to go to the toilet. She stopped very briefly to look down at Ms Wylucki on her way back, and then went to bed.

91. By the next CCTV check, entered by WO Tripp at 05:21, neither prisoner was moving, and no sounds could be heard on the CCTV footage. At 05:23 Const. New conducted a physical check, during which only Ms Wylucki's feet could be seen beyond the partition.

92. SC Borosak arrived on shift at approximately 05:50. He assisted a night shift officer putting away the laundry. He did a round of the cells to see if prisoners wanted a shower and was at cell 19 at 06:02. Ms Hircoe said that she wanted a shower. SC Borosak tried to rouse Ms Wylucki and saw that her feet were purple. She was deceased.

93. Following Ms Wylucki's death, QPS ESC officers attended the SPWH. Detective Sergeant Sharon Pickett prepared an Investigation Report dated 13 June 2019.

94. In her report, DS Pickett provided a photo of cell 19 and noted that the photo demonstrated the difficulty in observing and conducting a physical cell check on a prisoner positioned behind the privacy screen in cell 19.

95. DS Pickett concluded that hourly physical checks were conducted as required by OPM 16.9.5. Additionally, OPM 16.13.3 was complied with, in that, the Regional District Officer conducted a cell check at 21:01.

96. However, DS Pickett gave evidence at the inquest that she had concerns about the quality of the checks, and therefore requested that Inspector Marcus Cryer, who was then a Senior Sergeant and the Officer in Charge of the BCWH, review the CCTV footage and provide a statement giving his opinion in respect of each of the checks which was conducted.

97. In his statement, Insp. Cryer noted that the classification of Ms Wylucki as a Level 1, requiring hourly observations, was appropriate - if she had taken her medications as prescribed and had that medication with her at the WH. Insp. Cryer's view was that eleven of the hourly checks were inadequate for the relevant WH officer to make a determination, under section 16.13.3, to a satisfactory standard. Insp. Cryer was particularly critical of the 04:33 check during which Ms Wylucki is sitting awake at the end of her 'bed' as he comments "I am of the opinion Ms Wylucki is clearly observed by the officer, is awake and the opportunity to comply with 16.13.3, namely(iii) asking prisoners who are awake if they are well existed at that time". [5]

98. In his evidence at inquest, Insp Cryer agreed that the purpose of physical checks was so that WH staff complied with their obligation, under the OPM, to "continually reassess the healthcare needs of each prisoner".[6] Insp Cryer gave evidence that the reasons he concluded that eleven of the physical checks conducted on Ms Wylucki were inadequate were:

> *…on a number of - on a larger number of those occasions it was - in my opinion, it was a too quick of an inspection. It appeared to me what I would usually refer to that as a person count. It would be - a person would have to have very clear, concise eyes to be able to see a person's rise of the chest, possibly under a blanket or under a shirt. However, a number of these inspections were conducted when Ms Wylucki was behind*

[5] WYLUCKI H1 – Statement of Cryer, para 51.
[6] Transcript, Day 1, T76L3.

a concrete wall. And I think on one occasion you actually couldn't even see her and on other occasions you could see her feet. So they should have done more, in my opinion.[7]

99. He also confirmed the importance of constant monitoring of the CCTV screen, which allowed WH staff to observe incidents in the cells in between the physical checks. He confirmed that, if WH staff monitoring the screens had noticed Ms Wylucki vomiting, the appropriate action would have been:

    [i]mmediate attendance at the cell where she was and understanding possibly the cause of that. And if that was the case, the high probability of contacting the ambulance to come in and check on that person.[8]

100. In her report DS Pickett said that the failure of SPWH staff to comply with OPM 16.13.3 was not through a lack of awareness or knowledge as she considered that all staff interviewed were aware of their obligations regarding the duty of care of prisoners in custody and what was required when conducting physical checks. She gave evidence, in cross examination, that:

    The officers were all aware of what that requirement was. They were all asked to explain what they believed it to be and they all identified that it was to see if the prisoner was breathing or not. So it wasn't lack of knowledge, it just was just lack of compliance.[9]

101. As a result of this identified systemic failure, DS Pickett advised in her report that:

    To mitigate any further risk for the QPS an email was distributed on 16 March 2018 to all officer's (sic) in charge of watchhouses throughout the state to remind their staff of OPM Section 16.13 regarding inspections of prisoners.[10]

102. In her report, DS Pickett also commented that "[t]aking into account the high number of non-compliance physical checks this investigation has identified, it is plausible to suggest this lack of compliance is not restricted to the SPWH but may be a systematic issue in all WHs across the state".[11] DS Pickett recommended that random audits be conducted on physical cell checks across the state to ensure compliance with the OPMs.

103. In the supplementary form 1, dated July 2019, DS Pickett recommended that random audits be conducted on the physical checks throughout the state to ensure QPS staff were complying with Chapter 16. In a supplementary form 1 dated 23 July 2020, DS Pickett indicated that she had met with Inspector Peter Mansfield from Inspections Teams, Integrity and Performance Group, ESC, regarding the current inspections conducted in WHs across Queensland. This team sampled detention logs and correlated them with the respective CCTV footage.

104. DS Pickett recommended that Inspector Brown, WO Gould, WO Hanna, A/Sgt Morris, Const. New, WO Shaw and SC Tarrant be subject to disciplinary action, in accordance with the *Police Service (Discipline) Regulations 1990,* on the basis that the members "demonstrated behaviour that was inefficient and demonstrated a distinct failure in their diligence in failing to conduct physical cell

[7] Transcript, Day 1, T76L48 – T69L5.
[8] Transcript, Day 1, T74L27 – 29.
[9] Transcript, Day 1, T68L47 – T67L1.
[10] Transcript, Day 1, T68L47 – T67L1.
[11] WYLUCKI B1 – ESC Investigation Report, para 5.5.

checks in accordance with QPS Policy and Procedures".[12] DS Pickett recommended that local managerial action be taken.

105. The following QPS staff were subject to a Local Resolution Plan (**LRP**): WO Gould, WO Hanna, A/Sgt Morris, Const. New, WO Shaw and SC Tarrant. The corrective or remedial actions to address the failure to comply with section 16.13.3 of the OPMs was for the relevant officers and staff to participate "in a group discussion regarding the investigative findings, relevant Service policies concerning the custody management of prisoners and ways to improve on systems already in place".[13] The copy of the plan provided to the court shows that all staff with the exception of WO Hanna had complied with the LRP by 6 November 2019.

106. DS Pickett was asked, at inquest, if she thought that the outcome could have been different for Ms Wylucki if the cell checks had been conducted as they were supposed to have been according to the OPMs. DS Pickett's evidence was that:

> *I think given the timings of what the cell checks were done, I think perhaps the only opportunity where there may have been a different outcome is when [Ms Wylucki] was sitting up. Had she been observed sitting up by that officer and if that officer had maybe asked her, and then that would depending I guess on how she responded, because as per that OPM at the night, if they were awake and sitting up, you would probably engaged a conversation with her to see if she was okay, depending on her response.*[14]

107. Insp Cryer was asked whether the setup of Cell 19 was appropriate to accommodate two people in the cell. He advised that it was not, and agreed that the configuration of that cell made it more difficult for the WH officers to conduct their inspections. He was also asked if the outcome for Ms Wylucki could have been different, and gave the following answer:

> *I probably myself go back to when Ms Wylucki was sitting up. I often thought about that after this when I reviewed it. There was an opportunity to actually simply ask her, "Are you okay?" That might have transitioned to, "Actually, no, I'm not. I'm feeling really awful," and from that something else could have happened as in medical attention. So I often thought about that, even like last night and today, that there was an opportunity for that to happen. However, the person may not have seen that opportunity and obviously it never happened.*[15]

Issue 1 conclusions – Ms Wylucki

108. On the basis of the evidence outlined above, I make the following findings in respect of this issue:

    a. With the exception of the physical check conducted by Const. New and WO Hanna at 22:41 on 28 February 2018, the physical checks conducted on Ms Wylucki between 22:00 on 28 February 2018 and 05:23 on 1 March 2018 (inclusive) were inadequate because, as the CCTV footage makes clear, the WH officers could not see Ms Wylucki sufficiently well to assess her on cell checks;
    b. Ms Wylucki's placement in Cell 19, a single occupancy cell, with another prisoner, contributed to the inadequacy of the cell checks; and

[12] WYLUCKI B1 – ESC Investigation Report, para 1.9.
[13] WYLUCKI B5 – Local Resolution Plan, p 1.
[14] Transcript, Day 1, T65L3 – 9.
[15] Transcript, Day 1, T79L10 - 16.

c. Had the checks on Ms Wylucki been conducted in accordance with the OPMs, there may have been an opportunity for her to receive medical attention before her death. Whether or not such medical attention may have prevented her death is discussed below.

