CORONERS COURT OF QUEENSLAND

2022-23 ANNUAL REPORT

QUEENSLAND COURTS

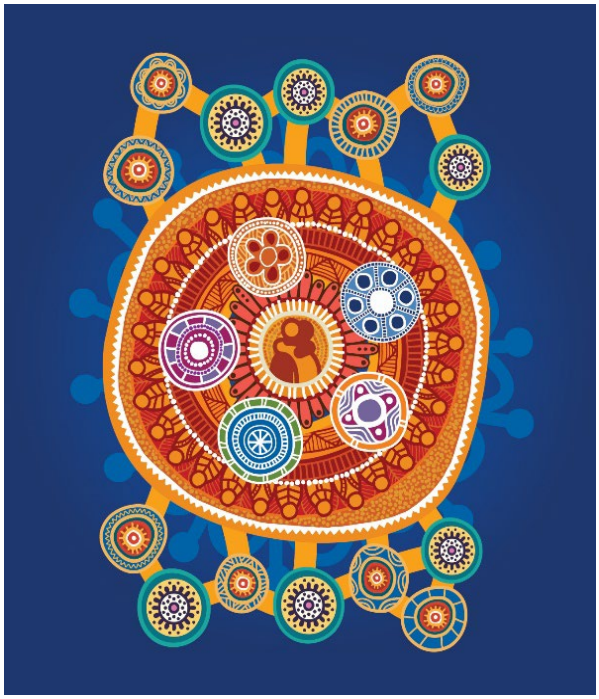
The coronial system is underpinned by a shared understanding that society values and protects the life of every person.

We appreciate that each death brings sadness, disruption, and trauma to the families of those who are entrusted to our care.

When someone we love dies suddenly or in a way that is unexplained or unexpected, those feelings are magnified.

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

WARNING: Please be advised some content in this report may be distressing to readers. First Nations people are advised that this report contains the names of people who have passed away.



Acknowledgement of Country

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

22 November 2023

The Honourable Yvette D'Ath MP
Attorney-General and Minister for Justice
and Minister for the Prevention of Domestic and Family Violence
GPO Box 149
BRISBANE QLD 4001

Dear Attorney-General

In accordance with section 77 of the *Coroners Act 2003*, I am pleased to present the Coroners Court of Queensland Annual Report for the year ended 30 June 2023.

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

During the reporting period the State Coroner's Guidelines were updated in relation to Chapter 3 – Reporting Deaths, regarding the reportability of deaths under the *Voluntary Assisted Dying Act 2021* which commenced operation on 1 January 2023.

The guidelines are publicly available at: https://www.courts.qld.gov.au/courts/coroners-court.

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

Yours sincerely

Terry Ryan
State Coroner

Purpose

The Coroners Court of Queensland Annual Report provides information about the Court's structure and operations as well as financial and non-financial performance measures for the period 1 July 2022 to 30 June 2023. The report has been prepared in accordance with the requirements of the *Coroners Act 2003*. This report is accessible online at: Publications Queensland Courts or https://www.coronerscourt.qld.gov.au/resources/ccq-annual-reports

Data

Data contained in this report has been obtained from the Coroners Case Management System (CCMS). CCMS is a 'live' operational database, in which records are updated as the status of the coronial investigations change and/or input errors are detected and rectified.

Content presented in this report was correct at the time of publication but data verification may result in variance of figures over time.

Enquiries

If you have any questions about this report, please contact:

Coroners Court of Queensland
GPO Box 1649
Brisbane QLD 4001
Telephone: (07) 3738 7050
Email: state.coroner@justice.qld.gov.au.

For further information about the Coroners Court of Queensland, please visit our website: https://www.coronerscourt.qld.gov.au/.

Feedback

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

Interpreter

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

Contents

2022–23: IN REVIEW

Performance measures - cases

6,530	5,999	91.9%	17.7%
Cases lodged	Cases finalised	Clearance rate	Backlog indicator

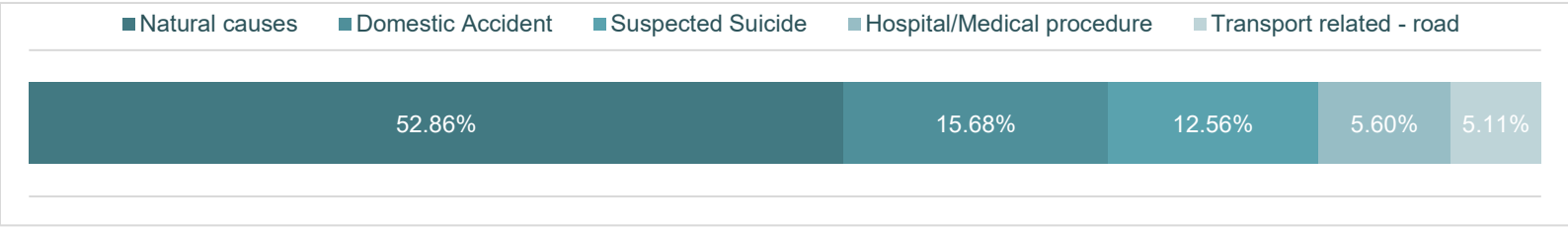
Timeframes

108	88.71%
Average days to finalise case	Cases are finalised in less than 12 months

Inquests and Recommendations

20	24	3	81
Inquests finalised	Deaths investigated at inquest	Joint inquests finalised	Recommendations made

Type of Reportable Death



Death Type

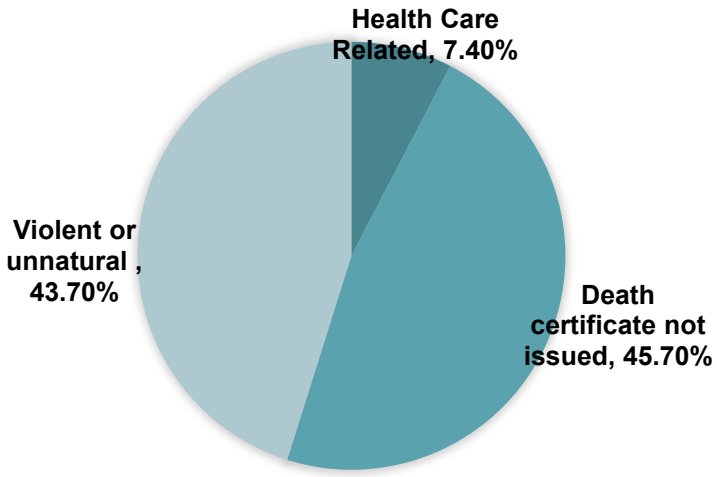


Figure 1: Death Type Percentage Graph

***Death Type (refers to top three reported) and Type of Reportable Death (refers to top five reported). The totals may be different from cases lodged as multiple can be selected.**

State Coroner's Overview

I am pleased to present the Coroners Court of Queensland Annual Report for the financial year 2022-23.

The year saw another record-breaking number of lodgements with 6,530 lodgements. This represented an 8% increase compared to the previous financial year (6,044 lodgements).

Once again, the court was able to reduce the average number of days taken to finalise cases from 144 to 108. The significant increase in lodgements also saw the Court's backlog indicator increase to 17.7%. Around half of the cases in the backlog are awaiting criminal proceedings or are the subject of an inquest. The increasing backlog also reflects the continued increase in the number of new deaths reported to the court over the past two financial years.

The court has continued to strive to achieve a 100% clearance rate. While this was not reached during this reporting period, 5,999 cases were finalised in 2022-23. This is 1,000 more cases (a 20% increase) compared to 2012-13 (4,999) and represents the second largest number of finalisations since the court was established.

During 2023-24 the Coronial System Board will progress the Coronial Services Reform Project including a Coronial System Backlog Reduction Strategy and the Coronial System Family Engagement Strategy.

It was pleasing to see that the Queensland Government recognised the need for additional resources in order for the court to meet increasing demand in the 2023-24 budget process, which saw the allocation of funds to enable the appointment of three additional coroners and associated staffing. I am very grateful for the allocation of additional resources to the court, particularly to support the wellbeing of court staff.

Once again, I extend my thanks to my fellow coroners, the coronial registrars, and the dedicated and skilled legal and administrative staff of the court, led capably by the Director of the Coroners Court, Raelene Speers. Together with our partner agencies including the Coronial Support Unit in the Queensland Police Service and Queensland Health Forensic and Scientific Services, their contributions are critical to the work of the Queensland Coronial System in providing independent, family centred and timely death investigations.

Our Court

The Coroners Court of Queensland (CCQ) works in partnership with the Queensland Police Service and Queensland Health (Forensic and Scientific Services and Forensic Medicine Queensland) to provide Queenslanders with a consistent and coordinated system to investigate deaths that are sudden or unexpected or occur in custody, police operations, or in care.

Our jurisdiction

The operation of the CCQ is provided for by the *Coroners Act 2003* (Qld) (the Act). Broadly, the Act provides for a coronial system and other purposes represented below.

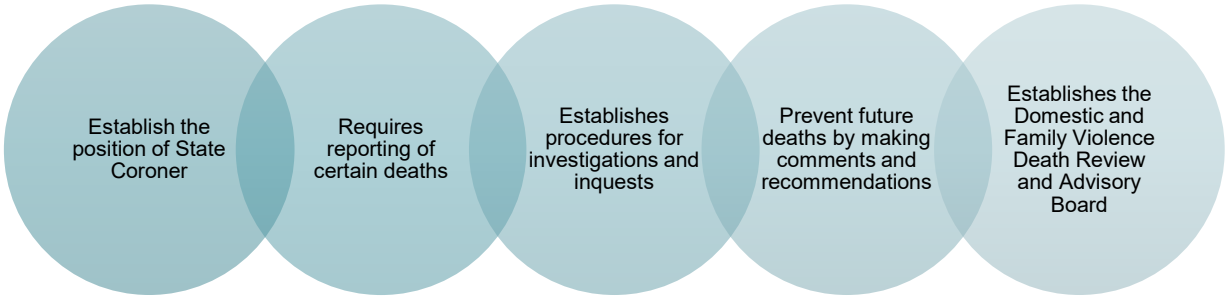


Figure 2: *Functions of the Coroners Act 2003*

Our purpose

Coroners and registrars are responsible for investigating 'reportable deaths' as set out in section 8 of the Act. Not all deaths that occur in Queensland are reportable; only those considered to warrant scrutiny by virtue of the nature of the incident that triggered the death, or due to the deceased person's particular vulnerability are deemed reportable and are further investigated.

Similarly, not all deaths require an inquest to be held. Whether an inquest is held as part of the investigation of a death is determined by requirements outlined in sections 27 and 28 of the Act. Circumstances requiring an inquest include deaths occurring in custody or care. Coroners have a broad discretion to hold an inquest if satisfied it is in the public interest. Most deaths are finalised administratively through the completion of chamber findings.

Coroners are required to establish (if possible) who the deceased person was, when, where, and how they died, and the medical cause of the death. A coronial investigation is an independent, impartial, open, and transparent inquisitorial process. The investigation provides answers to families and informs the community about death prevention. It is not the role of a coroner to find people guilty of criminal or civil offences.

Our commitment

Where an inquest is held coroners consider whether the death may have been preventable. Coroners can make comments and recommendations about systemic issues or policy and procedural changes that could contribute to improvements in public health and safety, the administration of justice, or prevent or reduce similar deaths in future.

Our Vision

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

Our interconnected system

The coronial jurisdiction is multidisciplinary, with the work of the CCQ supported by our two key partner agencies the Queensland Police Service and Queensland Health. Each agency has specialist skills which are applied at different stages of the coronial process. Coronial services operate as an interconnected and interdependent system.

The Coroners Court of Queensland (CCQ)

The CCQ sits within the Magistrates Courts Service and supports the State Coroner's statutory function to administer and manage a coordinated state-wide coronial system in Queensland. The CCQ provides registry, administrative and legal support to coroners and registrars across the State.

The CCQ is also a central point of contact for families about coronial matters. We aim to deliver family-focused services and are continuously working towards improving how we engage and support bereaved families, our stakeholders, and our coroners. The CCQ also administers the CCQ Funerals Assistance Scheme and manages Government Contracted Undertakers for burial and cremation assistance and coronial conveyance services.

Queensland Police Service (QPS)

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

Queensland Health (QH)

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

Coronial Family Services, also based in Brisbane provide information and counselling support to relatives, work through objections to autopsies, organ and tissue retention and inform families of post-mortem examination findings.

Forensic Medicine Officers (FMO) within Forensic Medicine Queensland (FMQ) based in Brisbane, provide independent clinical advisory services, including toxicology interpretation, expert opinions and advice about issues requiring further investigation. The FMQ supports the Northern and Central Coroners, while the Gold Coast Forensic Medicine Team based in Southport assists the Southeastern Coroner.

Our Coroners

Queensland has eight specialist coroners located in Southport, Brisbane, Mackay, and Cairns.

State Coroner – Terry Ryan

State Coroner Terry Ryan was appointed as a magistrate and as State Coroner in July 2013. After being admitted as a solicitor in 1991, he worked in private practice before returning to the Queensland Government where he commenced his career in 1984 as a social worker in the fields of child protection and youth justice. State Coroner Ryan holds a Bachelor of Social Work, Bachelor of Laws (Hons), Master of Laws and a Graduate Diploma in Legal Practice.

In the period 2001 to 2010 State Coroner Ryan served as the Director of the Strategic Policy Unit and Assistant Director-General, Strategic Policy, Legal and Executive Services in the Department of Justice and Attorney-General (DJAG). From 2010 up until his commencement with the Coroners Court, State Coroner Ryan was the Deputy Director-General of DJAG. State Coroner Ryan was the Chair of the Domestic and Family Violence Death Review and Advisory Board until October 2022.

Deputy State Coroner – Stephanie Gallagher

Deputy State Coroner Gallagher was appointed as a Magistrate on 29 July 2021 and commenced in the role of Brisbane Coroner on 2 August 2021. On 23 May 2022, Magistrate Gallagher was appointed to the role of Deputy State Coroner. Deputy State Coroner Gallagher has more than 30 years' experience as a solicitor and barrister with specialisation in the regulation of the health professions, medical and health-related litigation and policy, mediations, guardianship matters, special health matters and coronial inquiries. She was Chair of the Queensland Interim Medical Board in Queensland (QMING) for approximately one year, the chair of the Professional Standards Committee of the Nursing Council for 7 years and sat on the Boards of St Andrew's War Memorial and QEII Hospitals. She also sat as a member of Institutional Ethics Committees at tertiary hospitals for more than 15 years. Deputy State Coroner Gallagher is an Adjunct Associate Professor in the School of Applied Psychology at Griffith University.

Brisbane Coroner – Christine Clements

Prior to commencing in the Magistrates Court of Queensland, Coroner Clements was responsible for the Bundaberg Legal Aid Office and worked as a barrister and solicitor in private practice in South Australia since her admission in 1980. Coroner Clements was appointed as magistrate in 2000 and has worked exclusively in the coronial jurisdiction since 2002 when she was appointed as a coroner. Coroner Clements was the inaugural Deputy State Coroner, holding the position from 2003 for 10 years. In December 2013 Coroner Clements was appointed as a Brisbane Coroner.

Brisbane Coroner - Don MacKenzie

Coroner Don MacKenzie has worked within the Criminal Justice System for over 30 years, commencing as a law clerk in the Public Defenders Office in 1990. He holds a Master of Laws, a Bachelor of Arts and a Graduate Diploma of Military Justice. He was admitted as a Barrister in 1993, spending 5 years working for the Legal Aid Office and 14 years at the Office of the Director of Public Prosecutions (Qld), rising to the positions of Senior Crown Prosecutor then Consultant Crown Prosecutor. In 2008, Coroner MacKenzie joined the private Bar, practicing as a member of More Chambers in Brisbane. Coroner MacKenzie estimates that he has prosecuted or defended well over 800 jury trials (including dozens of murder trials), has appeared on hundreds of Court of Appeal matters and as sole counsel in the High Court of Australia. He is also an officer in the Royal Australian Navy with the Inspector-General Australian Defence Force and held the statutory appointment as the Chairman, Public Records Review Committee of Queensland before his appointment as a Magistrate in 2017 and Coroner in 2019. He

has regularly appeared as a guest lecturer on criminal law and evidence for the Queensland Law Society and at the University of Queensland and is the senior editor of the Thomson's loose-leaf publication Summary Offences Queensland. He was appointed a Brisbane Coroner in 2019.

Northern Coroner – Nerida Wilson

Coroner Wilson was appointed as a Magistrate in 2015 and instated as the Northern Coroner for Queensland in 2017. Coroner Wilson is based in Cairns. Coroner Wilson served as an Australian Federal Police Officer from 1987 until 1995 thereafter completing her degree and practising as a solicitor. She was called to the Bar in 2008 until her appointment as a Magistrate. Coroner Wilson was conferred the Queensland Regional Woman Lawyer of the Year award by the Women Lawyers Association of Queensland in 2013. Coroner Wilson was one of 45 women lawyers selected from across Australia to participate in the "Trailblazing Women and the Law" oral history project now archived in the National Library of Australia.

