



QUEENSLAND
COURTS

Office of the State Coroner

Annual Report 2009–2010





**QUEENSLAND
COURTS**

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20 December 2010

The Honourable Cameron Dick MP
Attorney-General and Minister for Industrial Relations
Level 18 State Law Building
50 Ann Street
BRISBANE QLD 4000

Dear Attorney,

Section 77 of the *Coroners Act 2003*, provides that at the end of each financial year the State Coroner is to give to the Attorney General a report for the year on the operation of the Act. In accordance with that provision I enclose that report for the period 01 July 2009 to 30 June 2010.

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. Guidelines issued by me under section 14 of the Act are publicly available and can be accessed at www.courts.qld.gov.au/1710.htm. I advise that in the reporting period there were no directions given under section 14 of the Act.

Yours sincerely

Michael Barnes
State Coroner



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State Coroner's overview



Michael Barnes
State Coroner

Coroners and their interdisciplinary partners are continuing to deliver high quality services to Queenslanders.

Despite reportable deaths increasing by 13.64 per cent during the reporting period (bringing the cumulative increase over the last three years to 21.1 per cent), the finalisation rate increased by 2.41 per cent. Additionally, there was a 9.30 per cent decrease in the number of matters more than 24 months old – down from 226 to 205.

Coroners have little control over the time taken to finalise matters as they are dependent upon others to produce autopsy reports, investigation reports and the like. During the reporting period, 19.51 per cent of autopsy reports took longer than six months to be produced.

Coroners contribute to public health and safety and the prevention of unnatural deaths via the recommendations they make in inquest findings. During the reporting year 157 recommendations were made.

There is no obligation on any private or public body to respond to coroners' recommendations.


The Government sought to give impetus to the preventative focus of those recommendations by requiring all public sector bodies to advise the Attorney General of their response to them for inclusion in a report tabled in Parliament. The first of these reports was published in August 2009 and related to recommendations made during the 2008 calendar year. The 2009 report has not yet been tabled.

Prevention was also the focus of the numerous research projects undertaken with the benefit of information gathered during coronial investigations. A further 11 academics, scientists and other investigators have been accepted as "genuine researchers" under the Act and accessed coronial documents. A full list of those granted access is contained in Appendix 4.

Additionally, the Office of the State Coroner has joined with researchers from Griffith University and the Queensland University of Technology to undertake projects funded by the Australian Research Council. Details of these grants can be found under the heading 'Research Projects' later in this report.

There are now five full-time coroners in Queensland. The State Coroner, the Deputy State Coroner and the Brisbane Coroner are based in Brisbane. Both the State Coroner and Deputy State Coroner undertake inquests around the state when required.

The Northern Coroner is based in Cairns and generally investigates all reportable deaths that occur north of Mackay. The Southern Coroner is based at Southport and investigates all matters at the Gold Coast, Beenleigh, Logan City and Beaudesert. Between the full-time coroners, 2,989 reports were received, or 70 per cent of the 4,256 deaths reported throughout the state in the reporting year.



The remaining 1,267 deaths were reported to local magistrate coroners who must fit that work around their other court duties. In busy centres such as Maroochydore, Bundaberg and Rockhampton this places considerable stress on them.

In centres not served by a full-time coroner there is a risk that pressure of work and a lack of specialised expertise may mean some matters do not get the attention they need. In my view these problems urgently require the appointment of a full-time Central Coroner in Rockhampton or Mackay so that people living between Caloundra and Proserpine can receive the same level of coronial services as those in the south-east and northern parts of the state.

As I indicated at the outset, a coroner's work is essentially interdisciplinary: he or she is dependant upon investigators, pathologists, counsellors, medical and other specialists providing the information needed to make findings and preventative recommendations. Accordingly, I gratefully acknowledge the tremendous support given to my colleagues and me by the members of the Queensland Police Service, and the pathologists, toxicologists, forensic scientists and counsellors of Queensland Health Forensic and Scientific Services. We also receive dedicated support and assistance from the doctors attached to the Clinical Forensic Medicine Unit. Without the co-operation and willing contribution by the professionals in these other agencies, coroners could not do their job.