109. I accept the submission made by the representatives for the various WH officers from the SPWH that no criticism should be levelled at any officer for Ms Wylucki's placement in cell 19, as the officers were operating in a challenging environment and were constrained by the resources and facilities provided to them by the QPS.[16]

Ms Tilberoo

110. On the way to the BCWH in the early hours of 6 September 2020, Detective Senior Constable Andrew Hines went through a COVID questionnaire with Ms Tilberoo, and she said that she just had a bit of a head cold. At the WH her temperature was recorded as 36.5C.

111. Ms Tilberoo arrived at the WH at 04:05, and at 04:28 she was taken through the medical form by Senior Constable Martin Baxter and answered 'no' too all questions, advising that she did not have any illness or injury, she did not require any medication, she had not had alcohol, drugs or other substances in the past 24 hours, and she did not have a current mental health problem.

112. At inquest, SC Baxter gave evidence that he did not have an independent recollection of Ms Tilberoo, but that the answers to the health questions which he recorded in the custody record were given by her. He also said that he would have observed her during the booking-in process, and he did not have any concerns about her wellbeing. SC Baxter explained during cross-examination that if a prisoner does exhibit signs of alcohol or drug withdrawal during the booking-in process, he would call the doctor to see if that prisoner required medication.

113. After the booking-in process, Ms Tilberoo was charged, and at 06:42 she was put in a two-person cell in East Wing B2 with Nyakelei Apech. A prisoner in the cell next to Ms Tilberoo and Ms Apech's, Tamsyn White, said she remembers Ms Tilberoo constantly throwing up. In her evidence at inquest, Ms White agreed that she was in cell B2, and there was a light well between cells B2 and B1, where Ms Tilberoo and Ms Apech were housed. She could see them through the windows in each cell, which let light in from the light well. Ms White said that she could see Ms Tilberoo lean over the side of her bed to vomit, and that there was "a little river of vomit from [Ms Tilberoo's] bed to the little drain to the middle [of the cell]".[17] Ms White agreed at inquest that she did not go into Ms Tilberoo's cell at any time. Ms White also noticed that Ms Tilberoo was refusing to eat, and saw her refuse breakfast, lunch and dinner.

114. At 17:58, Ms Apech and Ms Tilberoo were woken for dinner. CCTV showed that Ms Tilberoo did not take her meal from the hatch and lay back down with her blanket over her head. The custody record for that meal notes "meal provided and declined".[18]

[16] Submissions on behalf of Wiss, Morris, Tarrant, New, Marshall, Shaw and Gould, para 14.
[17] Transcript, Day 5, T5L37.
[18] TILBEROO C15 – QPS Person Report (Custody), p 31.

115. Ms Apech was called to give evidence at the inquest but did not appear. She told QPS during the investigation that when Ms Tilberoo was brought into the cell, she "was really sick, she was shaking". CCTV showed that she was sleeping fairly quietly until just after declining dinner, at which point she became very restless and frequently hanged her head over the side of the bed to dry retch. At 20:21, she could be heard and seen vomiting a small amount of clear fluid. Although Ms Tilberoo vomited and dry retched throughout the remainder of the night, that was the only time that any vomit could be seen on the CCTV.

116. At 21:36, Ms Tilberoo placed her mattresses on the floor between the beds and lay across the cell with her with her head on the edge of her bed and her feet on Ms Apech's bed. Ms Tilberoo's mattress covered the area where she had vomited earlier. At 22:45, Ms Tilberoo got into Ms Apech's bed with her. Ms Apech asked her if she was alright and if she wanted staff to call an ambulance. Ms Tilberoo said no, that she just wanted to lie next to someone.

117. WO Cheryl Mole was conducting physical cell checks that night. She noticed during the 22:59 check that Ms Tilberoo was not in her assigned bed. When Ms Tilberoo did not respond to being told through the cell door to return to her bed, WO Mole asked SC Baxter to accompany her to Ms Tilberoo's cell. The CCTV recorded that WO Mole and SC Baxter entered the cell and spoke with Ms Tilberoo, telling her she needed to go back to her own bed. Ms Tilberoo was reluctant, and eventually the officers lifted her by the top of her arms and put her back on her own bed. SC Baxter was asked at inquest whether he saw any vomit in the cell at that time, and he said that he did not. At inquest WO Mole confirmed that she did not see any vomit in the cell and explained that she moved Ms Tilberoo to ensure that neither she or Ms Apech fell out of bed, and so that Ms Apech could have her own space. WO Mole confirmed that if Ms Tilberoo had been unwell at that time, she would "notify the Senior Sergeant to call an ambulance immediately".[19]

118. Ms Apech told QPS that soon after the officers left, Ms Tilberoo started throwing up and was still throwing up "green stuff" later in the day. That assertion is not supported by the CCTV, which showed Ms Tilberoo sleeping restlessly for the remainder of the night, but not vomiting or dry retching.

119. Ms White gave evidence that she herself had morning sickness and vomited into the toilet in her cell at about 03:00 in the morning of Monday 7 September. She remembered that:

> *I'm pretty sure a female officer came in and ask me if I needed to go to the hospital, and I said, "No it's just morning sickness." Like I'm pretty sure I said to her, "Why don't you take her to the hospital?" They didn't do anything.*[20]

120. Ms White clarified during her evidence that by 'her', she meant Ms Tilberoo, and that the female officer knew who she meant. Ms White did not know Ms Tilberoo's name at this stage. During cross-examination, Ms White advised that she was in cell B1 on her own when she was sick and the female officer entered to check on her.

121. At 6:44 on Monday 7 September WO Satdeo Singh delivered breakfast. Ms Tilberoo did not take her meal from the hatch. At 08:26 Ms Tilberoo was asked

[19] Transcript, Day 2, T55L1.
[20] Transcript, Day 5, T6L4 - 7.

by WO Singh over the intercom if she wanted to see the WH Nurse, and she declined.

122. At 09:36, Ms Tilberoo had a meeting with a lawyer in Visitor Room 2 and was then returned to her cell. Later that day, Ms Tilberoo appeared in the Brisbane Magistrates Court via video link from the WH and was refused bail and remanded in custody until her next appearance for mention on 7 October 2020. At this stage, Ms Tilberoo became a QCS prisoner awaiting transfer to the Brisbane Women's Correctional Centre (**BWCC**) at Wacol.

123. Ms White gave evidence that, while she was in the BCWH, the only time she saw Ms Tilberoo get up from her bed was when she went for her court appearance. Ms White's evidence was that Ms Tilberoo was able to walk to the meeting with the lawyer without assistance.

124. At 10:33 Ms Tilberoo and Ms Apech were moved out of cell B2 so that it could be cleaned. In his evidence at inquest, WO Moore explained that the cleaners not only clean the cell, but also search the cell for contraband. He said that the cleaners would draw his attention to anything unusual in the cell. He did not recall them reporting to him that there was any vomit in Ms Tilberoo's cell on that day. CCTV showed that, at the time the cleaners enter the cell, there is no visible sign of vomit on the floor of the cell. CCTV showed that Ms Tilberoo returned to cell B2 at 10:38 and put her mattresses on the bed that Ms Apech had been lying on. Ms White gave evidence that Ms Apech came into her cell and told her that she couldn't stay in a cell with Ms Tilberoo "because [Ms Tilberoo] kept vomiting and it was too much for [Ms Apech]".[21]

125. Lunch was provided to Ms Tilberoo at 11:36, and CCTV showed that she did not take the food. Her refusal was not noted in QPRIME. WO Singh's shift finished at 14:00, and he gave evidence at inquest that he could not recall having had any concerns about Ms Tilberoo's wellbeing, but that if he had, he would have called the nurse.

126. At 14:55, Ms Tilberoo declined an offer to speak with a representative of Murri Watch offered via video link, and at 15:10 declined an offer to speak with a representative of Sisters Inside, also offered via video link. Ms Tilberoo did not eat her dinner that evening, and she refused breakfast the next morning.

127. A new prisoner, Rachel Smithers, came into the BCWH that day and CCTV showed that she was moved into cell B2 with Ms Tilberoo at 16:55. Ms Smithers gave evidence at the inquest that Ms Tilberoo was not eating any of the meals that were brought to their cell, but that she didn't remember seeing Ms Tilberoo vomit while she shared a cell with her. She said that she did recall Ms Tilberoo yelling "I wanna go to jail" but, other than that, Ms Tilberoo didn't really want to connect, and Ms Smithers was having difficulty dealing with her own stress at being in the WH, so did not try much herself.

128. CCTV showed that at 17:53 dinner was provided to Ms Tilberoo and Ms Smithers. Ms Smithers got up and took dinner from the hatch and put Ms Tilberoo's meal on the floor, near her bed, but Ms Tilberoo did not respond or take the food. It was noted in the custody record at 18:03 that Ms Tilberoo

[21] Transcript, Day 5, T7L43.