Southeastern Coroner – Carol Lee

Coroner Lee was appointed as a Magistrate on 23 May 2022 and is the Southeastern Coroner based in Southport. Coroner Lee holds a Bachelor of Laws in addition to the qualification of registered nurse. She has held senior positions in a number of leading law firms, where she specialised in the field of health law. She has had extensive clinical experience in the Queensland public hospital system and has a deep understanding of the multifaceted environment in which the health sector operates. Coroner Lee has also served as a legal member on the Queensland Mental Health Review Tribunal, the Chiropractors and Osteopaths Board of Queensland, West Moreton Human Research and Ethics Committee, General Practice Training Queensland and Acting Ordinary Member of the Queensland Civil and Administrative Tribunal. Coroner Lee has also undertaken nationally accredited mediation training and has been awarded Best Lawyer status in the fields of Health and Aged Care and Medical Negligence for 10+ years.

Central Coroner – David O'Connell

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

Brisbane Coroner – Christine Roney

Coroner Roney is a long serving Magistrate who has worked in a number of Brisbane and suburban courts, Longreach and the Southport Courts. Previously she has also been commissioned as a member of QCAT, a commissioner at the Queensland Industrial Relations Commission and is a former Chair of the Veterinary Surgeons Disciplinary Tribunal. During 2022-23, the Chief Magistrate continued to allocate Coroner Roney to work in the coronial jurisdiction on a part-time basis.

Our Registrars

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

Coronial Registrar – Ainslie Kirkegaard

Ainslie Kirkegaard is the inaugural Coronial Registrar of the Coroners Court of Queensland. This is a unique judicial registrar role designed to triage deaths reported daily across Queensland. Ainslie has held this role since early 2012 and previously held the positions of Counsel Assisting the Deputy State Coroner and Director, Office of the State Coroner. Ainslie became a part of the Queensland coronial system in 2008, bringing more than 15 years' experience in policy and legislation development in the health, education, and justice portfolios, with specialist expertise in coronial and health regulatory law and policy. Having been appointed as an Acting Magistrate since April 2015, Ainslie now also relieves as coroner when required.

Coronial Registrar – Jessica Lambert

Jessica Lambert was appointed as Coronial Registrar on 16 September 2021. Prior to her appointment as Coronial Registrar, Jessica held the quasi-judicial appointments of Supreme and District Court Corporations Registrar and Deputy Admiralty Marshal. Admitted as a Legal Practitioner since 2006, she has held various positions at the State ODPP and within QUT Law School. Jessica is currently a Member appointed to multiple committees including FSS Human Ethics and QLS Dispute Resolution & Government Lawyers Committees. Her civil expertise sees her as a co-author of Thomson Reuters Publication Queensland Civil Procedure. As QLS Nationally Accredited Mediator, Jessica is also an inaugural Member of the Commonwealth Department of Health's National Sports Tribunal.

Our Governance and Structure

Under the leadership of Director, Ms Raelene Speers, the CCQ employed 78 team members as of 30 June 2023. The CCQ is comprised of an establishment of experience and professionalism with positions ranging from various administrative and professional levels that build the structure of the below five streams that encompass the CCQ.

Business Services

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

Operations

Provides case management of coronial investigations and progress matters to inquest, working closely with coroners and registrars and liaising with families and other stakeholders. With eight coronial teams, throughout Queensland, operations is the largest team within the CCQ overseen by three Coronial Support Coordinators who provide management support based on regional location and/or team.

Domestic and Family Violence Death Review Unit

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

Legal Services

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

Directorate

Comprises of the Director of the CCQ responsible for the strategic leadership, governance and accountability of the registry and the Executive Support Officer who supports both the Director and State Coroner.

During the reporting period the CCQ only funded 49.81 FTE positions with the remainder of positions funded by temporary funding and those allocated as part of the government budget outcomes for ‘inquest related’ purposes. While captured in the establishment, the two coronial registrar positions are not managed by the registry and report directly to the State Coroner.

Senior Leadership Team

In addition to the five business streams described above, a Senior Leadership Team, consisting of the Director and senior manager from each stream, meets regularly to manage issues arising within the investigative and business functions of the Court. The Senior Leadership Team, reviews court policies and procedures to ensure continued effectiveness; identifies training and professional development needs of court staff; discusses workload issues and progresses major projects. The Senior Leadership organisational structure is depicted in Figure 3 below.

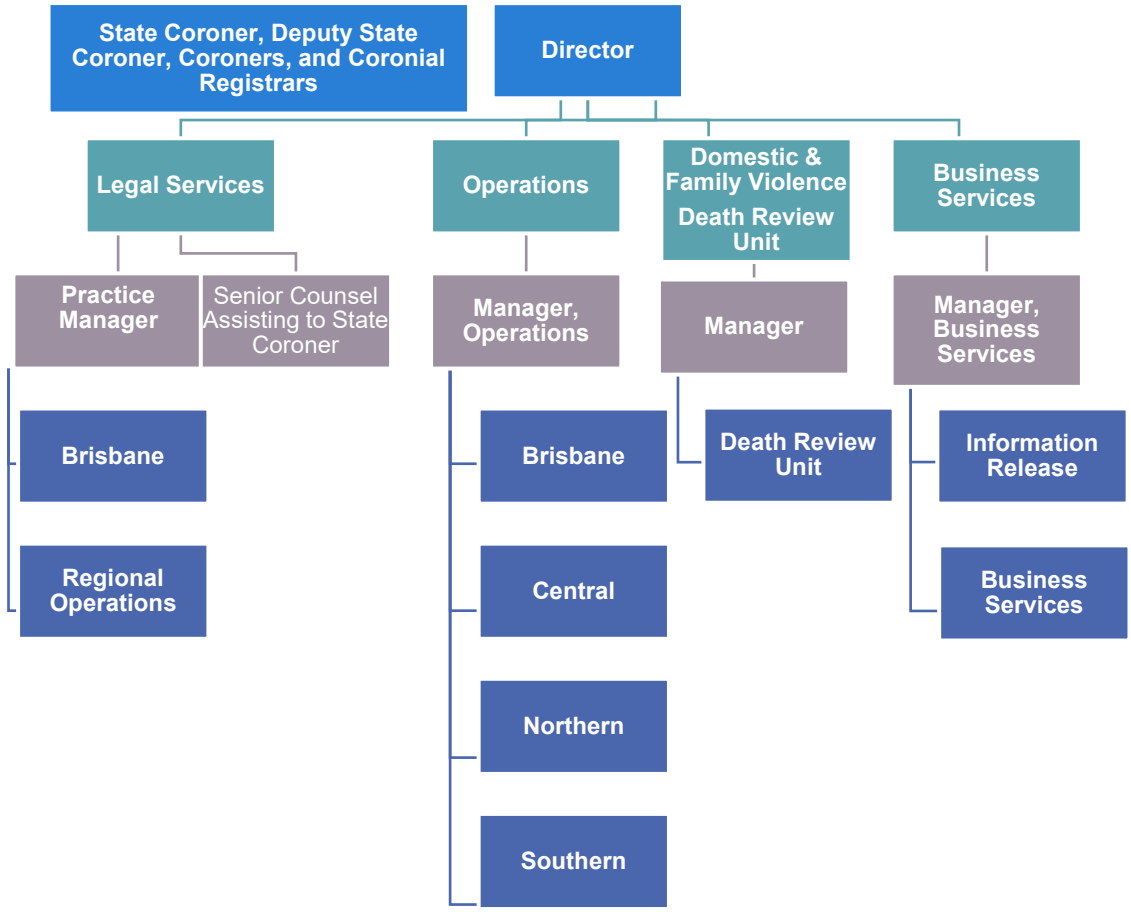


Figure 3: Senior Leadership Organisational Structure

Registry profile

The CCQ registry profile captures the locations of employees within one of four regional registry locations, either in Brisbane, Southport, Mackay or Cairns and work in a team-based structure to support coronial investigations and/or the administrative functions of the Court.

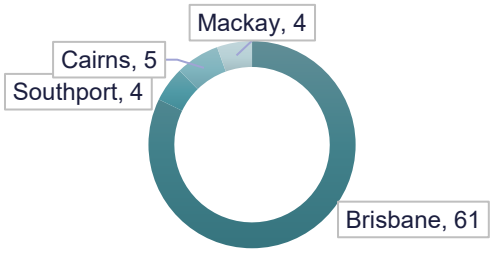


Figure 4: Registry Profile

Reforming our coronial system

Over the past three reporting periods the coronial system has been responding to the challenges and recommendations identified in the Queensland Audit Office (QAO) report[1]. The audit assessed the performance of the three key agencies involved in delivering coronial services and the support provided by these agencies to coroners and families. The QAO report identified the coronial system is complex and under stress and highlighted reforms to improve the system. The report has been instructive in focusing improvements on priority areas to deliver real change, resulting in better coronial system coordination between partner agencies and sustainability.

Coronial Services System Delivery Framework 2021-2025

A key sustainability action has been the development of the Coronial Services System Delivery Framework 2021- 2025[2] (the Framework). This is an important system planning document, providing a strategic framework for the delivery of multidisciplinary coronial services ensuring family focus, sustainability and performance. Released in September 2021, the Framework was developed through a series of strategic conversations and cross-agency workshops. It explains the partnership approach that underpins the coronial system and sets out its vision, purpose and partnership principles. The Framework provides the overarching strategic charter for agencies delivering coronial services aiming to facilitate a co-ordinated system putting families at its centre.

Coronial System Board

The establishment of the Coronial System Board (the Board) in July 2021 was another step forward in the transformation of Queensland's coronial system through greater coordination and planning to deliver family-centred services. It provides strategic direction, enhanced partner collaboration, innovation and performance, and will drive implementation priority actions within the Coronial Services Delivery Framework over the next five years with the Coronial System Coordination Group (see below). Chaired by the State Coroner, membership consists of senior leaders from the DJAG, QH, and the QPS. The Board met three times during the reporting period.

Coronial System Coordination Group

In May 2023, the Coronial System Coordination Group (the Group) met to consider priority actions within the Coronial Services System Delivery Framework. Chaired by the Deputy State Coroner, with membership from senior departmental officers from partner agencies, it seeks to operationalise the Board's priorities to deliver improved services to families and the community.

The Group is focused on implementing priority actions that extend the current reforms and complete the remaining QAO recommendations. **Key achievements and priorities for the Group during the 2022-23 period included:**

- Achieving full automation of the Form 1 – Police Report of a Death to a Coroner – *to achieve efficiencies in death reporting through integration of agency IT systems.*
- Ongoing consideration and consultation of outstanding Queensland Audit Office (QAO) Coronial Services recommendations.
- Establishing the Coronial Services Reform Project, aiming to deliver a contemporary best practice state-wide model of service delivery.

[1] Delivering Coronial Services – Report 6: 2018-19 - https://www.qao.qld.gov.au/reports-resources/delivering-coronial-services
[2] Coronial Services Delivery Framework - https://www.courts.qld.gov.au/__data/assets/pdf_file/0003/692301/ccq-delivery-framework-2021-2025.pdf

Investment in coronial services

Government has supported and invested in coronial services in recent years to support reform and renewal activities and to progress domestic and family violence death investigations.

As part of the 2022-23 Budget, the Department of Justice and Attorney-General was allocated funding of $4.5m ($3.7m controlled, $0.80m administered) from the Women's Safety and Justice Taskforce Report 1, *Hear Her Voice*. The funding provides support for temporary FTE positions to enhance and address domestic and family violence death reviews and to maintain and expand Queensland's domestic and family violence homicide and suicide data set. Specifically, this investment is aimed to deliver a more effective, efficient and sustainable coronial system including:

- $2.5m limited life funding, eight temporary FTEs and a temporary coroner to enhance domestic and family violence death reviews,
- $1.2m limited life funding and three temporary FTEs to maintain and expand Queensland's domestic and family violence homicide and suicide data set,
- $153,000 and one permanent FTE to enhance contract management of government undertakers.

Farewell to Coroner Clements

Prior to commencing in the Magistrates Court of Queensland (in 2000), Coroner Clements was responsible for the Bundaberg Legal Aid Office and worked as a Barrister and Solicitor in private practice in South Australia.

Coroner Clements worked exclusively in the coronial jurisdiction since 2002 when she was appointed as a Coroner and was the inaugural Deputy State Coroner from 2003, a position she held for 10 years.

In more than 20 years in the jurisdiction, Coroner Clements has made a significant contribution to Queensland's coronial system. She was a pioneer of the modern coronial system in Queensland, finalising investigations into over 6500 deaths, including 60 inquests and made an invaluable contribution in supporting and mentoring new coroners and CCQ staff. Over the course of her tenure, Coroner Clements developed expertise in health care related death investigations and was largely responsible for these matters in Southeast Queensland until 2008, when a second full time coroner was appointed to Brisbane.

Coroner Clements presided over several high-profile inquests including the deaths in custody of First Nations man, Mulrunji on Palm Island and Antonio Galeano in Far North Queensland. The recommendations made arising from these inquests demonstrates Coroner Clements' contributions to improving public health and safety and the administration of justice. The inquest into the death of 22-month-old Jet Paul Rowland is an example of her contribution to the everyday safety of the Queensland community. Jet's Law became the first eponymous law in the state of Queensland. It requires people with a medical condition (such as epilepsy) that may affect their fitness to safely drive a motor vehicle to inform the Department of Transport and Main Roads immediately and provide medical confirmation of their fitness to drive safely.

Coroner Clements' tenure is marked by her open mindedness to the evidence, steadfast impartiality in the face of intense media coverage and public speculation and her sensitivity to the needs of bereaved families. Coroner Clements' professionalism, dedication, and empathy, alongside the body of case law and precedent created in the coronial jurisdiction is evident in her service as a coroner. Her service to the Queensland community including the vulnerable and disadvantaged, and her contribution to the development of the Queensland coronial system is recognized and appreciated.

Our Achievements

State Coroner's Guidelines – s14 of the Coroners Act

One of the State Coroner's functions is to issue guidelines about the investigation of deaths and other matters under the Coroners Act[3]. These guidelines aim to ensure best practice in the coronial system. The State Coroner must consult with the Chief Magistrate before issuing any guidelines or amendments to guidelines.

During the reporting period, Chapter 3, which deals with the reporting of deaths was amended. This amendment included the insertion of the Deaths under the *Voluntary Assisted Dying Act 2021*. The *Voluntary Assisted Dying Act 2021* amended the *Coroners Act 2003* to provide that the death of a person who has self-administered, or been administered, a voluntary assisted dying substance under that Act is not a 'reportable death' under the *Coroners Act*.[4] This reflects the underlying intent of the Voluntary Assisted Dying legislation which expressly provides that a person who dies in this manner does not die by suicide; rather they are taken to have died from the disease, illness or medical condition from which they suffered.[5] Nor does conduct which is authorised by the *Voluntary Assisted Dying Act 2021* in connection with the person's death under the process attract criminal liability.[6]

This amendment to the Act gives effect to the Queensland Parliament's view that a coronial investigation for a voluntary assisted dying death would be unnecessarily intrusive for the person's family. A death that occurs under the voluntary assisted dying process is the planned and expected outcome of a person's decision to hasten their inevitable and imminent death as a result of their incurable disease, illness or medical condition.

Courts Services Queensland (CSQ) Awards

On 1 March 2023 the annual CSQ Staff Awards were held with over 60 nominations across the Magistrates Court. The CCQ were nominated in a number of categories including Customer Focus, Leadership, Performance and Behind the Scenes, with the following staff and teams winning their nominated categories;

- Winner for Leadership - Kristy-Lee Holmes (Operations)
- Winner for Customer Focus - The Baxter/Clarke Inquest Team
- Highly Commended Individual Award – Darryl Jackson (Operations)

Justice Services Divisional Excellence Awards

On 4 May 2023, CCQ teams and individuals were finalists in the Justice Services Divisional Awards, winning both the *Customer Focus and Leadership* categories;

- *Winner for Customer Focus*, Baxter/Clarke Inquest Team
- *Winner for Leadership*, Kristy-Lee Holmes (Operations)

DJAG Staff Excellence Awards

On 12 July 2023, CCQ continued to represent their work and commitment to the court with wins at the 2023 DJAG Staff Excellence Awards held at Parliament House. The Baxter/Clarke Inquest Team won Best Customer Focus and Kristy-Lee Holmes won the Highly Commended award for Leadership.