I express my gratitude to and admiration of the staff of the Office of the State Coroner, the two regional coroners' registries and the coroners' clerks in Magistrates Court registries around the state. The volume, intensity and often distressing nature of their work far exceeds that usually expected of administrative staff members.

I also acknowledge the fine leadership of the administrative staff by Ms Brigita White. I pay tribute to the work of my colleagues, the magistrate coroners around the state, and the fulltime coroners in Brisbane, Southport and Cairns. I am particularly grateful for the support and assistance provided to me by the Deputy State Coroner, Ms Christine Clements.

Our People

Registrar's report

The Registrar's responsibilities include managing the financial and administrative arrangements for the Office of the State Coroner (OSC), overseeing coronial operations in regional registries across the state and managing the interface between the OSC and the State Coroner, Deputy State Coroner and other full-time coroners and judicial officers.

The role of the OSC is to support the State Coroner to deliver a consistent and efficient coronial system. The OSC maintains a register of reported deaths, supports Queensland's involvement in the National Coroners Information System (NCIS) and provides ongoing legal and administrative support to the State Coroner, Deputy State Coroner, Brisbane Coroner, Northern Coroner, Southern Coroner, local coroners and court staff. The OSC also ensures there is publicly accessible information available for families and others regarding the coronial system and provides a central point of contact for coronial matters.

The OSC also supports the *Cremations Act 2003* and the *Burials Assistance Act 1965* and administers the burials assistance scheme and the conveyance of bodies programs through the management of contracts with funeral directors and local councils across the state.

The OSC comprises 30 staff members with 22 based in Brisbane, four in the Northern Coroner's office in Cairns and four in the Southern Coroner's office in Southport.

Major achievements of the office during 2009-10 include improving information available to families and health practitioners about the coronial process; the successful implementation of the new Coroners Case Management System (CCMS) and overseeing changes to coronial processes necessitated by amendments to the *Coroners Act 2003* made on 2 November 2010. The OSC also commenced a major tender and evaluation process for new undertaker contracts in preparation for the expiration of the existing contracts on 30 November 2010.

Courts where deaths are reported

As at 30 June 2010 there were 19 reporting centres across the state. The Deputy State Coroner and Brisbane Coroner are responsible for investigating deaths in the Greater Brisbane area including Caboolture and Redcliffe.

The Southern Coroner investigates deaths in the area covering Rochedale, south to the border of New South Wales, Beenleigh and Logan.

Deaths in the area from Thursday Island to Proserpine, north to the Papua New Guinea border and west to the Mount Isa district are reported to the Northern Coroner.

Deaths are also reported to local coroners based at the following Magistrates Courts:

Caloundra	Ipswich
Charleville	Kingaroy
Dalby	Mackay
Emerald	Maroochydore
Gayndah	Maryborough
Gladstone	Murgon
Gympie	Rockhampton
Hervey Bay	Warwick

During 2010, steps were taken to re-allocate coronial investigations to reduce pressure on regional magistrates in Bundaberg and Toowoomba. From 4 January 2010 matters previously reported to Bundaberg were reported to Rockhampton, and from 1 March 2010 matters previously reported to Toowoomba were reported to Warwick.

In-house counsel assisting at inquests

Coroners are aided by counsel assisting during an inquest. Outside Brisbane, police prosecutors often perform this role. In 2009-10, the Queensland Police Service Police Prosecution Corp assisted local coroners in eight of the 78 inquests held across the state, and

their contribution to the coronial process is greatly appreciated.

In some inquests police prosecutors are unable to appear as counsel assisting because there is a clear conflict of interest (for example, when the death is a death in custody or the police investigation is in issue) or because the matter involves systemic reform in complex areas such as aviation, mining or health care. In these cases coroners will engage private counsel or use in-house lawyers to assist them at inquest.

A legal officer assists each of the five full-time coroners. These legal officers are increasingly performing the role of counsel assisting. During 2009-10 they assisted in 33 inquests. As a consequence coroners can be supported by lawyers with specialised skills and experience in the jurisdiction, keeping inquest costs to a minimum.