"[a]ppears to be declining to eat dinner. Is able to be awoke. Movement observed."[22]

129. Ms White was given bail that afternoon and left the BCWH at around 18:00, on Monday 7 September. She gave evidence that she had not raised concerns with WH officers about Ms Tilberoo other than when she spoke to the female officer when she was sick. Her evidence was that this was because this was pointless, as she was a prisoner herself, and she agreed that she told ESC Officers during her interview that it was because she was scared of consequences to herself. At the inquest, Ms White agreed that she had made posts on FaceBook relating to Ms Tilberoo sometime after she heard Ms Tilberoo had died. She said that the posts were true, but that she took them down because she was worried she might get into trouble for them.

130. At 18:59, CCTV showed that Ms Tilberoo turned towards the edge of her bed and was either coughing or retching. Ms Smithers briefly looked at Ms Tilberoo. That was the last time during her period in custody that the CCTV showed Ms Tilberoo appear to cough or dry retch. During the night, Ms Tilberoo appeared to be sleeping. CCTV showed that at 02:02, Ms Tilberoo looked towards the door and waved as a WH officer went by doing cell checks. She sat up and kept waving till she got the attention of the officer. At 2:04, she had a conversation with a male officer through the hatch. Ms Tilberoo asked if she was going to jail today and the officer said that no one was going to jail that day. She said she won't eat here, and he replied that she had a special meal. Ms Tilberoo got up to use the toilet after that conversation, and then went back to bed.

131. As Ms Tilberoo was then considered by QPS to be eligible for admission to QCS custody, her name was placed on the prisoner movement sheet/daily intake list sent to QCS SMS on Tuesday 8 and Wednesday 9 September 2020. There was evidence before the inquest that, at the time these daily lists were sent, BWCC was taking a maximum of five prisoners each day due to COVID restrictions. The advice provided to the BCWH after each request was *"Preadmission not requested by centre".*[23] The inquest was advised that what was meant was that QCS had not included Ms Tilberoo on their list of prisoners on whom pre-admission checks should be done by QCS to confirm their eligibility. There is no other correspondence between QPS and QCS about Ms Tilberoo, meaning she was not identified as a priority case for QCS to consider for transfer to a QCS centre.

132. It was later ascertained that the BWCC did not routinely have a Wednesday intake of prisoners from WHs because of staff lock down for training. QCS advised it could make exceptions, where necessary, for instance, if a WH prisoner has been identified as a priority transfer. In advice to the BCWH QCS stated:

The decision to bring a prisoner into QCS custody is two fold, the Chief Superintendent (and in their absence the Superintendent) will indicate whether the centre has capacity to accept a further prisoner into the centre and the Lawful Detention Unit (an arm of sentence management) will determine whether the prisoner can be lawfully detained.[24]

[22] TILBEROO C15 – QPS Person Report (Custody), p 22.
[23] TILBEROO D - Correspondence between Insp Coote and QCS about priority admissions.
[24] TILBEROO D - Correspondence between Insp Coote and QCS about priority admissions.

133. I accept the submissions from QCS which note that, given the circumstances, there were only two days that Ms Tilberoo was eligible for and awaiting transfer to QCS custody, and that any delay by QCS must be viewed in the context of the COVID-19 restrictions which were in place at the time. I accept that these restrictions had an impact on how many prisoners could be transferred on each day during this period, and that QCS was, at the time, quite properly attempting to mitigate risks to staff and vulnerable prisoners across the state by imposing restrictions.[25]

134. WO Stuart Pinteritsch commenced his shift at 06:00 on Tuesday 8 September 2023. He did a shift handover with the night shift officer, WO Robert Connelly. WO Pinteritsch gave evidence that he recalled WO Connelly telling him that Ms Tilberoo did not have her tea the night before. WO Pinteritsch delivered Ms Tilberoo her breakfast that morning, and when he collected the rubbish, he noticed that she had drunk her juice but that she hadn't eaten the meal. He gave evidence that "I asked her if she wanted the breakfast, I could leave it there for her and she could eat it at her – whenever she wanted. And that's when she said she didn't want it and told me to fuck off.[26] WO Pinteritsch recorded Ms Tilberoo's refusal of breakfast in the custody log.

135. There is no record in the custody log that prisoners were asked whether they wanted to see the WH Nurse that morning. However, in his evidence at inquest, WO Pinteritsch said that the nurse comes to the cells between 9 and 10 each morning, and when the nurse was there that morning:

> *We asked if the – anyone wanted to speak to the nurse. And we just do a blanket announcement across the intercom with – if anyone wants to speak to the nurse. And the – and anyone who does puts their hand up and the nurse goes and sees them…*[27]

136. At 09:51, the CCTV showed that Ms Tilberoo got up and walked in and out of the cell a few times. She asked to use the exercise yard but was told she had to wait a bit. At 10:11, WO Pinteritsch told Ms Tilberoo she could go outside into the exercise yard. She was outside for about 15 minutes.

137. WO Pinteritsch gave evidence that when he collected the rubbish from lunch, he noticed that Ms Tilberoo had not eaten her meal again. He asked her why she wasn't eating, and she said "I'm going to prison so I'm going to starve myself".[28] WO Pinteritsch said that:

> *…My response to that was, "By not eating, it's not going to stop you from going to prison. You're going to go to prison," because she had been sentenced to go to prison. "All you're going to do is go to prison hungry. But if you're starving yourself for other reasons, then I will go and see the nurse". And, just to cover my own peace of mind, I contacted the nurse and advised them of the conversation I had with her. And, knowing that there has been a history of Aboriginal people in custody doing – fasting or starving themselves not wanting to go to prison. So I just made sure that I had covered those by speaking to the nurse. She advised me as long as she was drinking that – she would be ok. But if she stopped drinking then we would have to take it further.*[29]

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[25] QCS submissions, para 9.
[26] Transcript, Day 2, T85L16 - 18.
[27] Transcript, Day 5, T87L12 - 15.
[28] Transcript, Day 2, T86L34.
[29] Transcript, Day 2, T86L37 - 47.

138. WO Pinteritsch was asked, at inquest, about his general observations of Ms Tilberoo while he was on shift that day. He gave evidence that he did not see her vomiting at any time, she did not seem ill, and that no other prisoner told him that she was ill or vomiting. He said that she was mostly lying down on her bed, and always had the blanket over her head. He said that "I repeatedly asked her to take the blanket off her head, because I needed to see that she was breathing. And her response was quite animated".[30] He explained that if he had seen Ms Tilberoo vomiting, he would have hit the emergency button to get backup and gone into her cell to see if she was ok. If she needed medical attention, he would have called the ambulance.

139. WO Ian Young came on shift at 14:00 and took over from WO Pinteritsch. WO Young gave evidence at inquest that he became aware that Ms Tilberoo had been refusing meals, either during the handover from WO Pinteritsch or by reviewing the custody logs. Ms Tilberoo did not eat the dinner that WO Young provided, although he gave evidence that he offered Ms Tilberoo several opportunities to eat the meal. WO Young said that, although he noted that Ms Tilberoo refused the meal, he was not overly concerned as it is quite common for prisoners to refuse meals. WO Young gave evidence that he had met Ms Tilberoo in the BCWH before, and that on 8 September she did not seem different: "she was just lying there and she was responding, but yeah, just sort of – she was laying there. I didn't notice anything, you know, sort of alarming".[31] WO Young said that Ms Tilberoo did not seem ill, and that none of the other prisoners raised any concerns about her. If they had, he would have called the nurses if they were onsite or call the ambulance if it was after hours.

140. CCTV showed that at 16:05, Ms Tilberoo was transferred to cell A2. She responded to a call from WO Young over the intercom, picked up her blankets and mattresses, and walked to cell A2, which was empty. Ms Smithers came into the same cell at 16:29 and Ms Tilberoo told her to go to the other cell because she had been snoring. Ms Smithers stayed in A2 with Ms Tilberoo. Ms Tilberoo did not take her dinner from the hatch that evening. WO Young told investigators that he left the meal on the hatch to the cell in case she changed her mind, and when he collected the rubbish he again offered her the meal. She declined again. WO Young recorded her dinner refusal in the custody record.

141. That night, WO Mardi Holst worked the 22:00 to 06:00 shift. She gave evidence that the shift was uneventful, and if anyone had been ill or a prisoner had reported that someone had been ill, she would have noted it in the custody log. She gave evidence about the way that she conducted physical cell checks during the night and said that she would check each prisoner to see if they were moving or breathing. She would use a torch to see them better if necessary and would sometimes enter the cell if she was "not really sure".[32] CCTV showed that Ms Tilberoo slept for most of the night. She sat up a few times, used the toilet, and at one point appeared to be coughing, but was not showing signs of illness or distress.