---

[3] [3] Coroners Court of Queensland. (2013). *State Coroners Guidelines 2013*. Brisbane: Queensland Government. Available at: https://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/resources-and-legislation

[4] *Voluntary Assisted Dying Act 2021*, section 171

[5] *Voluntary Assisted Dying Act*, section 8

[6] *Voluntary Assisted Dying Act*, section 147

Communication and Corporate branding

In May 2023 the CCQ conducted a review and refresh of the Coroners Court of Queensland-Charter. This Charter was created to outline the objectives of the Office of the State Coroner upon its establishment. The Charter now reflects the CCQ Vision*: 'Coronial services that partner to deliver independent family-centred and timely investigations'*, which is further reflected in the various subsections of the Charter, (such as *Our Court, Our purpose, Our partnerships* and *Our commitment)*.

Form 9 – Medical practitioner report of a death to a Coroner (Electronic Cause of Death Certificate) project

During 2022, the Registry of Births, Deaths and Marriages Queensland (RBDM) engaged with the CCQ to progress implementation of their service provider portal for the electronic submission and authorisation of Form 9 cause of death certificates.

The first phase of the project released on 3 August 2022 between RBDM and CCQ was limited to 'Form 1A-Medical Practitioner Report of a Death to a Coroner' pathway which was initially released to a select cohort of private hospitals. This allowed hospitals to submit the draft 'Form 9-Cause of Death Certificate' through the portal and relevant paperwork to the CCQ for review. The second iteration was released in January 2023 and involved the Form 1 – Police reports of a death to a coroner for apparent natural causes deaths only. This release saw a significant increase in use in the portal for the CCQ with QHFSS pathologist submitting electronic draft Form 9s to the court.

From this release date to 1 July 2023 – **452** Form 9s were electronically submitted and authorised by the court. The court has continued to work with the RBDM for the third phase which will see a restructure of the Form 1A and make it accessible via the service provider portal so it can be completed online and submitted electronically with the draft Form 9. This project has already seen significant improvements in timeliness of reporting and actioning of matters and the registration of deaths with the RBDM.

CCQ For You

The CCQ For You working group continued its focus on delivering engaging and thought-provoking information sessions for the CCQ and its partner agencies. Eleven in-house and external agency presentations were delivered. The sessions continued to provide an invaluable opportunity for staff to better understand the practices of other agencies, how we can work together to progress coronial investigations and improve our interactions with and support to families.

External agency presentations included the Office of the Director of Public Prosecutions; Wildlife and Threatened Species Operations (regarding crocodile attacks in Queensland); Donate Life; Beyond Blue (for Mental Health week); the Aged Care Quality and Safety Commission (regarding the Serious Incident Response Scheme); and the Victorian Office of Public Prosecutions Court Dog Program, where court dog Lucy said hello to the CCQ staff.

Internal information sessions were held concerning conveyancing processes by our Business Services Team and an overview of patterns of domestic and family violence by our Domestic and Family Violence Death Review Unit.

CCQ For Fun

CCQ4FUN is a staff-run social club developed in 2021 to focus on staff wellbeing. Committed to creating a dynamic and inclusive work environment, CCQ4FUN organises an array of engaging events and activities that go beyond the daily grind. From themed lunches and friendly baking competitions to in-office sideshow alley and charity initiatives, CCQ4FUN provides employees with opportunities to connect, take a breath, and build relationships with other teams across the office. This valuable group

fosters a sense of community among our staff, promoting not only a more enjoyable work experience but also improved collaboration.

CCQ For Wellness - *Vicarious Trauma Prevention Strategy Project (VTPSP)*

Due to the nature of its work the CCQ recognises vicarious trauma is a significant risk factor within the organisation and has had a renewed focus on mitigating and managing vicarious trauma. The CCQ is continuing to develop its 'wellness program' which targets both prevention and support to its staff in managing vicarious trauma. It has engaged an external provider who specialises in psychosocial wellbeing in the workplace to assist.

The CCQ engaged a team of organisational and clinical psychologists from Converge International to undertake a multi-stage program to assess and identify strengths and areas for targeted action, develop and execute a pilot program of support to staff and leadership, and provide a three-year wellbeing strategy.

The main areas of focus for this pilot program revolved around upskilling leaders' ability to manage mental health and vicarious trauma and providing psychoeducation and support to staff regarding vicarious trauma, suicide awareness and building resilience. Throughout the delivery of this program, there were apparent cultural and team-related issues that arose.

It was proposed the pilot program incorporate team-based, bespoke training programs, on-site psychological support, professional supervision, and wellbeing planning sessions. These services were provided on an opt-in basis to staff and leaders.

In May 2023, the external provider delivered the CCQ Wellbeing Strategy report, following the successful completion of the pilot program.

Continuing this level of tailored vicarious trauma support in the workplace has been identified as a critical service delivery need for the CCQ.

Cultural capability

The CCQ worked towards a practice direction for the investigation of deaths in custody with a particular focus on convening inquests in a culturally appropriate manner. The CCQ has observed Welcome to Country and Acknowledgment of Country during a number of inquests, conducted community visits on Country and acknowledges the importance of referencing First Nations people by their 'skin name'.

A new position of Manager, Cultural Capability will commence in the next reporting period and will enhance the ability of the court to effectively support families, as well as coroners and the Domestic and Family Violence Death Review Advisory Board in their investigation and review of domestic and family violence related deaths of First Nations people. The position will provide training to all coroners and court team members and provide expert advice and assistance for relevant reportable deaths.

Asia Pacific Coroners Society (APCS) Conference

The Asia Pacific Coroners Society (APCS) conference was successfully hosted by the CCQ and held at the Surfers Paradise on the Gold Coast between 8 and 11 November 2022, with over 150 attendees participating in various conference activities over the three-day period.

Led by keynote speaker Professor Sidney Dekker's presentation, '*Just Culture in Coronial Investigations'*, the conference program focused on innovation beyond the pandemic, including approaches to investigations, embracing the principles of restorative justice, the impact of human rights law, the role of the media and innovative forensics.

The next APCS conference is scheduled to be hosted by New South Wales from 13 to 15 November 2024 and will explore the theme of Truth Telling in the coronial jurisdiction.

Coronial Performance

The performance measures for the coronial jurisdiction align with the national benchmarking standards outlined in the Report on Government Services. Coronial performance is measured by reference to a clearance rate and a backlog indicator.

Clearance rates

During 2022–23, a total of 6,530 deaths were reported to the CCQ for investigation. This represents the highest volume of deaths lodged with the court in its history and an 8% increase in the lodgement of deaths from the same time last year (an additional 486 deaths).

Despite this increase, the CCQ finalised 5,999 cases, achieving a clearance rate of 91.87%. Although this represents a slight reduction in the clearance rate from the previous financial year, this is attributed to the increased number of cases lodged during 2021-22 and 2022-23 periods.

Year	Cases lodged	Percent change	Cases finalised	Clearance rate	Backlog	Inquests Finalised[7]
2022-23	**6,530**	**8%**	**5,999**	**91.9%**	**17.7%**	**20**
2021-22	6,044	5.78%	6,115	101.2%	14.82%	27
2020–21	5,714	1.47%	5,845	102.29%	14.18%	26
2019–20	5,631	-2.86%	5,744	102.02%	14.81%	28
2018–19	5,797	-0.26%	5,860	101.09%	17.58%	29
2017–18	5,812	4.02%	5,618	96.66%	18.43%	52
2016-17	5,587	5.67%	5,014	89.7%	16.6%	30
2015-16	5,287	6.54%	5,313	100.5%	13.6%	49

Figure 5: Performance figures 2015-16 to 2022-23

The CCQ receives reports of deaths across the state, reported to one of four registry locations. The figures below account for all deaths reported to the court by regional reporting location of death. Figure 6 below outlines performance figures across each location.

Deaths reported by coronial region	Brisbane	Northern	Central	Southeastern
Number of deaths reported for investigation	4387	687	673	783
Number of coronial cases finalised	4101	585	644	669
Number of coronial cases pending	1626	519	355	333
Coronial cases pending - *Greater than 24 months old*	285	110	56	51

Figure 6: Statewide Performance Figures[8]

[7] Figure refers to inquests finalised, not the number of deaths investigated at inquest. Multiple deaths can be heard conjointly.
[8] These figures represent the numbers recorded within the particular region the death was reported i.e., the State Coroner, Deputy State Coroner and Coronial Registrars can receive reports of deaths state-wide.

Backlog indicator and pending cases

Coroners are aware that delays in finalising coronial matters can cause unnecessary distress for families. However, finalising a coronial investigation can be dependent on other agencies completing their investigative processes (for example, the completion of autopsy, toxicology and police reports). The CCQ may also be required to await the outcome of criminal proceedings. The CCQ has continued its focus on addressing the backlog (cases more than 24 months old) and implement strategies together with its partner agencies (QPS and QH).

With a continual increase in lodgements, the CCQ backlog indicator percentage has increased from the 14.8% the previous year to 17.7%. The overall number of lodgements pending increased from 2,281 in the previous reporting period to 2,833 in 2022-23 (a 24.2% increase).

Of the total 2,833 lodgements pending, 1,820 were less than 12 months old, 511 between 12 and 24 months and 502 cases were pending more than two years.

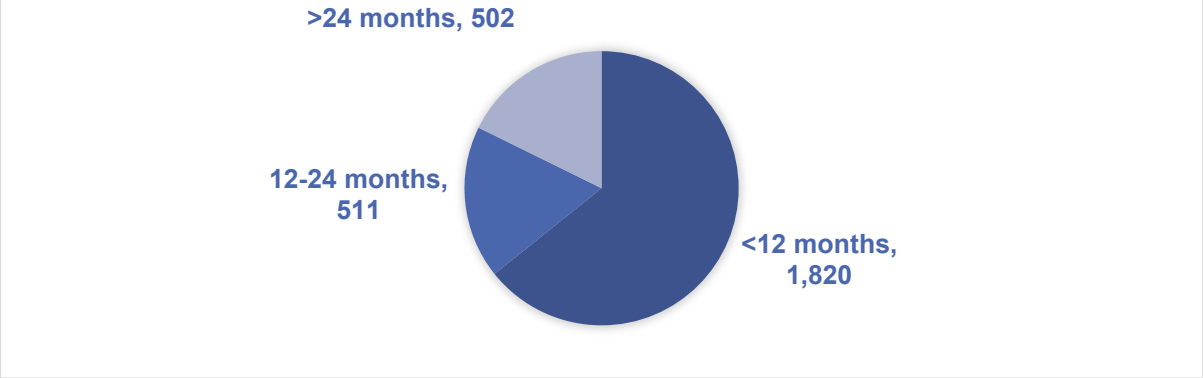


Figure 7: Backlog Indicator Breakdown

Not reportable matters

Many matters reported to the CCQ are found to be not reportable within the terms of the Act, or reportable but not requiring autopsy or further investigation. Of the deaths finalised during 2022-23, 2,992 were found to be not reportable matters within the meaning of section 8(3) of the Act. These matters are included in the Court's lodgement figures as significant work is involved in determining whether these matters are reportable or whether a death certificate can be authorised. This work can involve reviewing medical records, discussing the death with treating clinicians and family members, and obtaining advice from FMQ.

Review applications

The State Coroner has a review function under the Act with respect of decisions about whether a death is reportable, whether an inquest should be held and whether an inquest or non-inquest investigation should be reopened. During the reporting period, the State Coroner received 31 applications in this regard and finalised 20 matters of this nature.

Types of Reportable Death

Section 8(3) of the Act defines the types of deaths reportable to a coroner for investigation. The number of deaths reported to the CCQ within each category are shown in Figure 8 below.

Category of death	TOTAL
Suspected death (missing person)	23
Death in custody	29
Death as a result of police operation	14
Death in care	144
Health care related death	481
Suspicious circumstances	17
Violent or unnatural	2871
Death certificate not issued and not likely to issue	2987
Unknown persons	10

Figure 8: Deaths reported statewide by type[9]

How deaths are reported

The CCQ receives reports of death from both police (via Form 1) and by medical practitioners (via Form 1A). The CCQ also receives 'Other' reports of deaths for review and investigation. These can include phone calls from medical practitioners, funeral directors, or aged care facilities, family members, missing person reports/advice, child death advice/ notifications from the National Disability Insurance Scheme (NDIS).

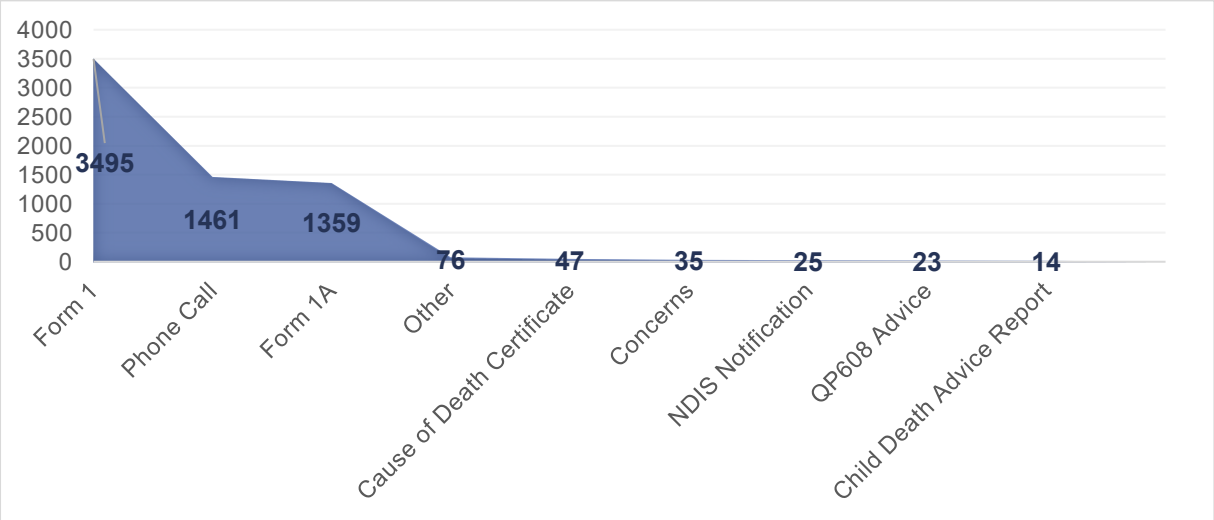


Figure 9: Deaths reported by initiating type

[9] The total *Reportable Type* may be different from *the total number of cases lodged*, as multiple *Reportable Types* may be selected on a case in the CCMS.

Coronial Registrars

The Coronial Registrars use a multidisciplinary approach to triage deaths reported to the CCQ. This includes:

- **investigating apparent natural cause deaths reported by police** (via Form 1) because a death certificate has not been issued and is unlikely to be issued;
- **reviewing deaths reported directly by medical practitioners** via Form 1A seeking authority to issue a cause of death certificate for apparently reportable deaths;
- **reviewing deaths notified by funeral directors, disability service providers, families and other entities including the Office of the Health Ombudsman, the National Disability Insurance Scheme Quality and Safeguards Commission and the Queensland Ambulance Service** to determine whether they are reportable deaths requiring coronial investigation;
- **providing telephone advice to clinicians** who seek advice about the reportability of the death before they issue a cause of death certificate. This provides an opportunity to filter out not-reportable deaths and to triage reportable deaths where a cause of death certificate may be authorised under section 12(2)(b) of the Act.

The two Coronial Registrars are supported by a dedicated administrative team comprising four AO3 Coronial Services Officers. Collectively they managed 4,507 deaths, representing 65.8% of the total number of deaths reported state-wide.

By the third quarter of 2022-23, it was evident the Court was experiencing increased reporting compared with 2021-22. Comparison of total lodgements between 1 July 2021 – 28 February 2022 (3905 deaths registered) and the corresponding period 1 July 2022 – 28 February 2023 (4415 deaths registered), demonstrated a 13.06% increase in total lodgements over 12 months.

Data from the CCMS presented in Figure 10 below, shows this increase was largely occurring in the triage space. There had been an increase of almost 50% in the number of clinician phone enquiries received by the Coronial Registrars and a 14.4% increase in deaths reported by police. Of the deaths reported by police, there had been a nearly 35% increase in the number of apparent natural cause deaths reported to the Coronial Registrars and a 4.35% increase in police reports to all coroners. There was a 6.24% increase in the number of deaths reported directly by clinicians using the Form 1A.