In-house lawyers acted as counsel assisting in the following inquests during 2009-10:

Mr Peter Johns, Senior Lawyer to the State Coroner

- Challis, George Edgar
- Cockshutt, Andrew James
- Jeffrey, Lawrence Edward
- Cramb, Fay - aka Valmae Beck
- Fraser Island 4WD Inquest - Ian Davy, Concetta Dell'Angelo and Takeshi Sakai
- Johnstone, Brett Thomas
- Preston, William Elliot
- Pont, Elles John
- Hirning, Amanda Lee
- Goodna rail incident - Duncan, Hayden; Duncan, Glen and Fisher, Reginald
- Miller, Michael James
- Congoo, Sharon Faye
- Costelloe, Anthony Gayle

- Cullen, Matthew Raymond
- Ash, Peter Edward and Ash, Nicole Florence
- Oram, Ronald Thomas
- Stanford, Tony John

Ms Eryn Voevodin, Lawyer to the Deputy State Coroner

- Hadlow, Barry Gordon

Ms Ainslie Kirkegaard, Lawyer to the Deputy State Coroner

- Millard, Allan Clive
- Hockey, Barry John

Ms Dionne Franklin, Lawyer to the Southern Coroner

- Gillis, Wayne Anthony
- Shekar, Sridhar

Ms Alana Martens, Lawyer to the Brisbane Coroner

- Spencer, Annette Lee
- McBride, Edward Alexander

Mr Peter Edson

- Juhas, Jeffrey; Donaldson, Virginia; Juhas, Jerome and McGill, Stephen

Four of the in-house lawyers attended the Australian Advocacy Institute General Advocacy Skills workshop from 26-28 March in Sydney to develop and refine their advocacy skills.

Coroners Case Management System

The Coroners Case Management System (CCMS) is a purpose built case management system for coronial matters that commenced operation on 1 July 2009. The CCMS was developed by Information Technology Services within the Department of Justice and Attorney-General following extensive consultation with court

staff involved in coronial matters. The user-friendly system has been well received by court staff across the state and other Australian coronial jurisdictions have expressed interest in adopting the system.

The CCMS assists coroners to manage coronial files and ensure compliance with statutory requirements by using automatic electronic bring-ups and tailored reports. Users are able to generate forms and template letters using data entered into the CCMS and save received documents against the electronic file. These streamlined file management procedures reduce double data entry and the need to refer to the hardcopy files. The CCMS interfaces seamlessly with the Department's electronic document management system (eDocs) ensuring that documents are stored in accordance with current legislative requirements for document management. These process improvements have enabled registry staff to cope with the increasing coronial workload.

The CCMS also interfaces directly with the National Coroners Information System (NCIS), which is a national database of coronial information. Information about Queensland coronial cases is uploaded into the NCIS to support coronial investigations, research and policy development. CCMS has reduced the amount of duplicate data entry required by automatically uploading some case information and the police narrative to the system. This has contributed to a significant improvement in the case closure rate and timeliness of Queensland's data entry during 2009-10.

System enhancements were made in November 2009 to accommodate amendments to the Coroners Act and in June 2010 further functionality improvements were made following feedback from users. The OSC provides training and support to regional registries and also keeps users updated with a regular newsletter. Face to face training was delivered to court staff from Caloundra, Maroochydore, Hervey Bay, Kingaroy and Murgon.

The Coroners Act requires the State Coroner to keep a register of deaths investigated under the Act. All matters

pending at 1 July 2009 were migrated to the CCMS. The Queensland Wide Interlinked Courts (QWIC) system continues to record details of deaths finalised prior to 1 July 2009.

Coroners and Other Acts Amendment Act 2009

The Coroners and Other Acts Amendment Act 2009 commenced on 2 November 2009 and made a range of procedural and technical amendments to the Coroners Act. The amendments did not involve a shift in the fundamental policy underpinning the legislation.

Important amendments included:

- clarifying the definition of 'health care related deaths' to make clear that deaths resulting from a failure to provide health care are reportable
- expanding the definition of 'death in care' to cover all children in 'out of home' child protection placements
- imposing a duty to report deaths on providers of residential services to people with a disability. The duty applies even if the death did not occur at the care facility and has been reported by someone else
- expanding the definition of 'death in custody' to include deaths in detention under all State and Commonwealth legislation (with limited exceptions)
- establishing a new category of reportable death for deaths that '*happened in the course of or as a result of police operations*'
- removing the requirement for coroners to make findings where a coroner decides that an autopsy is not necessary and authorises a death certificate to be issued
- introducing a model 'aid to coroner' provision to facilitate cross-jurisdictional assistance between coroners

- providing for review of decisions about whether a death is reportable and the reopening of an investigation or inquest by the investigating coroner
- simplifying the approval requirements for genuine researchers to access to investigation documents.