142. WO Vincent Toleafoa started his shift at 06:00 on 9 September 2020. He gave evidence that:

[30] Transcript, Day 2, T89L3 - 4.
[31] Transcript, Day 3, T3L44 - 46.
[32] Transcript, Day 3, T2L24.

I did give her breakfast and on the way through collecting the rubbish I remember she didn't have any breakfast. Asked her why. She said she wasn't hungry, I think, and then have just requested, "Well, at least drink the milk". She did. And that was – yeah, that was pretty much it".[33]

143. After breakfast Ms Tilberoo moved her mattresses to the common area outside her cell and was talking and/or watching TV with other prisoners.

144. At 08:46 WO Toleafoa asked over the intercom whether anyone wanted to see the nurse. Ms Tilberoo said no at first. WO Toleafoa gave evidence that:

I said, "Are you sure? Just because you didn't eat your breakfast." I'm not a medical person, but still, if someone's not eating, it's not a good thing, and that's all it was.[34]

145. WO Toleafoa said he kept asking Ms Tilberoo questions:

…"Is there anything you might need? Do you want to talk to somebody?" And then after a bit she said, "Yeah okay. I'll speak to them." And so I put her on the list to see the nurse.[35]

146. CCTV showed that Ms Tilberoo attended the nurse at 08:48 (for triage) and again at 10:26. Ms Tilberoo's visit to the WH nurse and her treatment is outlined further under Issue 2. Between and after these visits she was in the common area outside the cells. CCTV showed that she was called by the WH officer to get her medication at 12:00.

147. After getting her medication, WO Toleafoa said that Ms Tilberoo asked to go into the rec yard, and she lay in the sun for a bit. WO Toleafoa could not recall whether Ms Tilberoo had lunch that day, but gave evidence that, if she didn't eat it, he would generally have noted it in the custody log. CCTV shows Ms Tilberoo with food in the common area around the same time as she was called to get her medication.

148. WO Toleafoa finished his shift at 14:00. He gave evidence that, during his shift he did not see Ms Tilberoo vomiting or notice that she was ill. During cross-examination he said that, if he had seen Ms Tilberoo vomiting, he would have gone and checked on her, and then called the nurse or the ambulance as necessary.

149. WO Moore was working from 14:00 that day. He asked Ms Tilberoo over the intercom if she would like to see Murri Watch and Sisters Inside, and she declined. According to the custody record, he dispensed her medication to her. CCTV showed that Ms Tilberoo spent the early afternoon in the common area and returned to her cell around 15:42. Ms Smithers did not return to the cell.

150. On the afternoon of 9 September, Natalie Daniels was brought into the BCWH and she was put into the cell with Ms Tilberoo at 17:38. Ms Daniels told QPS during her interview that she had known Ms Tilberoo for a long time from living on the streets and thought of her as 'street family'. When Ms Daniels became homeless Ms Tilberoo took her under her wing and showed her good places to stay and how to get free food. Ms Daniels knew that Ms Tilberoo had a heroin habit, so she always watched over her if she saw her passed out anywhere. Ms

[33] Transcript, Day 3, T27L12 – 15.
[34] Transcript, Day 3, T28L32 - 34.
[35] Transcript, Day 3, T28L37 - 39.

Daniels and Ms Tilberoo had their dinner together in their cell, and they had some laughs and some tears talking about their friendship together. Ms Tilberoo was still feeling sick from the withdrawal, so she didn't eat all of her meal. CCTV confirmed that Ms Tilberoo ate some of her dinner. After dinner, Ms Daniels said that they lay down and tried to go to sleep.

151. Ms Apech, Ms Crawley, Ms Smithers and another prisoner, Anna Gold, had taken their mattresses into the room outside the cells to watch a movie. They were sitting and lying on the floor eating and watching the movie. Ms Apech said they were being loud and talking and giggling. At 18:31 Ms Tilberoo came out of her cell and told them to shut up and stop being so loud, and Ms Crawley said she said something like "Can you show us a bit of respect?" The prisoners said that Ms Tilberoo was a bit moody, but they understood that she was trying to sleep. They quietened down and watched the movie.

152. Ms Crawley said that she was the first one to go to bed after the movie, and that the time was then probably between 7 and 8pm. She remembered seeing Ms Tilberoo move in her bed when she was on her way to her cell. The other prisoners did not say whether they noticed Ms Tilberoo when they went to bed. None of the inmates recall hearing anything unusual during the night.

153. WO Debra Haigh commenced her shift at 22:00 on 9 September 2020. She gave evidence that she received a handover from WO Moore:

> *…He just told me who had diabetes, that Ms Tilberoo had a soft meal ordered on his shift, because, apparently, she had minimal teeth, and that's virtually it, and he had – they were all sleeping, and he had had no issue with anybody.*[36]

154. CCTV showed that, between 22:30 and 23:03 Ms Tilberoo moved a number of times. At 23:04, a sound like expelling air could be heard from Ms Tilberoo, and then she stopped moving. Between that time and 04:48 the next morning, WO Debra Haigh conducted 7 checks, each of which was recorded as "No complaints. No problems detected".

155. At inquest, WO Haigh gave evidence that, during her inspections, "I recall [Ms Tilberoo] lying on her left side facing her cellmate. I noticed she had a foot out of the blanket, and that's all I could see, and the top of her head".[37] In respect of her cell checks that night, WO Haigh told the court that she wasn't using a torch as she had forgotten to bring hers from home. She admitted that, without a torch, she could not see sufficiently into the cells to do her checks properly, but that she did not try to find a replacement torch at the WH. During cross-examination WO Haigh also agreed that she did not try to rouse Ms Tilberoo by tapping on the glass, using the intercom or asking another WO to enter the cell with her. She also accepted that "[i]n hindsight, I should have stood there and watched her longer to see if she had any movement".[38]

156. The last check on Ms Tilberoo was by WO Ecimovic at 05:50 on 10 September, at which time WO Ecimovic recorded that Ms Tilberoo was moving and breathing.

157. An investigation into Ms Tilberoo's passing was conducted by the QPS ESC. Detective Sergeant Christy Schmidt of the ESC provided an Investigation Report

[36] Transcript, Day 3, T42L33 - 34.
[37] Transcript, Day 3, T42L7 - 10.
[38] Transcript, Day 3, T63L45 - 46.

dated 21 May 2021. DS Schmidt advised that the investigation identified significant failings by QPS and WH officers. These failings related to section 16.13.3 of the OPM and the duty to inspect prisoners.

158. In her investigation report, DS Schmidt found that WO Haigh failed to correctly inspect Ms Tilberoo and to correctly record the assessment of Ms Tilberoo in the Custody Log. WO Haigh made seven false custody entries related to the inspections of Ms Tilberoo. WO Haigh was suspended from duty for six months and, when she returned to duty, she was redeployed to the Brisbane City Station in accordance with a Management Action Plan. DS Schmidt recommended WO Haigh be referred to a prescribed officer in relation to 'Failure of duty' and 'Interfere with or undermine an investigation, legal process or conduct matter'.

159. DS Schmidt also found that the night shift supervisor on 9 and 10 September, Senior Sergeant Damien Hayden, failed to inspect Ms Tilberoo on at least one occasion during the shift. It was recommended S/Sgt Hayden be referred to a prescribed officer in relation to 'Failure of duty'.

160. Finally, DS Schmidt found that WO Ecimovic initially failed as the 'inspection officer' to correctly inspect Ms Tilberoo and to correctly record the assessment of Ms Tilberoo in the Custody Log and WO Ecimovic made one false custody entry relating to the inspection of Ms Tilberoo. It was recommended WO Ecimovic be referred to a prescribed officer in relation to 'Failure of duty' and 'Interfere with or undermine an investigation, legal process or conduct matter'.

Issue 1 conclusions – Ms Tilberoo

161. On the basis of the evidence outlined above, I make the following findings in respect of this issue:

    a. While Ms Tilberoo was unwell while she was in the BCWH, generally the WH officers supervising her discharged their duty of care to her in a satisfactory way;
    b. It is likely that Ms Tilberoo died after 23:04 on 9 September 2023 which is when her last movement can be detected on the cell CCTV;
    c. The physical cell checks for prisoner inspection conducted on Ms Tilberoo by WO Haigh during her night shift on 9 and 10 September 2020 were inadequate because WO Haigh did not determine whether Ms Tilberoo was breathing in each of these checks;
    d. SSgt Hayden did not conduct a physical cell check;
    e. The first physical cell check for prisoner inspection conducted on Ms Tilberoo by WO Ecimovic during his shift 10 September 2020 was inadequate because WO Ecimovic did not determine whether Ms Tilberoo was breathing in the check;
    f. Had the physical cell checks on Ms Tilberoo been conducted in accordance with the OPMs, there may have been an opportunity for her to receive medical attention before her death. Whether or not such medical attention may have prevented her death is discussed below.