Data analysis - Line Item Data - Lodgement for 21-22 and 22-23							
							Percentage increase or decrease
TOTAL REPORTED 1 July 2022-28 Feb 2023	**4415**		**TOTAL REPORTED 1 July 2021 - 28 Feb 2022**	**3905**			13.06% increase
INITIATING FORM BY TYPE			**INITIATING FORM BY TYPE**			**INITIATING FORM BY TYPE**	**Percentage increase or decrease**
Cause of death certificate	31		Cause of death certificate	39		Cause of death certificate	20.51% decrease
ChildDeath Advice Report	11		ChildDeath Advice Report	7		ChildDeath Advice Report	57% increase
Concerns	17		Concerns	23		Concerns	26.08% decrease
Form 1	2399		Form 1	2097		Form 1	14.4% increase
Form 1A	1004		Form 1A	945		Form 1A	6.24% increase
NDIS notification	15		NDIS Notification	16		NDIS notification	6.25% decrease
Other	60		Other	190		Other	68.42% decrease
Phone call	861		Phone Call	583		Phone call	47.68% increase
QP608	17		QP608	5		QP608	240% increase
Form 1 by Coroner / Registrar 22-23			**Form 1 by Coroner / Registrar 21-22**			**Percentage increase or decrease**	
Coroner	1461		Coroner	1400		4.35% increase	
Registrar	938		Registrar	697		34.57% increase	

Figure 10: Data analysis lodgements for 21-22 and 22-23

These increases are not in keeping with general death registration trends according to data supplied by the Queensland Registry of Births, Death and Marriages which demonstrate a 6.8% increase in total death registrations between 2021-22 and 2022-23.

This analysis demonstrates rapidly increasing system demand at the front end of the coronial process with a pressing need for more effective strategies to prevent deaths being reported into Queensland's coronial system unnecessarily.

More effective triage by the health sector

Of the total number of deaths reported by initial clinician phone enquiry during 2022-23, 1305 were not reportable deaths. Combined with the sharp increase in clinician phone enquiries over the preceding 12 months, this perhaps reflects the considerable pressure on the Queensland health system and public focus on its perceived deficiencies with busy clinicians not having the time or readily accessible supports within their workplaces to help them identify when a death needs to be reported to the coroner.

Analysis of these enquiries reveals ongoing widespread knowledge deficits regarding how to write a cause of death certificate and when one can be issued. There is a clear need for medical teaching and training institutions, peak medical professional representative bodies and medical defence organisations to provide more effective training and ongoing clinical support to doctors regarding cause of death certificates. While clinicians are encouraged to seek advice from the CCQ regarding less than straightforward cases, the vast majority of the enquiries received suggest clinicians may be less well supported than they should be within their workplaces to work through whether the death actually warrants discussion with the CCQ. This is particularly so when patients happen to die proximate to but not as a result of recent health care interventions or a fall or collapse. Consideration needs to be given to strengthening local mortality review mechanisms within hospitals and public health services to more effectively manage the health sector's growing coronial referral rate.

The Coronial Registrars continue to provide education to clinical education forums on request.[10]

More effective triage of apparent natural cause deaths by Queensland Police Service

Following the QAO performance audit of coronial services in 2019, considerable work has been undertaken to strengthen reporting pathways for apparent natural cause deaths including:

- encouraging paramedics who attend a natural cause death to speak directly with the person's regular treating doctors to seek a cause of death certificate;
- providing first response police officers with 24/7 access to a forensic physician for advice about the likelihood of a cause of death certificate being able to be issued for a deceased person;
- ensuring police officers only make contact with regular treating doctors during business hours so doctors can properly consider whether they can issue a death certificate for their patient;
- establishing a dedicated triage role within the QPS Coronial Support Unit to identify matters reported to police where a cause of death certificate is likely to be issued;
- establishing a process of pre-registration triage whereby apparent natural causes deaths reported to police can be referred to a forensic physician from the CFMU for assistance in obtaining a cause of death certificate. Forensic physicians speak with regular treating doctors and families about the death and can also issue death certificates where there is sufficient information to enable them to do so.

The recent increase in apparent natural cause deaths reported to the Coronial Registrars by police suggest the pre-registration triage process may not be working as effectively as it could. Representatives from the QPS Coronial Support Unit and the CFMU Unit met to identify factors impacting on uptake of this pre-registration triage process. The QPS Coronial Support Unit subsequently undertook targeted refresher education with officers from each of the coronial hubs across the state, enhancing their efforts to obtain cause of death certificates and prevent deaths being reported to the Coronial Registrars unnecessarily.

Of the 3,510 deaths reported by police during the reporting period, 42.8% were apparent natural cause deaths reported to the Coronial Registrars. The multidisciplinary triage process involving duty forensic pathologists and coronial nurses achieved a cause of death certificate for just over two-thirds of the 1503 apparent natural cause deaths reported by police. This process diverted, 1,018 cases from coronial autopsy and further coronial involvement. The remaining third proceeded to varying degrees

[10] Refer to Appendix 1 for Coronial Registrar presentations delivered during 2022-23

of internal examination. The majority of these autopsy cases were finalised by the Coronial Registrars under section 12(4) of the Act as autopsy confirmed a natural cause of death, and the Coronial Registrars were satisfied there were no other issues requiring coronial investigation.

Management of Form 1A reports

The Form 1A reporting pathway operates under the *Births Deaths & Marriages Registration Act 2003,* and the Act, to enable cause of death certificates to be issued in a streamlined way for certain types of reportable deaths. Coronial authorisation will generally be given when the Coronial Registrar is satisfied that coronial autopsy is not necessary because the probable cause of death is known and there are no significant issues requiring further coronial investigation. Once coronial authorisation is given to issue the death certification, the coronial investigation ends.

Clinicians typically use the Form 1A to report mechanical fall related deaths, apparent health care related deaths, natural causes deaths in care and deaths from complications of historical trauma.

During the reporting period, 1,359 deaths were reported by the Form 1A. Of these, 92% were either not reportable or reportable but finalised by authorising the issue of a cause of death certificate. In this way the Form 1A reporting pathway diverted the majority of cases reported from unnecessary autopsy and lengthy coronial investigation.

A relatively high proportion of the deaths reported by Form 1A (402 cases, or just under one-third of cases reported in this way) were determined to be not reportable. In keeping with the trends identified for clinician phone enquiries, analysis of these cases demonstrated a variable clinician understanding of what comprises of a mechanical fall related or health care related death under the Act. This finding supports the need for better front-end support for clinicians when assessing whether their patient's death does in fact need to be reported to the coronial system.

Mechanical fall related deaths continue to be the most common death type reported using the Form 1A. Other coronial jurisdictions including New South Wales, New Zealand and most recently Western Australia, adopt a very different approach to frailty related fall injury deaths. In these jurisdictions, these deaths only become reportable to a coroner in limited circumstances, such as where the incident in which the person sustained the injury was suspicious, unusual or potentially caused by another's act or omission. In the context of Queensland's ageing population, consideration should be given to the extent to which coronial scrutiny is required for these deaths. The Department of Justice and Attorney-General has been considering the State Coroner's proposal for policy and legislative reform around this issue since 2014.

The CCQ has been working closely with the RBDM to implement online death registration. The Coronial Registrars and their support team have contributed to ongoing work to enable doctors to submit a Form 1A report via the online death registration portal.

Triaging into the future

The Coronial Registrars contributed to a body of work to map current triage processes in order to embed the apparent natural causes death and Form 1A triage process into the coronial process. Process maps supported by roles and responsibility documentation for both triage processes, were endorsed by the Queensland Coronial Services Board in 2023.

Strategies to address increasing demand on the systems current triage resources will be examined as part of the broader joint Coronial Service Reform Project led by QH. This project is endeavouring to design and deliver a contemporary best practice state-wide coronial services system. It is anticipated this will have implications for the role of the Coronial Registrars moving forward.

Deaths in care

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

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

Following the passage of the *Disability Services and Other Legislation (NDIS) Amendment Act 2019* the Act was amended to ensure a relevant service provider has a 'duty to report' a death in care and revised the definition of a 'death in care'[11]. In addition, on 1 July 2020 the National Disability Insurance Disability Scheme commenced in Queensland.

As a result of the Queensland Office of the Public Advocate's system advocacy report, *Upholding the right to life and health: A review of the deaths in care of people with a disability in Queensland* in 2016, the Coroners Court has committed to report on data in relation to deaths in care each year, including the categories associated with the definition of a 'death in care'.

During 2022-23, 144 'death in care' matters were reported to the Court for investigation, up by one-third from 2021-22 (109 matters). As demonstrated in Figure 11 below, the majority related to deaths in care of people with a disability.

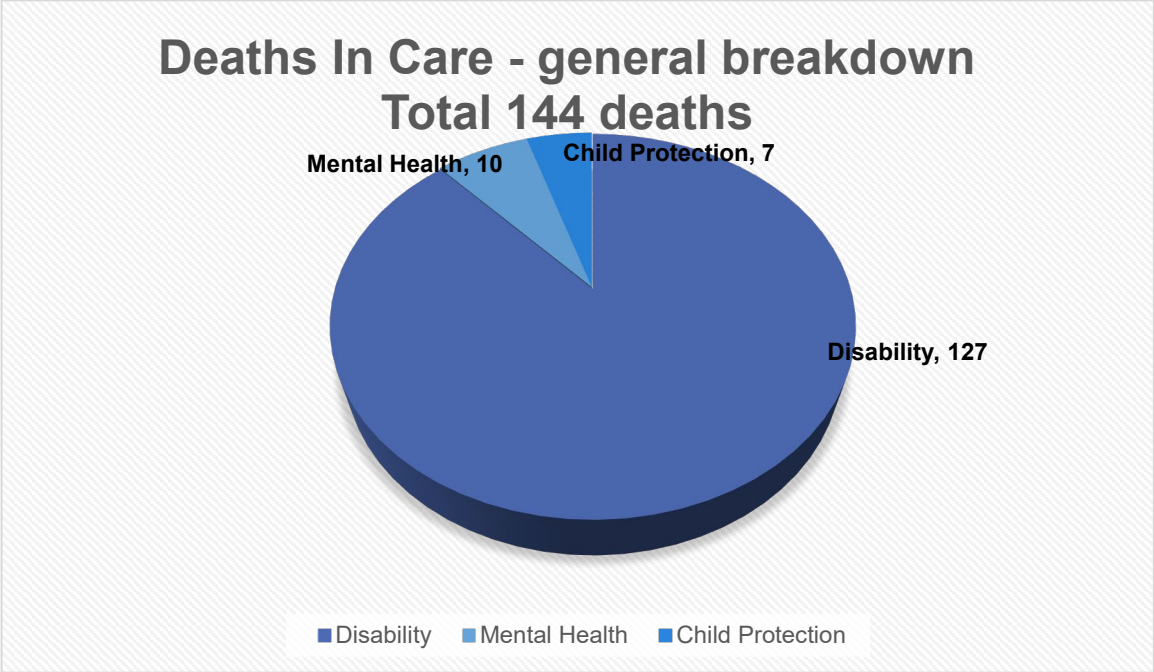


Figure 11: Deaths in care- general breakdown

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

Death in care (disability)

The majority of reported deaths in care of people with a disability were of NDIS participants receiving high level supports as residents in specialist disability accommodation or supported living arrangements operated by registered NDIS service providers. A subset of these deaths were of residents of Accommodation Support & Respite Services operated by the Department of Child Safety, Seniors and Disability Services for people with a primary diagnosis of intellectual disability.

A small number of reported deaths related to residents of facilities operated by public Hospital & Health Services where people with disabilities reside on a permanent basis (Halwyn Centre and Baillie Henderson Hospital Toowoomba) or residents of level 3 accredited residential services regulated under the *Residential Services (Accreditation) Act 2002*.

The deaths in care of people with a disability by type of care facility are shown in Figure 12 below.

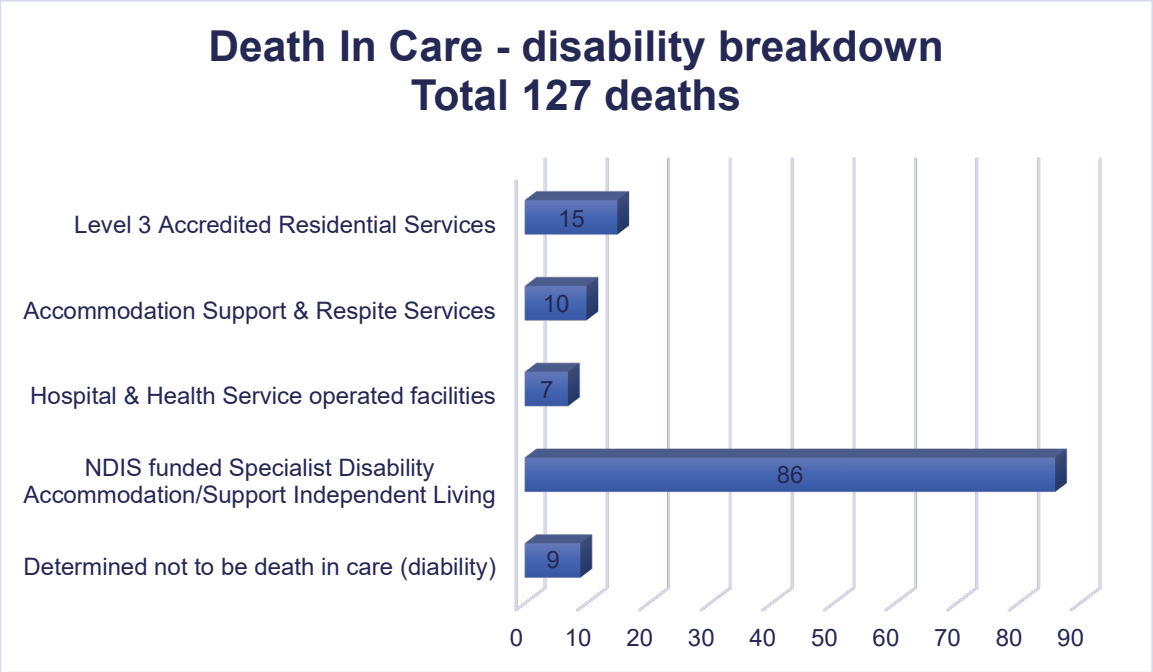


Figure 12: Deaths in care - disability breakdown

It has become apparent that the current definition of death in care (disability) inadvertently omits the death of a person with a disability who is not NDIS-eligible because of their age (over 65) but was receiving federally funded supported accommodation services under the Commonwealth Continuity of Support Program at the time of their death. This cohort are older people with a disability who were existing clients of state-administered specialist disability services at the time NDIS commenced in Queensland but were not NDIS eligible due to their age. They are a particularly vulnerable cohort by virtue of the combination of their age and disability. The Department of Justice & Attorney-General was alerted to this legislative oversight in 2021 but as at 30 June 2023 it was yet to be addressed.

The CCQ continues to experience a steady increase in the number of reported deaths in care of people with a disability. This corresponds with the separate legal requirement for NDIS service providers to report the deaths of their clients to the NDIS Quality & Safeguards Commission. The Court anticipates ongoing increased reporting with an ageing population of NDIS participants.

All but six of the death in care matters relating to people with a disability reported during 2022-23 were from expected natural causes. These reports are triaged by the Coronial Registrars who, with independent clinical input and information provided by the Office of the Public Guardian Community Visitor & Advocate and the NDIS Quality & Safeguards Commission, examine whether the circumstances in which the person died raise issues about their care. Where there are none, the

Coronial Registrar authorises the issue of a cause of death certificate for the person and the coronial investigation is finalised.

Of the six deaths from other causes, two raised issues regarding adequacy of the health care provision, two resulted from accidental choking on food, one was mechanical fall related and the other was due to hypothermia.

Death in care (involuntary mental health)

Of the ten deaths reported because the person died while subject to involuntary mental health assessment or inpatient treatment, half were from natural causes. The remaining five deaths raised issues relating to suicide risk assessment, access to illicit drugs, falls risk management and adequacy of medical management.

Death in care (child protection)

All seven of the child deaths reported because the child was subject to orders made under the *Child Protection Act 1999* at the time of their death were from natural causes. Four were children with complex needs being cared for in out-of-home care placements. The remaining three children were newborn babies placed in the custody of the Chief Executive at or soon after birth and who died from complications of prematurity. Three of the seven children identified as First Nations people. Coronial investigation revealed no concerns about the adequacy and appropriateness of the care each child received while in care.

During the reporting period Coroner Lee opened an inquest into the death of a 13-year-old who drowned at Cedar Creek Falls while subject to an interim child protection order which placed the child in residential care operated by an external service provider.

Forensic pathology services

Autopsies can be an important aspect of coronial investigations. However, they are invasive, costly, and can be distressing to bereaved families. In line with the State Coroner's Guidelines, coroners are encouraged to order the least invasive autopsy examination necessary to inform their investigation[12].

Coronial autopsies are performed by forensic pathologists employed by QHFSS in Brisbane, Gold Coast, Cairns and Townsville only. From July 2021, the budget and administration of coronial autopsies was transferred to Queensland Health for management.

The sustainability of forensic pathology services continues to be a focus of the CCQ in conjunction with QHFSS to ensure Queensland has access to timely and quality forensic pathology services. The 'triaging' process and the introduction of preliminary examination procedures are intended to divert cases from unnecessary autopsy.