In preparation for the commencement of the amendments the OSC reviewed the information available on the Internet about the coronial process. Forms, templates and coronial brochures were also amended in consultation with stakeholders.

The OSC developed a *Guide to the 2009 Amendments to the Coroners Act 2003* for distribution to coroners, court staff and coronial stakeholders. In consultation with the Queensland Health Patient Safety and Quality Improvement Service (PSQ) and Queensland Health Clinical and State-wide Services a new factsheet titled *Information for Health Professionals* and a set of FAQs were developed to clearly explain the reporting requirements in relation to deaths in a medical setting. These agencies were also actively involved in revising the Form 1A used by medical practitioners to report deaths occurring in a medical setting.

In the lead up to the amendments commencing on 2 November 2009 coroners and OSC staff were available on request to give presentations to medical staff including to the Queensland Health Directors of Medical Services, Royal Brisbane and Womens' Hospital, Princess Alexandra Hospital, Prince Charles Hospital, Mater Hospital and QEII Hospital.

Managing the provision of coronial autopsy and government undertaking services

The Registrar's responsibilities include overseeing arrangements for the transportation of deceased persons for autopsy under the Coroners Act and burials

and cremations under the Burials Assistance Act. Funeral homes and local authorities across the state are contracted to provide the services following an open tender process. The state has been divided into boundaries correlating to the Queensland Police Service (QPS) regions, districts and divisions. The most recent tender process conducted in 2005 resulted in 67 contracts being entered into with 46 service providers. The contracts are worth approximately \$2.4 Million annually.

Given that the current contracts expire on 30 November 2010 the OSC oversaw a significant procurement tender process during 2009-10 to ensure that new contracts are in place on 1 December 2010. An invitation to tender was released to market on 20 January 2010 seeking offers to provide the services in 70 boundary areas across the state. Offers closed on 18 February 2010 and are currently being evaluated.

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

The transportation of bodies for the purpose of autopsy is necessitated by the Coroners Act that requires an autopsy to be performed where a death is investigated by the coroner. There is an exception for cases where the coroner decides to stop investigating because, although the death is reportable, the cause of death is known and no further investigation is required. This often occurs for hospital related deaths which have been reported directly by medical practitioners using a Form 1A. In these cases, because no autopsy is required the family can collect the body from the hospital mortuary. The State Coroner encourages medical practitioners and coroners to use the Form 1A process where appropriate.

For those cases where a coroner must order an autopsy the coroner may order an internal or external autopsy. Autopsies are performed by forensic pathologists,

pathologists or government medical officers (GMOs) who are credentialed to perform autopsies. As a general rule external autopsies can be performed by GMOs but internal autopsies are performed by pathologists. Under the State Coroner's guidelines, the more complex autopsies (e.g. multiple deaths, suspicious deaths, child deaths, deaths during child birth and deaths in custody) are required to be conducted by a forensic pathologist. Forensic pathologists are only located at Brisbane, the Gold Coast, Toowoomba, Nambour, Rockhampton, Townsville and Cairns. Specialist pathologists who can perform other less complex internal autopsies are additionally located in Mackay and Bundaberg. An ongoing challenge for the coronial system is the availability of pathologists to perform autopsies in regional areas.

Because GMOs are more likely to be available locally transportation costs may not be as high when an external autopsy is conducted. The State Coroner has issued guidelines encouraging coroners to order external autopsies where appropriate. The Chief Forensic Pathologist has also been actively involved in triaging cases with coroners in regional and remote areas to ensure that internal autopsies are not performed unnecessarily.

One of the categories of reportable death is where a death certificate has not been issued and is not likely to be issued. If police are unable to contact a doctor to issue a medical certificate the death must be reported to a coroner and the deceased transported to a mortuary. The OSC is working with the QPS Coronial Support Unit to ensure that police make reasonable enquiries to satisfy themselves that a death certificate is not likely to issue before calling the government undertaker.