162. I accept the submissions made on behalf of WO Haigh that her failure to conduct adequate cell checks was not done out of malice or racial prejudice, and that there were some difficulties associated with seeing prisoners breathing at night time. I also accept that WO Haigh gave evidence that she has reflected on her

cell inspections of Ms Tilberoo and has made changes in her practices in respect of cell checks.[39]

163. I also accept the submissions made on behalf of WO Ecimovic that his failure to determine that Ms Tilberoo was not breathing when he first checked her appeared to have been a mistake, and that there was no deception or malevolent intent in his entry that there were no problems identified during his check.[40] Certainly WO Ecimiovic acted appropriately when it did become clear to him that Ms Tilberoo was not breathing.

164. Extensive submissions have been made to me on behalf of SSgt Hayden, and whether he was, as DS Schmidt found, required as shift supervisor to conduct at least a physical check during his shift. Essentially, SSgt Hayden said that, according to the OPMs, WH policies and procedures and evidence given by QPS personnel, physical inspections were not, in fact, required by the shift supervisor until some time after Ms Tilberoo's death.[41] I do not find that it is necessary for me to determine this issue. As I have noted above, the evidence shows that SSgt Hayden did not conduct a physical cell check of Ms Tilberoo. Whether or not SSgt Hayden was, in fact, required to do a physical cell check at the relevant time is a matter for the QPS, and the decisions made in that respect as well the actions taken by QPS have been set out above.

Issue 2 – The adequacy of the provision of clinical treatment in the watch house

Ms Wylucki

165. According to WO Marshall, Ms Wylucki advised him during the booking-in process that she had a heart condition, provided her medication to him and explained why she took each medication. WO Marshall said he asked Ms Wylucki if she would need the medications that night and Ms Wylucki indicated she did not need them and would be fine without them. WO Marshall did not consider that Ms Wylucki required medical attention at that time. The property record shows that Ms Wylucki handed in the following medication:

- Nitrolingual – pump spray;
- Monodur 120mg in blister pack;
- Eleva 50mg in open blister pack with 24 tablets remaining;
- Metoprolol 50mg in open blister pack; and
- Aspirin 100mg in open blister pack.

166. Sgt Wiss noted on the handwritten whiteboard that Ms Wylucki needed to see the WH nurse the following morning in order to review her medical condition and medication. Sgt Wiss gave evidence at inquest that the WH nurses were not on shift, so if Ms Wylucki had needed her medication that night, the medication could not be dispensed to her unless he made a call to the forensic medical officer (FMO) on call. Sgt Weiss explained that means that he would ring:

[the on-call] doctor, and we advise them what the conditions are, what medication it is, when it's required. And they let us know if we hand it out or whether they can wait and see the nurse the next day.[42]

[39] Submissions on behalf of Haigh and Ecimovic, para 5.
[40] Submissions on behalf of Haigh and Ecimovic, para 14.
[41] Submissions on behalf of Hayden.
[42] Transcript, Day 1, T17L31 – 33.

167. On further questioning, Sgt Wiss clarified that the FMO would only authorise that the WH officers dispense medication to a prisoner if that medication was in a bottle or package with a prescription label attached making clear the medication was prescribed to the prisoner. If not, the FMO would not authorise that the medication be given, even if the prisoner said they needed it. In those circumstances, the prisoner would have to wait for the nurses to review them in the morning. Sgt Wiss advised that the nurses were on duty at the SPWH from 9 to 5 on Sunday to Friday, and from 10 to 6 on Saturdays.

168. Sgt Wiss gave evidence that he did not make any call to the FMO for Ms Wylucki, because she had advised WO Marshall that she did not need her medications that night.

169. Sgt Wiss gave evidence that, if a prisoner who is brought in after-hours is alcohol or drug-affected to the point that they would need medical attention, he could refuse to accept them into the WH, and instead have the QPS take them to the hospital or call an ambulance. He said that, although he knew Ms Wylucki had drunk alcohol that night, he didn't think she was so badly affected by the alcohol that she couldn't be accepted. Sgt Wiss confirmed that he made this assessment of Ms Wylucki on the basis of his direct observations of her, as well as the answers she gave to WO Marshal during the booking in process.

170. Sgt Wiss was asked at inquest what the procedure would have been if he had been advised by the officers conducting cell checks that Ms Wylucki had been vomiting in her cell during the night. He gave evidence that "the procedure is to call the ambulance",[43] and that "[t]hat's what [he] would have done".[44] Sgt Wiss was asked whether that would also have been the procedure had he been advised that Ms Wylucki was experiencing chest pains, and he said that it was the same.

171. During the inquest, Registered Nurse (**RN**), John Gomersall, who treated Ms Tilberoo when she was in the BCWH, was able to assist the court with information about what a WH nurse may have been able to do if they were on-shift when Ms Wylucki was brought in to the SPWH. RN Gomersall was provided with the facts in respect of Ms Wylucki's admission to the SPWH and advised that, if he had been on shift,:

> *Basically, I would do a full assessment, if she was agreeable to it, and if she declined, I would be trying to persuade her to agree to see me. With my knowledge, you know, a flag, straight away, would be the GTN spray. That's for people with angina. It's a pretty serious cardiac condition, so I would be sitting her down and going through her history of her medication, who prescribes it, and has she been compliant. Also, because she has been drinking alcohol, I would go through a full assessment of her drug and alcohol use, how much she is drinking. Like they might say two bottles, but if you query them more, sometimes it's more. You would be assessing her blood-alcohol limit and how she performs on the blood-alcohol. Some people are what we call neuroadaptive, so they might blow .15 and most people most people would be pretty drunk on that, but if someone is behaving pretty normally, that would be something of a concern. They would be more likely to have withdrawals later. So yeah, you – it would be a pretty intense – well, I would be – I would be doing a pretty thorough assessment and encouraging her – well, talking to the doctor and formulating a plan….*[45]

[43] Transcript, Day 1, T21L15.
[44] Transcript, Day 1, T21L22.
[45] Transcript, Day 5, T38L4 – 18.

172. In respect of whether he would have encouraged Ms Wylucki to take her night-time medication, RN Gomersall said:

> *I suppose it's – it's – it would be something to discuss with the doctor, depending on the individual medications. The fact she is intoxicated, there might be contrary indications – contrary indicating for some of those meds, so that's why we talk to doctors – they know more than we do – but I would be certainly getting as much information. I would also be looking on those databases as well, as you mentioned before, and trying to, sort of, get a history of – after hours, it's a bit more difficult, because a lot of the GP practices or who's treating her may not be available to ring, so it's a bit more restrictive after hours and on weekends, when GP practices aren't open.*[46]

173. RN Gomersall also explained that, if nurses worked in the WH 24 hours a day, then if a patient was vomiting the nurse could do an immediate assessment of them to determine whether the FMO should be contacted or an ambulance should be called. He agreed that, without 24-hour nursing staff, such decisions must be made by non-medically trained WOs.

174. Dr Gregory Starmer, Interventional Cardiologist and Director of Cardiology at Cairns Hospital, was briefed to provide an expert opinion in respect of Ms Wylucki's medical condition. He was asked to review the medical records available to the inquest as well as coronial investigation material and to comment on Ms Wylucki's heart condition, the effect that her alcohol intake would have had on both her condition and the efficacy of her medication, and whether the failure to take her medication in the WH contributed to her death.