Accordingly, during 2022–23, there was a further reduction in the percentage of autopsies ordered (1,466) relative to the number of reported deaths overall.

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Deaths reported	5,287	5,587	5,812	5,797	5,631	5,714	6,044	**6,530**
Examinations ordered	2,550	2,730	2,629	2,476	2,353	2,095	1,524	**1380**
Percentage	48.2%	48.9%	45.23%	42.71%	41.78%	36.66%	25.22%	**21.13%**

Figure 13: Orders for examination issued for reportable deaths

	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
External	769	856	967	1,049	1,008	319	296	**171**
Partial internal	533	583	630	614	498	762	677	**638**
Full internal	1,248	1,291	1,032	765	800	520	551	**571**

Figure 14: Number and type of examinations ordered for reportable deaths

[12] Refer to State Coroner's Guidelines – Chapter 5 'Preliminary investigations, autopsies and retained tissue' https://www.courts.qld.gov.au/__data/assets/pdf_file/0015/206124/osc-state-coroners-guidelines-chapter-5.pdf

Funeral Assistance

The Department of Justice and Attorney-General (DJAG) can arrange for a simple burial or cremation service, where someone has died in Queensland and has no known relatives or friends who are willing or able to pay for a funeral, or where the deceased person's assets cannot cover the costs. This is referred to as 'Funeral Assistance'.

In 2022–23 the CCQ has continued to deliver the enhanced CCQ Funeral Assistance Scheme (the Scheme) under the authority of the *Burials Assistance Act 1965*.

Funeral assistance is not a monetary grant and eligibility is based on set criteria that must be met by the relevant applicants. Applications can be made by individuals or agencies (such as police officers or social workers where there are no known or willing next of kin) and are submitted in person at courthouses across Queensland (including Regional Services Outlets). When an application is approved, the CCQ authorises a simple funeral (burial or cremation) to be conducted by the Government Contracted Undertaker (GCU) in the Local Government Area boundary where the person died, and according to the deceased person's wishes (if known).

The CCQ is responsible for the administration of the Scheme, the budget, cost recovery activities, policy, procedure, strategic oversight and management and reporting. Appeals on applications also sit with the CCQ and are reviewed by the Director of the CCQ. Funeral costs may be recovered by the DJAG, subject to conditions of section 4A of the *Burials Assistance Act 1965*. This can include recovery of monies from the deceased's bank account, money held by the Public Trustee of Queensland (PTQ), the QPS, QH and other agencies as appropriate.

Under the Scheme, the CCQ also authorises return to Country transfers for First Nations persons who have passed away outside of Community, to enable them to be laid at rest within their traditional homelands. The cost of this transfer is usually required to be covered by the individual applicant. However, individual applicants may now also apply for special consideration for a return to Country transfer to be funded under the Scheme if they cannot cover the cost of the transfer themselves. This special consideration is subject to additional delegate approval and may involve a substantially longer application processing time. If approved, the return to Country transfer will be undertaken by an appropriate supplier as determined and contracted by DJAG. Funding will not be paid as a monetary grant to the applicant, or as a reimbursement of any transfer costs incurred by the applicant outside of the approved arrangement.

In 2022–23, the CCQ experienced a 9.5% increase in applications received from the previous financial year. Of these applications, 318 were approved (compared with 384 approved in 2021-22) at a total cost of $460,366.14. This figure is based on total expenditure outlaid by the Department ($916,251.60) less the total monies recovered under the Scheme ($455,885.46).

In comparison to 2021-22, the cost recovery rate increased significantly from 23.39% to 49.96% due to the success of the internal policy changes. Additional resources and funding will be required to ensure continued service delivery.

Note: All revenue reported as cost recovery under the Scheme each year includes funds recovered against applications approved in previous financial years, as applicants may discover funds at a later time, or the PTQ may administer a deceased's estate that the Scheme has registered an interest in.

Funeral Assistance Scheme figures for 2022–23:

318	**$916,251.60**	**$455,885.46**	**49.96%**
applications approved	state-wide expenditure	expenditure recovered	of expenditure recovered

Government Contracted Undertakers

DJAG, through the CCQ engages government contracted undertakers (GCUs), to undertake the provision of coronial services in Queensland. The current services comprise of Service A – the conveyance of deceased persons under the Act and Service B – the burial or cremation of deceased persons under the *Burials Assistance Act 1965*.

The State Coroner through the CCQ is responsible for ensuring all 'reportable deaths' are investigated. When a death is reported to the coroner, the deceased person must be conveyed by the GCU at the direction of a QPS officer or by the CCQ to transport the deceased person from the place of death to a facility such as the local hospital mortuary for a coronial investigation. Depending on the nature of the death and the local health resources available, the deceased person may be transported to another hospital or health facility for an examination, pathology, or autopsy to be conducted.

GCUs are also responsible for conducting a simple funeral service. Applications made under the CCQ Funeral Assistance Scheme (the Scheme) as described under the previous section.

The current standing offer arrangement (SOA) contracts are due to expire on 31 January 2024. The new tender process is currently underway. Unlike the current SOAs, the new SOAs, commencing 1 February 2024 will combine both Service A and B for efficiency.

The total number of claims accepted for conveyance of deceased persons in Queensland in 2022-23 was 5,631, at a total expenditure of $4,154,017.73.

Upon the completion of the new SOA, GCU site visits under the CCQ Assurance Program[13] will recommence. The program has been permanently implemented as part of day-to-day performance management and relationship building with both new and existing CCQ Suppliers.

GCU conveyancing figures for 2021–22:

5,631
conveyances by GCU

$4,154,017.73
state-wide expenditure of conveyances

[13] Previously known as the Voluntary Trial Assurance Program.

Accessing coronial information

The coronial system is an important source of information for researchers, whether it be to inform medical, scientific, or other research, who in turn provide an invaluable resource for coroners in their preventative role. Section 53 of the Act facilitates access to coronial documents by researchers. Additionally, the information gathered during a coronial investigation and the appropriate release of that information can also be therapeutic for a deceased person's family or for other investigative, systemic, legal, or other processes running concurrently in respect of a death.

Finalised information requests

Determining whether the release of coronial investigation documents (other than for research purposes) requires the '*consideration and balancing of competing interests – the privacy of the deceased and their family members; the openness and transparency of official processes; and the potential benefits to public health and safety'*. The deceased's family will generally be entitled to access coronial information however will determine whether someone has 'sufficient interest' in a document as per section 54 of the Act.

The below data refers to the 12month period from 1 July 2022 to 30 June 2023.

Information requests in 2022–23:

10	**866**
Genuine Researchers approved	Individual requests for documents on finalised cases

Genuine Researchers

Generally, researchers may only access coronial documents once the investigation is finalised. However, the State Coroner may give access to documents on open files if the State Coroner considers it appropriate having regard to the importance of the research and the public interest in allowing access before the investigation has finished. The Act requires the names of persons given access to documents as genuine researchers to be noted in the annual report. The following genuine researchers were approved under s. 53 of the Act during the reporting period:

Queensland Maternal and Perinatal Quality Council: *Maternal Deaths due to homicide in Queensland, Australia, 2009 – 2019: a retrospective documentary analysis.*

A collaboration between the Queensland Maternal and Perinatal Quality Council, the Queensland Centre for Mental Health Research and the Queensland Forensic Mental Health Service, an experienced team of researchers and clinicians sought to examine the deaths of female homicide victims who were killed from between 10 months pre-birth/end of pregnancy to up to 365 days post birth/end of pregnancy. The study aims to contribute to the evidence-base regarding maternal homicide through demographic examination of victims and perpetrators, determination of a maternal homicide rate and identification of clinical and service implications.

Queensland Tissue Bank - Reanna Morris: *3D Surface Scanning Technology to Establish a Virtual Library of Transplant Tissue for Reconstructive Surgery.*

Queensland Tissue Bank (QTB) scientist, Reanna Morris, examined tissue donated through the coronial approval process to inform the development of improved methods for meniscus allograft transplant surgery. The project aims to develop a novel technique for scanning meniscal surfaces and constructing corresponding 3D models in conjunction with Dr Huynh Nguyen's existing Genuine Researcher project to develop a 3D virtual library of all tissue held by QTB. The establishment and validation of a new method for measurement of the menisci's morphometric parameters is expected to aid in improved surgical planning, donor-recipient alignment, and health outcomes for knee cartilage transplant recipients.

Queensland Health Forensic and Scientific Services – Senior Forensic Chemists Andrew Griffiths and Amanda Thompson: *An overview of Designer Benzodiazepine Detections from Four States Across Australia from 2018 to mid-2022.*

Coronial toxicology data was examined by Queensland Health Senior Forensic Toxicology Chemists Andrew Griffiths and Amanda Thompson to inform contribution to a scientific journal article providing a national overview of the prevalence and toxicology of illicit designer benzodiazepines (DBZDs) in Australia. These drugs contain variable, unknown dosages which pose a health risk to the broader community. The article intends to track the types of DBZDs identified across multiple Australian jurisdictions and the findings are expected to be of interest to multiple national and international agencies across the scientific, legal and health care sectors.

Queensland Health Forensic and Scientific Services – Forensic Pathologist Dr Rexson Tse: *Comparing cardiac ventricular dimensions between two standard methods at post-mortem examination.*

Coronial autopsy data was analysed by Queensland Health Forensic Pathologist Dr Rexson Tse to inform research into cardiac ventricular dimensions and the utility of taking measurements when determining hypertrophy of the heart chambers at post-mortem examination. The study aims to develop improved processes for post-mortem cardiac assessment and examination as well as standardising the approach and methodology. Findings are intended for publication in forensic pathology journals and anticipated to improve clinical outcomes and practice.

Queensland Health Forensic and Scientific Services – Forensic Pathologists Dr Rexson Tse and Dr Melissa Thompson: *Pregabalin in coronial case work: a five-year retrospective study in Gold Coast, Australia.*

Coronial autopsy data was examined by Queensland Health Forensic Pathologists Dr Rexson Tse and Dr Melissa Thompson to document the prevalence of pregabalin in coronial cases. Pregabalin is commonly abused or misused in a polypharmacy setting due to its ability to potentiate the effects of other drugs, such as opioids. However, its characteristics, role and fatal levels in drug-related deaths are not fully established due to the limited literature around its prevalence in Australian coronial case work and postmortem study. Results are expected to enable pathologists to better interpret postmortem pregabalin levels, especially in polypharmacy settings, and ultimately assist in providing a more accurate cause of death for future coronial investigations.

Queensland Health Forensic and Scientific Services – Senior Forensic Chemists Lesley Sharp and Andrew Griffiths: *Protonitazene detection in a case of life-threatening opioid toxicity following use of a vape product within Australia.*

Senior Queensland Health Forensic Toxicology Chemists Lesley Sharp and Andrew Griffiths utilised coronial records to inform the Queensland Toxicology Laboratory's contribution to a research project conducted by the Emerging Drugs Network of Australia Victoria regarding protonitazene toxicity and vaping. The project aims to examine instances of protonitazene causing acute toxicity and help raise a public health message on the potential dangers of this new synthetic opioid in the community and the unregulated nature of vape products. The study is intended for publication in the Journal of Clinical

Toxicology and may also be disseminated in presentations to scientific/other interested agencies or submitted for publication in other international or Australian scientific journals.

Queensland Health Forensic and Scientific Services – Forensic Pathologists Dr Rexson Tse and Dr Melissa Thompson: *Are cardiac dimensions measured from postmortem photographs accurate? Implications for peer reviewing postmortem photographs.*

Data obtained from postmortem reports and photographs was accessed by Forensic Pathologists Dr Tse and Dr Thompson and analysed to compare heart dimensions measured at postmortem examination with measurements from postmortem photographs. Medical student Jack Garland assisted under Dr Tse and Dr Thompson's supervision. The completed quality improvement research project is intended for publication in forensic pathology journals.

Palliative Care in Prisons Project – Professor Jane Phillips: *National Palliative Care in Prisons Project: a Gap Analysis of the provision of palliative care in Australian prisons.*

The Palliative Care in Prisons (PiP) research project is a $1.2 million Commonwealth Department of Health funded study led by Primary Investigator Professor Jane Phillips and sponsored by the Queensland University of Technology in partnership with the University of Technology Sydney. The project aims to understand the availability and quality of palliative care provided to people with palliative care needs in Australian prisons. The retrospective review is intended identify individuals with palliative care needs who were admitted to a tertiary hospital during the last twelve months of life and died an expected or natural death. Analysis of this cohort will identify current pathways for people in prison to access to palliative and end of life care, identify the barriers and facilitators to the provision of palliative care in prisons, and to co-design and develop a National Framework for the Provision of Palliative Care in Australian Prisons. Findings from data collected in each jurisdiction will be fed back to support future quality improvement initiatives. National-level findings will be published in peer-reviewed journals. A Gap Analysis report of national-level findings will be published to provide feedback to Correctional/Justice Health Services and disseminate findings to the broader public.

Queensland University of Technology - Faculty of Law PhD Candidate Rebecca Keane: *Negotiating with Terrorists: A critical analysis of hostage negotiation methodologies within policing sieges.*

In continuation of Genuine Researcher approval granted in 2021 to inform the PhD thesis, additional coronial investigation documents were provided for the purpose of widening the study and including more recent findings. The research is intended to establish the differences between offenders in the context of a domestic and terrorist siege, their respective motivations and ideologies, what drives offending, and whether this influences their response to negotiation techniques used in domestic sieges. The project aims to determine whether domestic policing siege methodologies and crisis negotiation techniques are appropriate in the crisis response to a terrorist siege.

Queensland Mental Health Commission - *Interim Queensland Suicide Register and Queensland Suicide Register.*

Suicide surveillance systems are crucial for monitoring the success of suicide prevention activities, assessing the impact of public health initiatives over time, and driving systemic improvements. The Interim Queensland Suicide Register (iQSR) and the Queensland Suicide Register (QSR) supply the primary datasets for the state's suicide surveillance and monitoring system and provide the basis for data-informed service responses and suicide prevention activities. The Queensland Mental Health Commission has been granted ongoing access to coronial investigation documents for the purpose of recording the state's suspected and apparent suicides. This will assist the Commission in informing suicide prevention policy development and service providers' operational planning, and continuing provision of data-based advice to the Queensland Government and other key stakeholders about suicide and suicide prevention.

Inquests

An inquest is the 'public face' of the coronial process; an open proceeding that scrutinises the events leading up to the death. An inquest can help families understand the circumstances of their loved one's death and provide the public with transparency about a death. Inquests also provide the legislative authority for coroners to make comments and recommendations that aim to prevent or reduce deaths from similar circumstances in future. Each year only a small percentage of matters (less than one per cent) proceed to inquest.

Finalised inquests

During the reporting period the CCQ finalised inquests into the deaths of **24 persons with 20 inquest findings completed**[14]. This figure does not account for the number of inquests that were opened or had ongoing hearings by coroners during the reporting period.

Pursuant to the Act it is mandatory that certain deaths be investigated at inquest, including, those occurring in custody, in care or in the course of police operations, where there are issues about the care or police involvement. Inquests may also be held at the direction of the Attorney-General or District Court.

A coroner may also convene an inquest if there is reasonable doubt about the cause or circumstances of the death or they are satisfied it is in the 'public interest' in so far as drawing attention to the matter may prevent similar deaths in future.

Counsel assisting

Coroners are supported by in-house Legal Officers (referred to as Counsel Assisting). The Northern, Central, Southern and State Coroner are supported by Counsel Assisting in location, while the remaining Coroners are supported by Counsel Assisting located in Brisbane.

By employing full time Legal Officers in the role of Counsel Assisting, CCQ can better support coroners in their investigations and inquests. It has developed a team of specialised Legal Officers with unique backgrounds, ranging from Legal Aid, the Department of Public Prosecutions (DPP), mental health, and child protection. This allows CCQ to reduce costs by developing in house Legal Officers, and briefing out to members of the private bar, only as required, in line with equitable briefing practices. This may occur, for example, in order to acknowledge the unique nature of technical investigations involving air crashes, mining accidents, or matters involving First Nations deaths, in remote indigenous communities. Wherever possible, an in-house member of the Counsel Assisting team will instruct external counsel to develop skills and learn from more experienced Senior Counsel in certain matters. During 2022-23, in-house Counsel Assisting conducted all but two inquests finalised in the reporting period.

Inquest categories

During 2022-23 approximately 25% of inquests finalised were those in the 'public interest' with the same number finalised in relation to death in custody investigations.

Media and community interest

Coronial inquests and coroners' findings at inquest continue to receive considerable media attention and community interest. **During 2022-23 the CCQ responded to 301 media queries** (down from 401 in the previous financial year), relating to investigation updates, requests for exhibits, witness list and other general investigative enquiry updates.

The **CCQ received over 410,000 page views** on the Courts page (down from 484,000 the previous year), with over 360,000 page views on the '*Findings and upcoming inquests'* page.

[14] One inquest may include multiple deceased.

Deceased name	Coroner	Counsel assisting	Keywords
Vanelee Curtis Mitchell **(First Nations)**	Ryan	Josephine Villanueva	Inquest, First Nations prisoner, death in custody, natural causes, health care, human rights, sudden death in epilepsy, provision of anticonvulsant medication to prisoners, reception triage, monitoring of medication.
Adrian John Adams	Ryan	Katie Ward	Inquest, death in custody, natural causes, palliative care, exceptional circumstances parole.
Damian John Lawton	Ryan	Sarah Lio-Willie	Inquest, death in police operations, motorcycle crash, attempted interception, pursuit policy.
John William Chardon	Ryan	Alex Vanenn	Inquest, death in custody, natural causes.
Dennis William Childs **(First Nations)**	Ryan	Julie Pietzner-Hagan	Inquest, death in custody, natural causes, health care, refusal of treatment by prisoner.
Duy Linh Ho	Ryan	Rhiannon Helsen	Inquest, police shooting, death in custody, avoiding being placed into custody, use of force, mental health response, incident command, entry into residence, police training.
Madeleine Kate Moroney	O'Connell	J M Aberdeen	Inquest, Road accident, Passenger vehicle overturned on country road , "how" the accident occurred, Identity of the driver at the time of the incident
Brett Andrew Forte **Ricky Charles Maddison**	Ryan	Rhiannon Helsen	Inquest, domestic violence, shooting of police officer, siege, automatic rifle, police shooting of armed offender, adequacy of police investigations, incident command, police intelligence.
Martinus Van Hattem **Trista-Lee Applebee**	Lee	Ian Harvey	Inquest- operation of limited category, ex-military "Warbirds" aircraft in Australia- airworthiness and maintenance- pilot training for aerobatic flight activity- regulatory framework- reporting systems.
William George Grimes	Ryan	Rhiannon Helsen and Alexandra Sanders	Inquest, death in the course of police operations, conducted energy weapon, Taser, self-immolation, use of force, mental health response, incident command, police training.
James Sidney Murphy	O'Connell	J M Aberdeen	Inquest, Road accident, Pedestrian struck by unidentified vehicle, "how" the accident occurred, Identity of the driver at the time of the incident, admission as to driving

Billy-Joh Watts	MacKenzie	Sarah Lio-Willie	Inquest, Work, Health & Safety incident, Deceased fatally crushed by falling pipe from forklift unloading truck, Non-suspicious death
Jeffrey Lawrence Brooks	MacKenzie	Sarah Lane and Alex Vanenn	Inquest, potential homicide, earlier Inquest reopened at the direction of the Attorney-General (Qld), adequacy of police investigation, Section 48(2)(a) *Coroners Act (Qld)* "reasonable suspicion" an offence has been committed
Yvette Michelle Wilma Booth **Adele Estelle Sandy** **Shakaya George**	Wilson	M,Zerner (assisted by M Mahlouzarides)	Inquest, Rheumatic Heart Disease; Doomadgee, female; Care and treatment; North West Health Service; Doomadgee Hospital; Gidgee Healing Primary Health Service; Mount Isa Base Hospital; bicillin injections; prevention; primordial factors; primary health care; inability to share medical records; Aboriginal Controlled Health Care; siloed and fragmented health services; cultural safety; Qld Ending RHD Strategy.
Leslie Ball	Gallagher	Sarah Lane	Inquest into suspected death, 71 year old man reported missing in 1993, suspected death, police investigation
William Searle	Ryan	Brendan Manttan	Inquest, death in custody, Whipple procedure, restrained patient, supervision by correctional officers, mobilisation of prisoner in hospital, removal of nasogastric tubes, gastroparesis, deteriorating patient, aspiration.
Peter Timms	Ryan	Sarah Lio-Willie	Inquest, death in custody, elderly prisoner, natural causes, acute myeloid leukaemia, whether there was a delay in diagnosis and treatment.
Hayward Rasmussen	Ryan	Sarah Lio-Willie	Inquest, death in custody, natural causes, cirrhosis, splenomegaly, ruptured spleen, health care.
Mirko Civic	Ryan	Sarah Lane	Inquest, death in custody, natural causes, health care, provision of Aspirin and anti-hypertensive medication to prisoner with history of cardiac illness.
David Smith	Ryan	Alex Vannen	Inquest, death in custody, natural causes, essential thrombocytosis, provision of medication.

Figure 15: Inquests finalised during 2022-23

Public interest inquests: case summaries

The Act at s28 notes an inquest may be held into a reportable death if a coroner investigating the death is satisfied it is in the 'public interest' to do so. The 'public interest' is a discretionary consideration by a coroner. Some factors when assessing whether an inquest should be held include, but are not limited to, reasonable doubt about the cause or circumstances of the death, drawing attention to the death to prevent similar deaths in future, have previous inquests dealt with similar deaths and made recommendations that have not been adopted or is there the potential for publicity from an inquest to generate new evidence. The Attorney-General can also direct that an inquest be held.

The following sections provides a summary of inquests finalised by coroners during the reporting period that were convened in the 'public interest'.

Brett Andrew FORTE and Ricky Charles MADDISON

State Coroner, Terry Ryan – 14 March 2023

Circumstances of the death

Senior Constable Brett Forte worked for the Toowoomba Tactical Crime Squad (TCS) at the Toowoomba Police Station. His wife, Senior Constable (SC) Susan Forte, was the dedicated Domestic Violence Project Officer attached to the Toowoomba Station. In early 2017, they were both engaged in efforts to protect the community by apprehending Ricky Maddison, a violent and dangerous domestic violence offender. SC Forte died after he was shot by Ricky Maddison on a remote section of Wallers Road, Ringwood on the afternoon of 29 May 2017. SC Forte was driving a police vehicle in pursuit of Mr Maddison when Mr Maddison ambushed the police vehicle and shot at it with an automatic rifle, hitting SC Forte. SC Forte's passenger, SC Neilson, escaped from the vehicle without serious injury and assisted with removing SC Forte. After shooting SC Forte, Mr Maddison continued to fire rounds of automatic gunfire into the surrounding bushland, before retreating to the nearby shed where he had been living.

A siege commenced, and at around 5:00 pm on 29 May 2017, police started to negotiate with Mr Maddison. He was asked to surrender on no less than 85 occasions. Negotiators gave repeated assurances that he would be taken safely into police custody. During the siege, Mr Maddison fired at police at least 21 times. His last shots were fired at 11:05 am on 30 May 2017. Mr Maddison was then shot by SERT operators after he fired his automatic KS-30 rifle at Police and attempted to escape the inner cordon.

The Investigation

QPS Internal Investigations Group, Ethical Standards Command investigated the circumstances surrounding both deaths. Extensive coronial reports were provided in respect of each death with annexures, including witness statements, BWC AND Police Communications recordings, POLAIR footage, forensic examinations, and QPS records. QPS also conducted internal reviews of various matters, including the Gatton Police investigation into reports of automatic gunfire, the decision to re-institute charges against Mr Maddison, the QPS organisational response to Mr Maddison's telephone call, a critical incident review of the circumstances of SC Forte's death, a review of the SERT decision to use lethal force in respect of Mr Maddison's death, and a QPS Incident Command Review. As a result of the investigations and internal reviews, the QPS had already identified a number of shortcomings, and implements recommended changes to address these.

On 30 May 2017, a full internal and external post-mortem examination was conducted on SC Forte by Pathologist Dr Beng Ong. Toxicological testing, a CT scan and review of the medical records were also carried out.

On 31 May 2017, an external and full internal post-mortem examination was conducted on Mr Maddison by Pathologist Dr Nathan Milne. Toxicological testing and CT scanning was also carried out.

The Inquest

As SC Forte and Mr Maddison died in the course of a police operation s 27 of the *Coroners Act 2003* required inquests be held into their deaths. The State Coroner determined that the inquests would be held together. The joint inquest was held over 10 days in Toowoomba from 12 to 23 April 2021, with a further day in Brisbane on 12 November 2021.

In addition to the findings required by s45(2) of the Coroners Act 2003, the joint inquest considered the following issues:

a. the interaction between the QPS and Ricky Maddison in the lead up to the death, including the Gatton Police investigation into automatic gunfire at Wallers Road, Ringwood;

b. the circumstances which led to Senior Constable Brett Forte coming in to contact with Ricky Maddison on 29 May 2017, including previous attempts to locate him, as well as the decision and management of the pursuit and attempted apprehension of Ricky Maddison on 29 May 2017;

c. the appropriateness of actions by the attending police officers on 29 May 2017 in relation to Ricky Maddison;

d. the Queensland Police Service response following the shooting of Senior Constable Brett Forte, including the provision of assistance and retrieval;

e. the siege management strategies and negotiation processes employed, including the effectiveness of the negotiation processes;

f. the events that led to the decision by police to shoot Ricky Maddison; and

g. the adequacy of the investigation into the deaths conducted by officers from the Queensland Police Service (QPS) Ethical Standards Command.

Findings and Comments

The State Coroner found that the Gatton Police investigation into automatic gunfire at Ringwood was a missed opportunity to arrest Mr Maddison before SC Forte's death.

In relation to the police pursuit of Mr Maddison, the State Coroner found that the pursuit was conducted in accordance with QPS policies, but that the absence of a tactical command officer was a significant failure of leadership.

In relation to the siege and Mr Maddison's death, the State Coroner found that that all actions complied with the requisite siege management policies and procedures, including the decision to disable the vehicles, that the decision to fire upon Mr Maddison by the SERT operators was reasonable given the threat posed, and that lethal force was justified in this case.

In relation to the adequacy of the police investigations, the State Coroner found that the content of both investigation reports was comprehensive and assisted him in his task in making the necessary findings. However, the State Coroner noted that the process of investigating SC Forte's death had a significant and damaging impact on both Mrs Forte and SC Nielsen, both of whom were subject to complaints by the ESC investigator and subsequent unwarranted disciplinary action, which could have been avoided had the investigator squarely dealt with the concerns they had raised during the investigation.

Recommendations

The State Coroner made four recommendations:

1. that the QPS permanently establish District Duty Officer positions in the Toowoomba District at the level of Senior Sergeant.
2. that, as a matter of priority, the QPS implement a solution to enable searches to occur across all QPS information systems and intelligence holdings to ensure frontline officers have access to reliable and current information. The QPS should report on its progress in relation to the implementation of this recommendation within six months.
3. that the QPS ensure that all officers are regularly trained in relation to their obligation to enter intelligence information correctly within relevant QPS databases in a timely manner and the ongoing management of those databases.
4. that the QPS consider implementing a State-wide instruction in relation to Firearms Assessments as a mechanism to review shots-fired incidents with clear expectations in relation to the investigation of those incidents and associated reporting requirements. This might be modelled on the approach taken in the Darling Downs District.

Martinus Van HATTEM & Trista-Lee APPLEBEE

Southern Eastern Coroner, Carol Lee – 4 April 2023

Circumstances of the death

On 5 June 2019, Ms Applebee was a passenger in a scenic flight, with aerobatics, in an ex-military and historic aircraft known as a Warbird (a two seat, single engine, YAK model 52 aircraft, VH-PAE (VH-PAE)) piloted by Mr Van Hattem. When VH-PAE failed to return to Southport Airport a co-ordinated search was initiated in several locations on and near South Stradbroke Island. It was concluded by first responders that debris located during the search indicated that there had been a non-survivable impact over water. The remains of Mr Van Hattem and Ms Applebee were recovered.

The Investigation

Police investigation:

Following the accident, the Gold Coast Water Police assisted in co-ordinating local Search and Rescue. QPS obtained witness statements and gathered evidence for the coronial investigation.

Australian Transport Safety Bureau (ATSB) investigation:

An ATSB report prepared by a team including aviation engineers, human factors experts, flying operations personnel and other professionals was published by the Transport Safety Investigation Director on 24 February 2022. The report addressed factors including the circumstances surrounding the accident, de-identified witness observations, details of the assessment of the recovered wreckage, operational information and details of the regulatory context within which Warbird operations are conducted as well as safety related measures taken by ATSB.

The Inquest

The three day inquest into the deaths of Mr Van Hattem and Ms Applebee was conducted from 13 December 2022 to 15 December 2022 with evidence heard from 12 witnesses. In addition to the requirements under section 45(2) of the Coroners Act 2003, the following issues for inquest were considered:

1. Circumstances of the flight of VH-PAE on 5 June 2019.
2. Airworthiness and maintenance of VH-PAE as a YAK 52 aircraft flown in Australia.
3. Level and adequacy of Mr Van Hattem's pilot training for aerobatic flight activity endorsements and his aviation proficiency.
4. Adequacy of oversight and regulation of Warbird flying operations.
5. Matters relevant to the prevention of similar accidents in the future and whether any recommendations may be made to reduce the likelihood of deaths occurring in similar circumstances.

Findings and Comments

A number of potential causal factors were considered during the inquest, including meteorological conditions, operating outside of weight and CG limits, insufficient or tainted fuel, engine failure, aircraft structural failure, bird strike, loose articles affecting flight controls, maintenance failures, pilot proficiency/pilot error/radio communications, pilot illness/ medical fitness, pilot loss of consciousness as a result of (aerobatic) maneuvers and passenger or third-party involvement. However, no definitive findings were able to be made in relation to the cause of crash on the evidence available at the inquest.

Coroner Lee made the following comments:

1. CASA is urged to include within the foreshadowed investigation a consideration of whether the Mueller/Beggs method of spin recovery should continue to be included as a component of the

syllabus of flight activity endorsement training conducted by a flight instructor in a YAK 52 aircraft.

In relation to a proposed recommendation made by Counsel Assisting that "CASA (Civil Aviation Safety Authority) should review the Exposition & Self-Administration Manual (ESAM) that is currently in place for Australian Warbirds Association Limited (AWAL) and consider whether that constituent document should be amended to include a requirement or obligation that AWAL must inform CASA (within a specified period of time) of any disciplinary measure that AWAL has taken, in accordance with its rules or Code of Conduct, against a member and the circumstances in which the need for that action arose", Coroner Lee was satisfied that a review being undertaken by CASA of AWAL's ESAM would give effect to the proposed recommendation and made the following comment:

2. I therefore formally make a comment to acknowledge the submissions CASA advances about this issue and endorse the action that CASA says it is taking as a consequence.

Recommendations

Coroner Lee made the following recommendations:

1. CASA should review the extent to which its surveillance of flight instructors who conduct flight training for a flight activity endorsement of a pilot of a Warbird aircraft is sufficient and effective to ensure that those flight instructors are appropriately managing their safety risks, are complying with all relevant regulations and understand the requirements of applicable flight instructor standards of performance when conducting such endorsement training.
2. CASA should consider whether all flight instructors accredited to provide training and instruction for flight activity endorsements should be required to provide a minimum period or duration of training and instruction with relevant aerobatic manoeuvres and tasks demonstrated and performed in an appropriate sequence under an approved syllabus of flight activity endorsement training.
3. CASA should review the English version of the Aircraft Flight Manual or Pilot Operating Handbook for YAK 52 aircraft to ensure that it provides sufficient information for pilots relating to aerobatic manoeuvres and spin recovery techniques that enable the pilot in command to comply safely with the requirements, instructions, procedures or limitations concerning the operation of the aircraft that are set out in the AFM or POH.
4. CASA and AWAL should take appropriate steps to:

- ensure that a risk-based assessment of the available evidence concerning incidents in which objects or loose articles have moved to the rear of YAK 52 aircraft in the course of aerobatic manoeuvres, adversely affecting elevator control of the aircraft, is undertaken; and
- determine whether mandating the installation of foreign object damage barriers in the rear fuselage of YAK 52 is a necessary or desirable safety measure to be taken in an appropriate manner.

5. CASA should undertake and complete a comprehensive review and assessment of the need to establish an approved airframe life limit for YAK 52 type aircraft in Australia having regard to:

- the ATSB report of its investigation into the air accident involving VH-PAE;
- relevant United Kingdom Mandatory Permit Directives;
- airworthiness information obtained from the designer of the aircraft (A.S. Yakovlev);
- airworthiness information obtained from the manufacturer of the aircraft (Aerospace SA); and
- any other relevant airworthiness information and foreign state or foreign authority material that may be obtainable by CASA dealing with the issue of an appropriate airframe life for the YAK 52 aircraft type.

6. CASA and AWAL should review the way in which the existing Permit Index Assessment system for limited category aircraft is used, interpreted and applied by AWAL, in relation to YAK 52 aircraft, to

ensure that any risks to public safety posed by such aircraft, especially if flown over populous areas in the course of aerobatic flights, are fully, adequately and consistently assessed in accordance with the stated objectives of the Permit Index Assessment System.