175. In his report, dated 20 February 2023, Dr Starmer advised that he agreed with Dr Ong's report that the mechanism of Ms Wylucki's death was most likely arrythmia. He summarised Ms Wylucki's history of ischaemic heart disease and coronary artery disease, noting that:

> *Ms Wylucki has a recent (3 year) history of symptomatic heart disease. She had known obstructions which had previously been fixed and the post mortem suggests she had significant narrowings in all of the major coronary arteries which would certainly have explained her presentations with chest pain. She was on good medical therapy for the condition. On several of her presentations her cardiac biomarkers were elevated and therefore repeat coronary angiography under normal circumstances would have been desirable. This may have diagnosed her significant narrowings and resulted in revascularisation with further coronary stents or perhaps coronary artery bypass surgery. This would not have altered the existing scar on the surface of her heart (from her heart attack in 2015) and therefore it is difficult to say whether this upstream therapy would have altered the ultimate outcome.*[47]

176. In respect of how Ms Wylucki's alcohol intake would have affected her heart condition and/or the efficacy of her medication, Dr Starmer advised that:

> *Alcohol is known to have a detrimental effect on the cardiac muscle itself (myocardium). It does not directly result in atherosclerosis (cholesterol plaque) depositing and causing narrowings of the coronary arteries but rather can weaken the heart muscle. This in itself is known to lead to cardiac arrythmias. Given that this is the likely mechanism of death in this case, long term impact of heavy alcohol use could certainly be a factor. Given that there was no recent assessments of the heart function, it is difficult to exclude or confirm this. With the knowledge that there was extensive scarring on the posterolateral surface*

[46] Transcript, Day 5, T38L26 – 34.
[47] WYLUCKI H3 – Report of Dr Starmer, p 3.

of the heart, and known significant coronary artery disease, then this represents a much more likely primary contributor to the final arrhythmia as a mechanism of dying….Despite [effects that alcohol also has on the liver which can increase the metabolization or reduce the elimination of certain medications] I find it unlikely that alcohol would have had a significant impact on the medications that would contribute to the outcome.[48]

177. Finally, in respect of whether it could have been outcome changing if Ms Wylucki had taken her medications that night in the WH, Dr Starmer said:

Given the ultimate likely mechanism of death, the only medication that may potentially have had an impact on this would have been the Metoprolol. Beta blockers can reduce the incidence of arrythmias however do not prevent them and therefore sudden cardiac death due to lethal arrythmia does still occur despite chronic use of beta blockers. It is impossible to know whether administration of this medication on the evening in question would have altered the outcome.[49]

178. In his evidence at inquest, Dr Starmer confirmed the findings he made in his report. He explained that a fatal arrythmia of the type likely to have been experienced by Ms Wylucki would have been a very brief event. It is likely to have happened suddenly, with no preceding symptoms and, unless immediate resuscitative efforts are started, then Ms Wylucki was unlikely to have lived.

Issue 2 Conclusions – Ms Wylucki

179. Ms Wylucki, as a WH prisoner with specific medical needs, may have been disadvantaged simply because she was admitted to the WH after usual business hours. I find that Ms Wylucki's death may have been prevented if there was more consistent provision of medical services in the SPWH. Had a nurse been on-site at the time of Ms Wylucki's admission, there would have been an opportunity for Ms Wylucki to have had a medical assessment before she was taken to the cells. She could have been encouraged to continue her prescribed medication regime and her prescribed medication (or other appropriate medication) could have been dispensed to her that evening. The effects of her alcohol intake could have been assessed properly.

180. Although Dr Starmer's evidence is that, in Ms Wylucki's case, the effects of the alcohol and the failure to take her prescribed medication are unlikely to have been direct factors attributable to her death, this would still, in my submission, have been an important opportunity for a patient with clear medical needs to be given medical attention. This opportunity should not be dependent upon the time at which a prisoner is admitted – the legislated obligation of the QPS to care for the health and safety of persons in WHs is not confined to business hours.

181. Similarly, had a nurse been on-site when Ms Wylucki was vomiting in her cell, and assuming checks had been properly done so that this situation was known to WOs, a nurse could have made an immediate assessment of Ms Wylucki's condition and may have had an opportunity to provide life-saving resuscitative treatment. As has been made clear in the evidence during inquest, in the absence of nurses, non-medically trained WH staff must make these clinical assessments of prisoners, and then delays, while medical assistance is sought from the GMO or QAS, are inherent in the system.

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[48] Ibid.
[49] Ibid.

182. On the basis of the evidence outlined above I find that, due to the absence of 24-hour 7-day nursing services within the SPWH the provision of clinical treatment to Ms Wylucki in the SPWH was inadequate. In my submission, this is a systemic issue which is applicable to all prisoners in WHs in Queensland who do not have access to 24 hour a day nursing services on every day of the week.

183. I note the submissions on behalf of the Metro North Hospital and Health Service (**MNHHS**) which argue that a finding that this amounts to a systemic issue is not open on the evidence which did not include a comprehensive analysis of the health care available across WHs in Queensland. I do not agree. I also note the reference by MNHHS to Attachment B to the addendum statement of Acting Superintendent Scott McLaren (sworn 19 May 2023), which sets out the nursing arrangements in Queensland WHs as at that date. I note that this attachment reports that 5 of the 10 WHs in Queensland have nursing services "As needed/7 days". While this is encouraging, the 5 WHs do not include Brisbane or Southport WHs and that leaves prisoners in half the WHs in Queensland without what, in my view, is adequate nursing care.

<u>Ms Tilberoo</u>

184. At 08:48 on September 2020 Ms Tilberoo was seen by RN Gomersall and RN Gayle Armstrong, who was being trained by RN Gomersall to relieve in his position when he went on leave. RN Gomersall explained during his evidence that he is a drug and alcohol nurse at Biala and works predominately in the BCWH. RN Gomersall outlined to the court the usual procedures when a Biala nurse does the WH rounds – a review is undertaken of the prisoner files to identify anyone who may need medical treatment for drug and alcohol-related issues. A nurse then see those prisoners who have told WOs that they want to see a nurse and those identified by the nurse as needing review from the files.

185. Ms Tilberoo was triaged by RN Armstrong, and she told RN Armstrong that she was currently receiving Opiate Replacement Therapy (OPT) at South City Medical Centre from a Dr Reece. Ms Tilberoo said she couldn't remember at what pharmacy she received her dose. RN Gomersall said that when RN Armstrong advised him of this, he asked her to contact Dr Reece to confirm the details of Ms Tilberoo's OPT.

186. RN Gomersall said that he booked Ms Tilberoo in for an assessment while RN Armstrong phoned the Medical Centre and was advised that Ms Tilberoo had not attended for OPT since June that year. RN Gomersall gave evidence that, during the assessment, he advised Ms Tilberoo what the Medical Centre had said, and Ms Tilberoo admitted that she was not getting OPT but had in fact been taking $300 worth of heroin daily until her arrest. She said she had last taken heroin on Sunday 6 September, that she took it intravenously, and she described symptoms of withdrawal to the nurses. RN Gomersall took notes of the assessment and his observations of Ms Tilberoo.

187. RN Gomersall gave evidence that, after the assessment, he phoned the doctor on-call at the CFMU and they formulated a plan to treat Ms Tilberoo. The doctor prescribed Ms Tilberoo ondansetron, an anti-nausea medication, and Prodeine (paracetamol and codeine) to treat her withdrawal symptoms. She was to take this medication 3 times per day, and RN Gomersall subsequently explained to the WH officer that Ms Tilberoo would have to have the Prodeine tablets crushed as she was having difficulty swallowing.

188. Dr Allan Pascoe, Addiction Medicine Specialist and Senior Staff Specialist Psychiatrist and Clinical Director of the Toowoomba Alcohol and Other Drugs Service was asked to provide his opinion of the treatment of Ms Tilberoo in the BCWH.

189. Dr Pascoe also reviewed Ms Tilberoo's medical records and information from the coronial brief, and noted that when she was in the community, Ms Tilberoo had been on the Queensland Opioid Treatment Program (QOTP) a number of times for brief periods. He advised that, had Ms Tilberoo presented to a community clinic rather than to RN Gomersall on 9 September 2020:

…it is likely she would have received one of three treatment approaches: initiation into QOTP, short-term use of Buprenorphine to manage opioid withdrawal or short-term use of symptomatic medications to manage opioid withdrawal. Which approach to use would be determined by a number of factors, including but not limited to, consumer choice and treatment aims, availability of QOTP and Buprenorphine at the community treatment centre and whether [she] was presenting in a planned or unplanned manner to the community treatment centre.[50]

190. Dr Pascoe was advised that Ms Tilberoo was asked whether she wanted to see the WH nurse on 7 September but declined. He was asked to advise whether, in his view, Ms Tilberoo could have been reviewed by the nurse notwithstanding her refusal of medical care at that time. Dr Pascoe referred to the *Guardianship and Administration Act* 2000 which presumes that an adult has capacity to make decisions and provides that health care can only be provided without consent where the health care provider "reasonably considers the adult has impaired capacity for the health matter concerned". Having reviewed the BCWH records, Dr Pascoe determined that:

…there did not appear to be any documented concerns regarding her capacity to decline the RN review. As such, she would be presumed to have capacity for this matter and her decision to decline RN review should be respected.