Madeleine MORONEY

Central Coroner, David O'Connell – 10 February 2023

Circumstances of death

Miss Moroney and her boyfriend were travelling in a 4-wheel drive vehicle in western Queensland, a short distance from Windorah. They were the only occupants of the vehicle. In the early hours of the morning, the couple were travelling to a station homestead where they were to spend the night, before attending the local rodeo the following day. The road which led from the highway to the homestead was an unsealed road, the edges of which were quite soft in comparison to the reasonably well-trafficked centre area of the road.

As they were travelling on the homestead access road, they encountered some cattle on the road. The car was not travelling at an excessive speed, and the driver swerved to the left in an attempt to avoid the livestock. In doing so, the vehicle entered the softer sand area adjacent to the carriageway, and rolled over. Miss Moroney was ejected from the vehicle during the rollover, and became trapped beneath it. Tragically, she suffered fatal injuries.

The Investigation

The Police Service, through the local officer, as well as FCU officers, undertook a thorough investigation of the incident. Miss Moroney's boyfriend was interviewed by police later in the morning following the accident, and he advised police that Miss Moroney had been driving the vehicle at the time of the accident. The investigation also uncovered evidence which was capable of supporting an alternative version of events, namely, that Miss Moroney's boyfriend had in fact been the driver when the rollover occurred. A close examination of the vehicle was undertaken following the accident, but all forensic avenues of inquiry failed to provide any persuasive evidence pointing towards identification of the driver.

The Inquest

An inquest was convened with the primary aim of trying to establish, if possible, who had been driving the car at the time of the incident. Witnesses were called, and examined at some length, as to what Miss Moroney's boyfriend had said to the station manager shortly after the accident, and in respect of a conversation, which was said to have taken place sometime after the accident, wherein Miss Moroney's boyfriend had told an acquaintance that he had been driving at the relevant time.

Findings and Comments

The Central Coroner, upon considering all of the evidence, found there was sufficient evidence to record his finding that Miss Moroney had in fact been the driver when the accident occurred. With the focus of the inquest being upon determining the identity of the driver, no preventive recommendations were made by the Coroner. This was an instance of an inquest being convened where there were rumors, or suspicion, which pointed towards a different factual basis underlying the death of Miss Moroney. The function of an inquest, in trying to dispel rumors, or suspicion, has long been recognised as a proper function of a coronial inquest.

Reducing preventable deaths

Responses to coronial recommendations

All responses to recommendations directed at the Queensland Government are published on the Queensland Courts website adjacent to the relevant inquest finding. The response indicates if a recommendation is under consideration, if and how it will be implemented or the reason a recommendation is not supported. The Queensland Government aims to respond to coronial recommendations (involving government agencies) within six months of the recommendation(s) being made and provides implementation updates every six months until the recommendation(s) is implemented, or a decision made not to support the recommendation(s).

Some of the responses of note made during the reporting period include:

Noombah – State Coroner Ryan

On 10 February 2023 the Minister for Health and Ambulance Services and Leader of the House advised the recommendation regarding the development to culturally appropriate referral pathways for First Nations people in mental health crisis. Queensland Health has worked with Government and non-government service providers to expand Crisis Support Spaces.

Bailey Ezekiel Pini – Coroner Wilson

On 29 March 2023 the Minister for Department of Children, Youth Justice and Multicultural Affairs responded and implemented the recommendation and the endorsed suggestion, in respect of being fitted with appropriate key safes and coroners' endorsement of the implementation of an 'awake rostered staff member' on a needs basis. The department are undertaking a review of the fee for service funding arrangement to further support flexibility of funding to respond to the changing needs of young people as required.

Doreen Gail Langham and Gary Matthew Hely – Deputy State Coroner Bentley

On 7 May 2023 the Minister for Police and Corrective Services responded to the recommendation to amend the Police operations Procedure, to state officers must view a person's interstate record for every domestic violence matter. The amendments were published in October 2022.

Tyson Lee Jessen – State Coroner Ryan

On 7 May 2023, the Minister for Police and Corrective Services and Minister for Fire and Emergency Services, and the Minister for Health and Ambulance Services and Leader of the House responded to two recommendations, relating to the guarding of prisoners whilst receiving medical care and the review of the Operational procedures manual. The implementation of both recommendations are in progress.

Johann Ofner – Coroner MacKenzie

On 7 May 2023 the Minister for Police and Corrective Services and Minister for Fire and Emergency Services responded and implemented two recommendations, to review the relevant provisions of the Weapons Act (Qld) and Weapons Act Regulations (Qld) and the creation of a code of practice for armourers and the use of firearms in the film industry.

Monique Irene Clubb – Deputy State Coroner Bentley

On 7 May 2023 the Minister for Queensland Police and Corrective Services and Minister for Fire and Emergency Services responded to two recommendations to consider a further trial and/or implementation of airborne phone locations systems and an amendment to the relevant sections of the Operational procedures manual. Both recommendations is in progress and currently under consideration.

Systemic death review initiatives

Domestic and Family Violence Death Review Unit (DFVDRU)

The DFVDRU is based within the CCQ and provides specialist advice and assistance to coroners in their investigations of domestic and family violence related homicides and suicides and the deaths of children who were known to the child protection system. Through analysing demographic characteristics and static and dynamic risk indicators, and lethality risk indicators, the DFVDRU identifies trends and patterns regarding domestic and family violence related homicides and suicides to assist in identifying opportunities for prevention.

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

In the 2022–23 financial year, the DFVDRU completed 21 comprehensive case reviews to assist coroners in their investigations of domestic and family violence-related deaths, and deaths of children known to the child protection system.

The DFVDRU maintains two comprehensive statistical databases:

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

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

For example, the DFVDRU is a founding member of the Australian Domestic and Family Violence Death Review Network (the Network) and continues to work closely with other death review mechanisms in Australia and undertake research in partnership with Australia's Network Research Organisation for Women's Safety (ANROWS).

This year, the partnership published an analysis of intimate partner violence homicides that occurred between 1 July 2010 and 30 June 2018.[15] The research highlighted the highly gendered nature of intimate partner violence and intimate partner violence homicides, as most cases involved a male homicide offender. In many cases the domestic violence had been reported and there was some degree of police and court intervention prior to the homicide. The period leading up to and immediately following relationship separation was found to involve a heightened level of homicide risk. The data also showed a high prevalence of emotional and psychological abuse demonstrating the need for first responders and the broader service system to recognise the patterns of domestic violence behaviours that extend beyond physical violence.

[15] Australian Domestic and Family Violence Death Review Network and ANROWS. (2022). *Data report: Intimate partner violence homicides 2010–2018*. https://anrowsdev.wpenginepowered.com/wp-content/uploads/2022/02/ADFVDRN-ANROWS-Data-Report-Update.pdf

Domestic and Family Violence Death Review and Advisory Board (the Board)

The DFVDRU provides secretariat support to the Board. The Board is an independent body established by the Act to undertake systemic reviews of domestic and family violence deaths in Queensland and make recommendations to the Queensland Government to improve legislation, policy, and practice to prevent or reduce the likelihood of domestic and family violence deaths.

The establishment of the Board was a key recommendation of the Special Taskforce on Domestic and Family Violence in Queensland in their *Not Now, Not Ever* report.[16] This year, the terms of previous Board members ceased and a new Board was appointed.

The Board's functions[17] include:

- reviewing domestic and family violence deaths in Queensland
- analysing data and applying research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland
- conducting or commissioning research to prevent or reduce the likelihood of domestic and family violence deaths
- writing systemic reports into domestic and family violence deaths, identifying key learnings and elements of good practice in the prevention and reduction in the likelihood of domestic and family violence deaths in Queensland
- making recommendations to the Minister about improving legislation, policies, practices, services, training, resources and communication to prevent or reduce the likelihood of domestic and family violence deaths in Queensland
- monitoring the implementation of the Board's recommendations.

In its 2021–22 Annual Report, the Board focused on collaborative responses to risk, safety and danger with a focus on reviewing cases in areas where a High Risk Team and Integrated Service Response was operating. This report generated interest across the sector, and the DFVDRU, on behalf of the Board, were invited to deliver presentations about the report and the role of the Board to organisations and multi-agency teams across the sector, including:

- Queensland Police Service
- Red Rose Foundation High Risk High Harm training
- Logan High Risk Team
- Centre for Women & Co – Logan Central
- High Risk Team program integration officers and High Risk Team core members
- Victims Assist
- WorkUp Qld
- Beenleigh/Logan Integrated Service Response.

The DFVDRU are committed to engaging with the service system and community to share insights from the work of the Board that can enhance understanding of domestic and family violence, support best practice service delivery and collaboration and inform efforts to eradicate domestic and family violence deaths.

Further information about the Board can be found in the Board's annual reports available on the Coroners Court of Queensland website.[18]

[16] Special Taskforce on Domestic and Family Violence in Queensland. (2015). *Not Now, Not Ever: Putting an end to domestic and family violence in Queensland*. https://www.justice.qld.gov.au/initiatives/end-domestic-family-violence/about/not-now-not-ever-report
[17] As described in section 91D of the *Coroners Act 2003*.
[18] https://www.coronerscourt.qld.gov.au/dfvdrab/annual-reports-and-government-responses

Deaths in custody: case summaries

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

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

Peter John TIMMS

State Coroner, Terry Ryan – 13 March 2023

Circumstances of the death

Mr Timms was 71 years old at the time of his death. He was serving a term of imprisonment at the Woodford Correctional Centre. On 29 March 2020 he was diagnosed with terminal acute myeloid leukemia, after a short period of rapidly deteriorating health commencing in January 2020. On 19 April 2020, he experienced worsening fatigue and shortness of breath and was admitted to the Caboolture Hospital for palliative care. His condition continued to deteriorate, and he died in hospital the following day.

The Investigation

Mr Timms' death was investigated by the Corrective Services Investigation Unit. The investigation concluded that there appeared to be no insufficiency of care, and no suspicious circumstances of the death. The Clinical Forensic Medicine Unit was also asked to examine Mr Timms' health care and provided a report to the State Coroner.

Findings and Comments

The State Coroner found that Mr Timms died from natural causes. The State Coroner accepted that Mr Timms was reviewed and referred for specialist hematology review in a timely manner. There were no comments or recommendations made pursuant to s46 of the *Coroners Act 2003*.

Hayward RASMUSSEN

State Coroner, Terry Ryan – 10 March 2023

Circumstances of the death

Mr Rasmussen was a 45-year-old man with a complex medical history consisting of several significant comorbidities, including splenomegaly. On 28 August 2019, he collapsed while working in the prisoner computer lab. He was transported to the Ipswich Hospital by ambulance for treatment, where he ultimately died from intra-abdominal hemorrhage caused by a ruptured spleen.

The Investigation

Mr Rasmussen was in custody at the Borallon Training and Correctional Centre since 5 May 2019. The Corrective Services Investigation Unit investigated his death. The investigation concluded that there appeared to be no insufficiency of care, and there were no suspicious circumstances in relation to his death. The Office of the Chief Inspector (OCI) also investigated Mr Rasmussen's death and made no adverse findings or comments.

Professor Leggett, a Specialist in Gastroenterology and Hepatology, and Professor Wullschleger, a General and Trauma Surgeon, also examined Mr Rasmussen's medical records and reported on them for the State Coroner.

Findings and comments

The State Coroner found the death was from natural causes and that there were no suspicious circumstances associated with it. Mr Rasmussen was given appropriate health care in prison, and his death could not reasonably have been prevented. The State Coroner made no comments or recommendations under s 46, *Coroners Act 2003.*

Duy Linh HO

State Coroner, Terry Ryan – 25 November 2022

Circumstances of the death

Mr Duy Linh Ho (Mr Ho) was a Vietnamese man who died on 22 July 2019 after being shot by a Queensland Police officer acting in the course of duty. Mr Ho was aged 41. Mr Ho lived with his partner (Ms Luu) and their four children in a residence at Doolandella. On the morning of 22 July 2019, Ms Luu contacted the Queensland Ambulance Service (QAS) flagging concerns that Mr Ho was expressing suicidal ideation and was self-harming. Members of the QAS and Queensland Police Service (QPS) attended the residence. Mr Ho was behaving in an aggressive and threatening manner whilst holding a sword. QPS Officers removed the other occupants from the residence and attempted to negotiate with Mr Ho to disarm himself. Those negotiations were unsuccessful and Mr Ho advanced on one of the QPS officers (SC Low), ignoring verbal commands to drop the sword, and came into close physical proximity to him whilst brandishing the sword. SC Low discharged his firearm three times; Mr Ho was struck twice, to the torso and head. Attempts at resuscitation were commenced immediately but were unsuccessful. Mr Ho was declared deceased at the scene.

The Investigation

An investigation was conducted by the QPS Ethical Standards Command (ESC). It was accepted that QPS were not dealing with a hostage situation. Mr Ho was not stopping any person from leaving the residence. Ms Luu provided a history Mr Ho that identified he would experience episodes of depression, that he had experienced childhood trauma, had a history of drug use, including methylamphetamine (ice) and had experienced the deaths of his mother and brother in the months leading up to the fatal event. Records from Mr Ho's GP also identified that he experienced entrenched opiate dependence since at least 2004.

The investigation identified that QPS Officers, when first attending, determined the most appropriate plan was to place Mr Ho under an Emergency Examination Authority (EEA). Attempts to de-escalate the incident were unsuccessful and Mr Ho remained agitated during his interactions with QPS. The plan then shifted to containing Mr Ho, whilst the other occupants of the residence were removed, then use less lethal force to apprehend him. During his interactions with QPS, Mr Ho made statements to the effect that he wanted them to draw their weapons on him.

The investigation considered the requirements of the Situational Use of Force Model in OPM 14.3.2 that must be satisfied for an application of force to be regarded as lawful. The investigation was satisfied that the use of lethal force in that instance was justified, noting that tactical withdrawal and repositioning was utilized to remove QPS officers from harm, SC Low was not able to move out of harm's way in time. Whilst the use of a Taser or OC spray may have been effective in apprehending Mr Ho, there was no safe or tactically sound method for SC Low to ensure deployment at such close range. SC Low's actions were consistent with QPS training ad authorised, justified and excused by law.

The Inquest

The inquest had the benefit of a post-mortem examination report that confirmed the cause of death as gunshot wounds to the head and torso. Toxicology results identified that Mr Ho had high levels of methamphetamine (0.62 mg/kg) and morphine capable of causing death. He had also been exposed to heroin and cocaine. Mr Ho's behaviour during the incident may have been influenced by these drugs. The inquest also heard evidence from the QPS Operational Review Unit and its findings into the QPS response to the incident.

Findings and comments

In making findings the State Coroner had regard to the findings and recommendations identified by the QPS Operational Review Unit in their report, and steps taken to implement those recommendations. In those circumstances no further recommendations were made.

Mirko CIVIC

State Coroner, Terry Ryan – 25 January 2023

Circumstances of the death

Mr Civic was born in Croatia on 30 August 1948. He moved to Australia in 1966 and became a dual citizen. Mr Civic had four children and over a dozen grandchildren. He told custodial correctional officers (CCOs) during his time in custody that he felt supported by his mother and children.

Mr Civic's medical history included ischaemic heart disease, a self-reported myocardial infarction, hypertension, asthma, dormant tuberculosis, prostate carcinoma, post-traumatic stress disorder and depression.

Mr Civic had frequent appointments with medical and mental health practitioners during his time in custody. Some treating practitioners had difficulty with Mr Civic refusing medication for extended periods, which would have had an impact on the effectiveness of any medical treatment given.

Mr Civic had sporadic bouts of blood in his urine throughout the early years of his incarceration which he verbalised to staff. Mr Civic also suffered from bouts of lower abdominal pain. While he would often complain to Correctional Officers about these conditions, he would refuse to attend the Medical Centre. His records indicate attendance at approximately twenty psychology and mental health appointments from 2011, where he expressed attitudes of pessimism and self-persecution.

Mr Civic's outlook appeared to improve over his time in prison. At WCC and Palen Creek Mr Civic was able to engage in work as an electrician, groundsman and a landscaper, and is said to have enjoyed this work. In September 2017, when Mr Civic attended the Palen Creek psychologist, he was reported to have no notable concerns with regards to his mental health or circumstances.

On 16 September 2018, Mr Civic attended the lunch-time muster at 12:10pm before returning to his room. At 3:43pm, the afternoon muster was commenced by CCOs in the common area of Block B.

Mr Civic was not present at the line-up. He was found in his cell, unresponsive, with no pulse and cold to the touch. The CCOs called a Code Blue (medical emergency) at approximately 3:52pm before commencing cardiopulmonary chest compressions (CPR). Despite attempts by medical staff and Queensland Ambulance Officers to resuscitate Mr Civic, a life extinct certificate was issued at 4:29pm.

The Investigation

Senior Constable Pritchard from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) led the investigation into the circumstances leading to Mr Civic's death. The investigation was informed by statements from the relevant custodial correctional officers, medical and nursing staff as well as recordings, Corrective Services records and photographs. SC Pritchard concluded that Mr Civic passed away from natural causes, that he was provided with adequate medical care in prison and that there were no suspicious circumstances associated with the death. The State Coroner was satisfied that the CSIU investigation was professionally conducted and that all relevant material was accessed.

Dr Aran Thillainathan from FMQ also examined Mr Civic's medical records. Dr Thillainathan raised concerns that Mr Civic had not been prescribed aspirin while in prison, ceased taking hypertensive medication, and was not subject to regular blood pressure monitoring.

Further expert opinion was sought from Dr Gregory Starmer, Interventional Cardiologist and Director of Cardiology at the Cairns Hospital. Dr Starmer's view was that aspirin should have been prescribed for the period of Mr Civic's incarceration, may have been contra-indicated due to historical episodes of bleeding suffered by Mr Civic. Dr Starmer noted that Mr Civic was prescribed and taking aspirin in the last year of his life, which would have had the necessary therapeutic effect at the time of his death. He noted that the attempts to control Mr Civic's hypertension with medication were appropriate and ceased

because Mr Civic experienced adverse side effects. Dr Starmer did not consider Mr Civic's hypertension to have been a significant issue in terms of a risk of a further cardiac event. In Dr Starmer's view, the medical care given to Mr Civic in custody was imperfect, but acceptable.

The Inquest

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

Findings and Comments

The State Coroner found that Mr Civic died from coronary atherosclerosis, a common cause of sudden death. He found that none of the inmates, correctional or health care staff at Palen Creek caused or contributed to his death. There were no suspicious circumstances.

The State Coroner agreed with Dr Starmer's opinion that the medical treatment afforded to Mr Civic in prison was imperfect but acceptable. He noted that changes to clinical practice have been implemented as a result of Mr Civic's death to ensure that prisoners with a history of cardiac illness and elevated blood pressure are monitored and managed.

John CHARDON

State Coroner, Terry Ryan – 15 November 2022

Circumstances of the death

At the time of his death, Mr Chardon was a prisoner in custody at the Wolston Correctional Centre. On 11 September 2019, he was sentenced in the Supreme Court of Queensland, having been found guilty of the manslaughter of his wife, Novy Chardon. Mr Chardon was not eligible for parole until 10 September 2031.

On 21 October 2020, Mr Chardon experienced a health episode that resulted in a 'Code Blue' response from staff at Wolston Correctional Centre.

The Investigation

Mr Chardon's death was investigated by a member of the CSIU, Further material was also obtained by the Coroner Office.

Findings and Comments

The State Coroner found Mr Chardon had comorbidities including obesity, hypertension and peripheral vascular disease. Although he was largely symptom free in the months preceding his death, he was at increased risk for coronary artery disease. He died following a sudden cardiac arrest at Wolston Correctional Centre. The cause of death was found to be Coronary atherosclerosis. Noting the circumstances and cause of death, no further recommendations or comments were required.

David SMITH

State Coroner, Terry Ryan – 24 January 2023

Circumstances of the death

At the time of his death, Mr Smith was a remand prisoner at Woodford Correctional Centre. Mr Smith suffered from essential thrombocytosis, a disorder leading to the overproduction of platelets. This condition was the result of a genetic mutation of the calreticulin gene (CALR) and placed Mr Smith at

increased risk of ischaemic and haemorrhagic complications. Mr Smith was being treated with Anagrelide and Hydroxycarbamide to reduce his platelet count. He was also prescribed Rivaroxaban (an anticoagulant) to reduce his risk of thromboembolism that might otherwise lead to strokes or heart attacks. Following a medical episode on 9 July 2019, Mr Smith was taken from Woodford Correctional Centre to the Caboolture Hospital. CT brain scans and angiograms identified an evolving infarct. On 10 July 2019, Mr Smith was transferred to the Royal Brisbane and Women's Hospital so he could receive tertiary level care. Additional CT scans confirmed an evolving, moderate-effect acute infarct in the left mid-cerebral artery territory. He was commenced on a Heparin infusion with close monitoring. He responded positively to the treatment. By 17 July 2019, it was planned to transfer him back to Caboolture Hospital however, on 20 July 2019, the day he was due to be transferred, he suffered a catastrophic, inoperable cerebral infarct. Mr Smith was placed on life support but proceeded to brain death on 21 July 2019. He was continued on life support until 22 July 2019 to allow for organ donation. He was pronounced deceased on that day at 11:30am.

The Investigation

Mr Smith's death was investigated by a member of the CSIU, Further material was also obtained by the Coroner Office.

The Inquest

The inquest was held at Brisbane on 24 January 2023 before the State Coroner. All statements, records of interview, medical records, photographs, and materials gathered during the investigation were admitted into evidence. No witnesses were called to give oral evidence. The issues considered in the inquest were the findings required by s45(2) of the Coroners Act 2003, whether the medical treatment received by Mr Smith was reasonable and appropriate in the circumstances and whether there were any further recommendations which could be made which could prevent deaths from happening in similar circumstances in the future.

Findings and Comments

The State Coroner found Mr Smith's cause of death was Haemorrhagic transformation of cerebral infarction, due to, or as a consequence of Bilateral internal carotid artery thrombosis (anticoagulated), due to, or as a consequence of Essential thrombocythemia. There was no evidence of any systemic deficiency in the care and treatment Mr Smith received while in custody, and no basis for making any further comment or recommendations.

Adrian ADAMS

State Coroner, Terry Ryan – 23 September 2022

Circumstances of the death

At the time of his death, Mr Adams was serving an eight-year head sentence at Wolston Correction Centre. His parole eligibility date was 10 May 2023 and full-time discharge date 9 May 2027. Mr Adams was sentenced on 6 September 2019 in the Brisbane District Court for three counts of indecent treatment, and three counts of rape. He had no prior criminal history. The offending behaviour occurred when he was aged between 64 and 66 years.

The Investigation

Mr Adam's death was investigated by a member of the CSIU, further material was also obtained by the Coroner Office.

The Inquest

The inquest was held in Brisbane on 23 September 2022. All statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. No oral evidence was heard. The primary issue for consideration, apart from the findings required by s 45 of the Coroners Act 2003, was whether Mr Adams had access to, and received, appropriate medical treatment while in custody. Despite the minor issue raised by Mrs Adams about several instances of missed or incorrect medication, this was corrected. It appears that Mr Adams' medical care was otherwise comprehensive, noting Dr Pidgeon's concerns about the challenges in managing breakthrough pain after hours.

Findings and Comments

The cause of Mr Adam's death was a small bowel obstruction and acute renal failure, due to or as a consequence of metastatic colorectal carcinoma. Other significant contributing factors were hypertension, left bundle branch block, type 2 diabetes mellitus and hypercholesterolaemia. The circumstances of Mr Adams' death were not unexpected. His cancer was terminal, and he had a poor prognosis with a life expectancy of six to twelve months even before he was sentenced and imprisoned. On the material gathered in the coronial investigation, it appears that Mr Adams received regular and appropriate medical care during his incarceration, including consistent clinical engagement with the Senior Medical Officer, an allocated prisoner carer, and nursing/diversional therapy support. The focus of Mr Adams' care, in accordance with his Advanced Health Directive, was comfort and pain management as his terminal cancer progressed.

First Nations people: case summaries

The need for public scrutiny and accountability that requires all deaths in custody be investigated by the State Coroner or the Deputy State Coroner and mandates they be investigated arose out of the recommendations made in the Royal Commission into Aboriginal Deaths in Custody. The following section provides a summary of the mandatory death in custody and directed inquests finalised during the period that involved the passing of First Nations people.

WARNING: First Nations people are advised that the following section contains the names of people who have passed away.

Dennis William CHILDS

State Coroner, Terry Ryan – 15 November 2022

Circumstances of the death and suspected death

Dennis Childs was a First Nations man, who was 64 when he passed on 9 December 2018. He was serving a life sentence for murder at the Woodford Correctional Centre (WCC). As such Mr Childs death was a 'death in custody' and an inquest was mandatory. In 2005, while imprisoned in South Australia, Mr Childs was diagnosed with mouth and throat cancer requiring surgery to remove part of his gum and jaw. In 2017, he underwent further mouth and jaw surgery to repair facial disfigurement and to assist in allowing him to chew foods. Mr Childs' also suffered from Chronic obstructive pulmonary disease (COPD), Congestive cardiac failure, Cirrhosis of the liver, Hypertension, Depression and Anxiety (for which he received psychological treatment while incarcerated). Mr Childs became unwell on 7 December 2018. He was assisted by staff at WCC. Mr Childs had expressed some resistance to seeking hospital treatment. He was eventually transferred to Caboolture Hospital for emergency surgery. Towards the end of the procedure Mr Childs suffered multiple organ failure before going into cardiac arrest. Despite extensive resuscitation efforts he was unable to be revived.

The Investigation

A direction was issued for a targeted coronial investigation. This included seeking medical records, interviewing the next of kin about any concerns and obtaining statements from relevant treating medical officers, corrective services officers and fellow prisoners. A Coronial Report was prepared and provided to the Coroners Court in December 2019.

The Inquest

An inquest was held at Brisbane on 15 November 2022. All materials gathered during the investigation were admitted into evidence. The issues at inquest were the findings required by s45(2) of the Coroners Act 2003 and whether Mr Childs' care at WCC and Caboolture Hospital Service was appropriate and adequate.

Findings and Comments

The State Coroner found that Mr Childs died on 9 December 2018 at the Caboolture Hospital. The cause of death was Peritonitis, due to or as a consequence of a ruptured gallbladder, due to or as a consequence of gallstones. Other conditions identified were ischemic heart disease, cirrhosis, COPD and chronic pleural effusion. The State Coroner concluded that Mr Childs' care at WCC and Caboolture Hospital Service was appropriate and adequate, although some opportunities for improvement emerged after the death and he acknowledged the ethical and legal challenges presented by the principle of allowing an adult with capacity to make their own decisions regarding health care in custodial settings, as had been identified in a prior matter.

Vanelee Curtis MITCHELL

State Coroner, Terry Ryan – 02 September 2022

Circumstances of the death

Mr Vanelee Mitchell was a First Nations man who passed away at the Townsville Correctional Centre on 10 April 2020. He was aged 30 years. At 7:10am Mr Mitchell failed to present for the morning head count. When Corrective Service Officers gained access to his cell, Mr Mitchell was found lying in bed on his stomach, he was unresponsive to sound or touch. Attempts at resuscitation were commenced immediately but Mr Mitchell could be revived, and he was pronounced deceased at 8:07am.

The Investigation

The investigation into the circumstances of Mr Mitchell's death was performed by the QPS, Townsville Criminal Investigation Branch (CIB). The investigation identified Mr Mitchell's period of imprisonment had commenced on 25 September 2019. He was serving a 5-year term of imprisonment with a parole eligibility date of 25 December 2020. He had pre-existing medical conditions of epilepsy, acquired brain injury with mild cognitive impairment and gastro-oesophageal reflux disease. The epilepsy and brain injury were acquired in January 2014 when he was the victim of an assault. Mr Mitchell's medical treatment included Sodium Valproate and Levetiracetam, to manage his seizures and he continued to receive that treatment whilst he was in custody.

The Inquest

Queensland Corrective Services (QCS) and the Aboriginal and Torres Strait Islander Legal Service (ATSILS) were granted leave to appear at the inquest.

The issues for inquest were the matters required under s.45 of the *Coroners Act 2003*, there were no other issues. The inquest considered the results of an external and full internal port-mortem that confirmed the presence of Mr Mitchell's anticonvulsant medication in a femoral blood sample. The level of medication was "*below the reported therapeutic ranges*". There was no evidence of any injury to Mr Mitchell, nor evidence of any underlying condition of disease process that may have otherwise caused or contributed to death. Cause of death was given as: "*sudden an unexpected death in epilepsy*". His death was regarded as 'natural causes.

A review by the CMFU of Mr Mitchell's care and treatment whilst in custody, did not identify any concerns with the medical care that had been provided to him or any missed opportunities that may have changed the outcome. FMQ identified there were occasional titrations in the levels of Mr Mitchell's medication however these were done appropriately.

ATSILS raised issues including whether the care and treatment received by Mr Mitchell was delivered in a culturally appropriate manner, whether Mr Mitchell was able to access health services without discrimination, consistent with his right under s.37 of the *Human Rights Act 2019*. Evidence was heard from QCS and the Executive Director, Clinical Governance of the Townsville Hospital and Health Service (THHS). The THHS acknowledged there was scope to improve cultural appropriateness of health support and identified work being undertaken to implement a Health Equity Strategy 2022-2025 to reduce inequality in health outcomes in line with the Closing the Gap initiative. Other strategies included improving information sharing protocols between QH and QCS.

Findings and Comments

At the conclusion of the inquest, findings were made pursuant to s.45 of the *Coroners Act 2003*. The cause of death ("*sudden unexpected death in epilepsy*") was accepted. Noting the steps already being taken by THHS to implement strategies for culturally informed treatment and care, no further recommendation was made however they were encouraged to continue developing and implementing those strategies.

APPENDIX 1

Presentations by Coronial Registrars, Ainslie Kirkegaard, Jessica Lambert and Deputy State Coroner Gallagher

- **Gold Coast Private Hospital – Coronial Registrar Kirkegaard**
  - *Never Fear (if) the Coroner is here!* – 6 July 2022
- **University of Queensland School of Medicine - Coronial Registrar Kirkegaard**
  - Autopsy Symposium in Integrated Clinical Studies (panel member) – 23 September 2023
- **Australian College of Critical Care Nurses Annual Education Meeting - Coronial Registrar Kirkegaard**
  - Coronial Processes following a child death – 20 October 2023
- **Sunshine Coast University Hospital Medical Directors – Coronial Registrars Kirkegaard & Lambert**
  - Q & A – 23 March 2023
- **Sunshine Coast Hospital & Health Service Gran Rounds – Coronial Registrar Lambert & Deputy State Coroner Gallagher**
  - Coronial Matters – 26 March 2023

APPENDIX 2 Glossary

ADFVDRN / The Network	Australian Domestic and Family Violence Death Review Network	**EEA**	Emergency Examination Authority
ANC	Apparent Natural Causes death	**ESC**	Ethical Standards Command
ANROWS	Australia's National Research Organisation for Women's Safety	**FMO**	Forensic Medicine Officers
APCS	Asia Pacific Coroners Society	**Form 1**	Form 1 – Police Report of a death to a coroner
ATSB	Australian Transport Safety Bureau	**Form 1A**	Medical practitioner report of a death to a coroner
ATSILS	Aboriginal and Torres Straight Islander Legal Services	**Form 9**	Form 9 – cause of death certificate
AWAL	Australian Warbirds Association Limited	**FTE**	Full-time equivalent
CASA	Civil Aviation Safety Authority	**GCU**	Government Contracted Undertakers
CFMU	Clinical Forensic Medicine Unit	**NDIS**	National Disability Insurance Scheme
CCMS	Coroners Case Management System	**PTQ**	Public Trustee of Queensland
CCOs	Custodial Correctional Officers	**SC**	Senior Constable
CCQ	Coroners Court of Queensland	**SOA**	Standing Offer Arrangement
CCQ FAS / The Scheme	Coroners Court of Queensland Funeral Assistance Scheme	**The Coroners Act / The Act**	*Coroners Act 2003* (Qld)
CIB	Criminal Investigations Branch	**THHS**	Townsville Hospital and Health Service
CPR	Cardiopulmonary Chest Compressions	**TCS**	Tactical Crime Squad
CSCG	Coronial System Coordination Group	**QAO**	Queensland Audit Office
CSIU	Corrective Services Investigation Unit	**QCS**	Queensland Corrective Services
CSB / The Group	Coronial System Board	**QH**	Queensland Health
CSQ	Courts Services Queensland	**QHFSS**	Queensland Health Forensic and Scientific Services
CSSDF / The Framework	Coronial Services System Delivery Framework 2021-2025	**QPS**	Queensland Police Service
DFV	Domestic and Family Violence	**QPS CSU**	Queensland Police Services Coronial Support Unit
DFVDRAB / The Board	Domestic and Family Violence Death Review Advisory Board	**RBDM**	Registry of Births, Deaths and Marriages
DFVDRU	Domestic and Family Violence Death Review Unit	**VTPSP**	Vicarious Trauma Prevention Strategy Project
DJAG	Department of Justice and Attorney-General	**WCC**	Woodford Correctional Centre
DPP	Director Public Prosecutions		
ESAM	Exposition and Self-Administration Manual		