[Ms Tilberoo] also did not appear to have a mental illness that would meet criteria for involuntary assessment under the Mental Health Act 2016…Part 3 of the Act (Interpretation) explicitly outlines that "a person must not be considered to have a mental illness merely because…the person takes drugs or alcohol".[51]

191. Dr Pascoe noted that Ms Tilberoo's symptoms were consistent with what would be expected of a person withdrawing from using $300/day of heroin, and that these symptoms were appropriately managed "given her presentation, the treatment setting and the medications available to manage her withdrawals. Finally, Dr Pascoe advised that:

In my opinion, based on the material supplied, the documents referred to in this report and my clinical experience, lack of clinical care for opioid withdrawal did not hasten or cause [Ms Tilberoo's] death.[52]

192. During his evidence at inquest Dr Pascoe advised that prisoner cannot be initiated into treatment under the QOTP while in the WH, which is usually short-

[50] TILBEROO F2 - Report of Dr Pascoe, p 3.
[51] TILBEROO F2 - Report of Dr Pascoe, p 4.
[52] TILBEROO F2 - Report of Dr Pascoe, p 5.

term, because of the time during which the prisoner must wait to clear the opiates already in their system, and then they need four or five days of monitoring after the initial dose under the QOTP. He advised that initiation into QOTP is starting to become available to prisoners in QCS custody, but that he is aware there are waitlists because of the demand for the treatment as well as the treatment being dependant on the "availability of appropriately trained staff".

193. Professor Christian Gericke, Neurologist and Epileptologist and Clinical Director of Neurology at the Prince Charles Hospital, was briefed to provide an opinion in relation to the cause of Ms Tilberoo's passing. Prof Gericke reviewed Ms Tilberoo's medical records and the coronial investigation material. He advised that the only possible treatments for Ms Tilberoo's berry aneurysm, had it been detected, would have been surgical clipping or the insertion of a coil from inside the artery. Prof Gericke confirmed, during his evidence at inquest, that he could find no evidence in Ms Tilberoo's medical records that she had ever had any symptoms which would have warranted investigations to determine whether she had an aneurysm.

194. Prof Gericke was asked to provide his opinion as to whether Ms Tilberoo's withdrawal symptoms which she experienced in the WH could have caused or contributed to the rupture of her aneurism. Prof Gericke advised that "[v]omitting and nausea has not been identified as a risk factor for saccular aneurysm rupture in the scientific literature". He considered whether, conversely, Ms Tilberoo's vomiting and nausea could have been caused by the onset of the rupture, rather than been true symptoms of her withdrawal, but dismissed this possibility, noting that:

It is not documented that the deceased reported a devastating new onset headache which is the hallmark sign of a subarachnoid haemorrhage and the deceased as well as the nurse seemed to attribute [Ms Tilberoo's] symptoms on 9 September 2020 to opiate withdrawal. As the watch house nursing notes are otherwise quite detailed, I have no doubt the nurse would have documented a severe headache had [Ms Tilberoo] reported it.

…

[Ms Tilberoo] and the watch house nurse both had good reason to attribute [her] symptoms on 9 September 2020 to opiate withdrawal as she was effectively in opiate withdrawal and nausea, vomiting and diarrhoea, and goose bumps are typical symptoms for this.

Furthermore, according to the evidence in her medical records, opiate withdrawal is a condition with which the deceased was very familiar as she had experienced it many times since she started injecting heroin about the age of 34, that is for the last 15 years.

The deceased did not report symptoms typical of a subarachnoid haemorrhage. In my opinion, the deceased's saccular aneurysm rupture and subsequent fatal subarachnoid haemorrhage were not preventable. I could not find any fault with the care provided by the staff at the Brisbane City Watch House.[53]

195. In his evidence at inquest, Prof. Gericke clarified that a thunderclap headache would have been so severe that neither Ms Tilberoo or the people around her would have been able to ignore it. He said that "it is one of the most extreme

[53] TILBEROO F1 – Report of Dr Gericke, pp 8 – 9.

pains we can experience",[54] and there was no indication that Ms Tilberoo was in this amount of pain, and accordingly, there were no onset symptoms of the burst aneurism which could have been acted upon by medical staff at the WH and potentially prevented Ms Tilberoo's passing.

Issue 2 Conclusions – Ms Tilberoo

196. As a WH prisoner who did not have access to round the clock nursing care, I find that Ms Tilberoo was at a similar disadvantage to Ms Wylucki. Had Ms Tilberoo had an assessment with a nurse upon her admission, she may have been encouraged to have disclosed her heroin withdrawal and have been provided with appropriate treatment for her withdrawal signs and symptoms at an earlier time. Again, while the expert evidence is that her withdrawal symptoms were not a direct contributor to her passing, and earlier treatment in Ms Tilberoo's case would not have been outcome changing, this is still indicative of a systemic issue within Queensland WHs.

197. Ms Tilberoo's circumstances draws attention to another systemic issue within the WH setting: the inability for WH prisoners who are experiencing drug or alcohol withdrawal to access OTPs because of the assumption of short-term custody in the WH. This issue is exacerbated when wait times for transfers into QCS custody, where appropriate treatment is more readily available, are extended. However, symptomatic treatment is still available within WHs. In addition, I note that Dr Pascoe said that a prisoner cannot be initiated into treatment under the QOTP while in the WH, which is usually short-term, because of the time during which the prisoner must wait to clear the opiates already in their system, and then they need four or five days of monitoring after the initial dose under the QOTP. I do not consider that the unavailability of OTPs within WH custodial setting amounts to an inadequacy in the provision of clinical treatment to Ms Tilberoo but comment that had she been transferred promptly, to a facility operated by QCS, she may then have been able to access OTP, the care Dr Pascoe says she would have been afforded in the community.

198. With those reservations, on the basis of the evidence outlined above, I find that the clinical treatment which was provided to Ms Tilberoo in the BCWH was appropriate and sufficient in the circumstances of her medical needs.

199. I accept the submission made on behalf of QCS that the wait times for transfers, should not, in Ms Tilberoo's case, be attributed to QCS,[55] and I note my comments at paragraph 133 above in this respect.

Issue 3 – The appropriateness of current QPS policies and procedures relating to the supervision of prisoners in watch houses

200. This issue was considered in each of the ESC investigations into the circumstances of the deaths.

Ms Wylucki

201. DS Pickett concluded in her investigation report, and confirmed in her evidence at inquest, that:

[54] Transcript, Day 2, T10L1.
[55] Submissions on behalf of QCS, para 5.

The internal investigation identified a lack of compliance of OPM 16.13.3. 'Inspection of prisoners'. The lack of compliance is not through lack of awareness or knowledge. All officers interviewed were aware of their obligations regarding their duty of care of persons in custody and what is required of them when conducting physical cell checks.[56]

202. At the conclusion of her investigation DS Pickett recommended that random audits should be conducted in WHs to ensure that physical cell checks comply with the OPMs. DS Pickett did not identify any issues with respect to the appropriateness of the QPS policies and procedures (as they were at the time) relating to the supervision of prisoners in WHs.

Ms Tilberoo

203. DS Schmidt concluded in her investigation report, and confirmed in her evidence at inquest, that her investigation found that BCWH officers failed to conduct inspections on Ms Tilberoo in accordance with the OPM in place at the time.

204. DS Schmidt made a number of recommendations at the conclusion of her investigation, including:
- WO training – this should be better monitored to ensure completion, and yearly refresher training should be conducted with respect to WO duties, roles and responsibilities, including the monitoring of a sleeping prisoner;
- Quality assurance of cell checks – shift supervisor should randomly view CCTV footage of WOS on shift to ensure their cell checks comply with the OPM;
- Prisoner medical conditions – identified medical conditions should be updated in the custody log, and nursing staff should be rostered 24 hours a day 7 days a week;
- Additional monitoring of prisoners – electronic wrist/ankle devices, mattress alarms and radar monitoring be considered as possible additional electronic monitoring options.

205. With respect to the relevant OPM, DS Schmidt concluded that the current procedures in relation to assessment of prisoners should be strengthened, and accordingly recommended that OPM s16.13.3 be updated. This recommendation led to the updates noted at paragraph 19 of these findings and, in particular, the addition of instructions as to how to observe a sleeping prisoner's breathing, and when to wake a sleeping prisoner to ensure that they are well.

Issue 3 Conclusions – Ms Wylucki and Ms Tilberoo

206. On the basis of the evidence outlined above I find that the current QPS policies and procedures relating to the supervision of prisoners in watch houses are appropriate.

207. I note that QPS has already made amendments to the OPMs in response to Ms Tilberoo's death, and the amendments are appropriate and reasonable. The amendments give clarification to WH staff in respect of how to carry out their physical checks on the prisoners in their care.

[56] WYLUCKI B2 – Supplementary Form 1, p 14.

208. I also note the submissions made on behalf of both families that to ensure compliance with the policies and procedures provided for in the OPMs, audits should be conducted to ensure WH officers and QPS officers are competently undertaking the relevant checks and those checks are being recorded accurately.[57] I will discuss this further at the end of my findings in relation to relevant recommendations.

Issue 4 – The appropriateness of cultural communication and liaison with Ms Tilberoo's next of kin

209. DS Schmidt gave evidence at inquest that, as the ESC Investigating Officer, she was responsible for liaising with Ms Tilberoo's next of kin during the investigation. In her report and her evidence DS Schmidt outlined in detail her interactions with Ms Tilberoo's next of kin, which included:

- initial enquiries to locate next of kin as none were listed in Ms Tilberoo's QPS records;
- telephone contact with family members on the day of Ms Tilberoo's passing to advise them of her passing and what they could expect to happen next;
- an in-person meeting with family members and the forensic pathologist at Forensic Scientific Services prior to the autopsy;
- arranging for the forensic pathologist to contact the family by phone after autopsy and advise them of the cause of death;
- meeting with the family outside court prior to the Pre-Inquest Conference;
- travelling to Woorabina to meet with the extended family and discuss the progress of the investigation;
- emailing updates to family members and responding to questions by phone and email throughout the process; and
- balancing the need for contact with the risk of retraumatising family members with that contact.

210. DS Schmidt's account of her interactions with Ms Tilberoo's family was not challenged or criticised by Counsel for the family. During cross-examination by Counsel for the family, DS Schmidt confirmed that QPS does not currently have a requirement that a QPS cultural liaison officer be used when notifying a family of a death in custody. DS Schmidt said that, during her investigation of Ms Tilberoo's passing, she took on the roles of investigating officer and family liaison officer. DS Schmidt also confirmed that the QPS does not have specific guidelines for dealing with coronial investigations for indigenous deaths in custody and agreed that such guidelines would assist in the future.

211. I find that DS Schmidt's cultural communication liaison and communication with Ms Tilberoo's family was thorough, respectful, responsive and appropriate. I accept the submission by Counsel Assisting that, notwithstanding this finding, there is certainly scope for the QPS to implement guidelines to ensure consistency and quality of cultural communication state-wide in matters involving deaths in custody.

[57] Submissions on behalf of Wylucki and Tilberoo families, para 21.

Findings required by s. 45

Identity of the deceased – Vlasta Wylucki

How she died – Ms Wylucki died in Southport Watch House from ischaemic heart disease due to coronary atherosclerosis.

Place of death – Southport Watch House SOUTHPORT QLD 4215 AUSTRALIA

Date of death– 01/03/2018

Cause of death – 1(a) Ischaemic heart disease
1(b) Coronary atherosclerosis (Previous angioplasty - stent)

Identity of the deceased – Shiralee Deanne Tilberoo

How she died – Ms Tilberoo died in Brisbane City Watch house from a subarachnoid haemorrhage, due to a ruptured berry aneurysm.

Place of death – Brisbane City Watch House BRISBANE QLD 4000 AUSTRALIA

Date of death– 10/09/2020

Cause of death – 1(a) Subarachnoid haemorrhage, due to, or as a consequence of
1(b) Ruptured berry aneurysm (Tilberoo)

Comments and recommendations

212. Pursuant to s46 of the Act, a Coroner may:

> *whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to –*
>
> *(a) public health or safety; or*
> *(b) the administration of justice; or*
> *(c) ways to prevent deaths from happening in similar circumstances in the future.*

213. Acting Superintendent Scott McLaren of the State Custody Group (**SCG**) gave evidence to the court in respect of progress on issues relating to state custody since September 2020.

214. A/Superintendent McLaren advised the court that, following Ms Tilberoo's passing, the Commissioner of Police initiated an internal inquiry into QPS WH operations. This inquiry was conducted by QPS State Custody Officer Superintendent David Tucker, who produced his State Custody Officer WH Inquiry (**SCOWI**) Report in January 2021.

215. A/Superintendent McLaren outlined the findings of the SCOWI report, which included:

- *The QPS does not have a core function in providing for the ongoing detention of a prisoner beyond 24 – 48 hours;*
- *QPS is responsible for providing a place suitable to detain persons, unable to be released on their own recognisance and required to appear before a court;*
- *The provisions of the* Corrective Services Act *permit an extension of detention in QPS Watchhouses which negatively impacts the service as our infrastructure has only been built and developed to support our core police functions as prescribed in the* Police Service Administration Act *and the* Police Powers and Responsibilities Act*;*
- *Historically the QPS has been required to support detention of a person in watchhouses for extended periods as a result of operational needs and the convenience of [QCS]; and*
- *A high proportion of detainees will be acutely affected by drugs and/or alcohol and QCS facilities have staffing and purpose-built capabilities to respond to such needs.*[58]

216. The establishment of the SCG was also a recommendation in the SCOWI report, which recognised the need for a body to "perform an oversight role across custody…issues within Queensland, providing guidance and direction around the review and development of policies, practices and training to improve operational effectiveness in custody…management".[59]

217. A/Superintendent McLaren explained to the court that the SCG have already implemented a number of changes since its formation, including:

[58] TILBEROO C57 – Statement of A/S McLaren, para 9.
[59] TILBEROO C57 – Statement of A/S McLaren, para 13.

- Regular meeting with District Officers and Officers in charge of WHs to discuss issues, co-ordinate consistent responses and to review and update policies;
- Training for WH staff in respect of community supports which are available to vulnerable persons in custody, including cultural awareness training in respect of First Nations prisoners;
- Liaison with QCS and the Department of Children, Youth Justice and Multi-cultural Affairs (**DCYJMA**) to enhance inter-agency understanding and establish new procedures to escalate priority transfer requests;
- Amendments to Appendix 16.1 of the OPM (not those noted above) to provide WH officers with more information about drug and alcohol dependency and how to assess prisoners who may be drug and alcohol dependent;
- Introduction of a 5-week training course at the Police Academy for all newly-hired WH officers; and
- Working with QH to increase the availability of medical staff in WHs.

218. Following the close of the inquest, A/Superintendent McLaren was requested to provide an addendum statement responding to specific enquiries by the court, and providing his view as to practical and suitable recommendations which could be made pursuant to s46 of the Act. The addendum statement was circulated to the parties to the inquest, and they were invited to advise if they required A/Superintendent McLaren for further cross-examination, but no party wished to do so.

219. On the basis of the addendum statement of A/Superintendent McLaren as well as the evidence which has been gathered during the investigation and inquest, Counsel Assisting put forward four recommendations for my consideration.

220. In their submissions, the parties to the inquest variously indicated their support for the recommendations suggested by Counsel Assisting, challenged them, and/or suggested other recommendations which I should consider making. I have carefully considered all submissions in respect of recommendations, and now make the following recommendations in this matter:

Recommendation 1

221. That, in addition to the recent Government response to the 'Hear Her Voice – Report Two', recommendations 105 and 106, and in order to ensure that the time for which all prisoners are held in WHs is minimised, the Queensland Government consider amendment to section 6(2) of the *Corrective Services Act 2006* to amend the time period in s6(2)(a) from 21 days to 72 hours, and to delete s69(2)(b).

Recommendation 2

222. That the Queensland Government consider providing additional resourcing to the QPS to support the increased training of WH officers and specialised police officers working within Queensland WHs.

Recommendation 3

223. That the Queensland Government provide additional resourcing to Queensland Health and to the Commissioner of Queensland Police to enable Queensland Health and the Queensland Police Service, jointly and in collaboration, to place nursing and/or paramedical clinicians in all Queensland WHs, in person or by technological means, on a 24hour a day, 7 day a week basis, and that those clinicians have access to CIMHA and ieMR where relevant

Recommendation 4

224. That, subsequent to, the implementation of Recommendation 3, the Queensland Police Service amend s16.13.1 of the Operational Procedures Manual to provide that that the initial health assessment of persons in WHs is conducted by a Queensland Health clinician.

225. In addition, both families made submissions that I consider additional recommendations.

226. A submission was that the Queensland Government appoint an agency external to the QPS to conduct random audits of WHs across the state to ensure compliance with the OPMs in relation to the supervision of prisoners and that these audits occur on an ongoing periodic basis.[60] In this respect, I note the submissions on behalf of the QPS Commissioner, which notes that there are already four regulatory agencies who have oversight of QPS custody: the Ethical Standards Command, the State Custody Unit, a community-oriented advisory group and the QPS Custody Advisory Group. The question of oversight is managed by the QPS Ethical Standards Command and has recently overhauled its inspection mandate of WHs to include these issues raised at the Inquest as a specific issue.[61] While I appreciate that these are not agencies external to the QPS, in my view, the QPS are taking sufficient steps in this area that a recommendation that an external agency be established is not warranted at this stage.

227. I make the following recommendation which was suggested by the family (as per above) and which I note was supported by the QPS Commissioner:

Recommendation 5

228. The Queensland Government provide additional funding to non-government organisations whose core business is the support of persons in custody. Greater access by non-government organisations to persons in custody at WHs will enhance external accountability and transparency.

I close the inquest.

Stephanie Gallagher
Deputy State Coroner
BRISBANE

[60] Submissions on behalf of Wylucki and Tilberoo families, para 25.
[61] Submissions on behalf of the QPS Commissioner, para 6.