The OSC is also responsible for administering funds for coronial autopsies performed by GMOs and pathologists not employed by Queensland Health Forensic and Scientific Services (QHFSS). Queensland Health sets the fees for services provided by these GMOs and pathologists.

Communication, stakeholder relations and business improvement initiatives

During reporting period the OSC continued to successfully engage with its major coronial partners: the QPS whose officers investigate on behalf of the coroners and Queensland Health which provides forensic and counselling services for coroners. Each of these agencies is represented on the Interdepartmental Working Group chaired by the State Coroner that meets on a bimonthly basis to review and discuss state-wide policy and operational issues.

The OSC worked closely with the Queensland Health Patient Safety and Quality Improvement Service (PSQ), which is responsible for co-ordinating coronial issues within Queensland Health, to improve information available to clinicians about the coronial process and to ensure a smooth transition following amendments to the Coroners Act in 2009. The OSC also participated in the development of an e-learning package for clinicians and the PSQ Management of Deceased Patients Project. This project aims to develop a comprehensive death management process within Queensland Health with standardised practices across the state.

The OSC also liaised closely with the QPS Coronial Support Unit to improve the timeliness and quality of police investigation reports. To ensure outstanding matters are monitored, police officers are now tasked directly through the QPS database QPRIME and a new CCMS report has been developed.

The OSC convenes quarterly meetings with funeral directors' associations, the QPS Coronial Support Unit and representatives of QHFSS who provide mortuary and counselling services. These meetings provide a forum to discuss issues and develop constructive relationships aimed at improving families' experience of the coronial system.

The OSC improved the information available to families during 2009-10 by developing a comprehensive inquest booklet explaining the inquest process. The brochures provided to families at the initial stages of the coronial investigation were also revised to ensure that families are provided with advice about the autopsy process and the requirement for the coroner to consider family concerns. Communication with regional registries was also improved through the production of a bi-monthly newsletter that is available on the intranet.

In addition to the introduction of the CCMS other business improvement initiatives continued during 2009-10 included ensuring that coronial findings are provided electronically where possible. New forms were developed including a new Form 1B which streamlines the reporting process for multiple fatalities where disaster victim identification is required. The Form 3 which is the pathologist's initial report to the coroner following autopsy was amended to encourage pathologists to give an early indication of autopsy results and make recommendations to the coroner about obtaining particular statements or advice.

All publications, forms, inquest findings and relevant contact details are accessible via the OSC web page at <http://www.courts.qld.gov.au/129.htm>

Coroners and their support staff – roles and responsibilities

Full-time coroners

There are five full-time coroners consisting of the State Coroner, Deputy State Coroner, Brisbane Coroner, Northern Coroner and Southern Coroner. During 2009-10, 70 per cent of reportable deaths in Queensland were reported to a full-time coroner.

State Coroner

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

In order to discharge this co-ordination function, the State Coroner has issued guidelines of general application that inform the way coroners manage coronial matters across the state. The guidelines can be accessed at www.courts.qld.gov.au/1710.htm.

The State Coroner also provides daily advice and guidance to coroners in relation to specific cases and liaises with other professions and organisations involved in the coronial process, for example, police, pathologists and counsellors.

Only the State Coroner or Deputy State Coroner may investigate deaths in custody and deaths happening in the course of or as a result of police operations. The State Coroner also conducts inquests into the more complex deaths that, if dealt with by a local coroner, would take him or her out of general court work to the detriment of the local court diary.

During the reporting period, the State Coroner sat in Brisbane, Bundaberg, Cairns, Goondiwindi, Hervey Bay, Mareeba, Maryborough, Mount Isa, and Townsville. During the reporting period 104 matters were reported to the State Coroner. The State Coroner conducted 36 inquests and finalised 71 investigations without proceeding to inquest.

Deputy State Coroner

The Deputy State Coroner, Ms Christine Clements, was reappointed on 11 December 2008 for a further five years. Along with the State Coroner, the Deputy State Coroner may investigate deaths in custody and deaths happening in the course of or as a result of police

operations. The Deputy State Coroner acts as the State Coroner, as required.

During the reporting period 1,647 matters were reported to the Deputy State Coroner and the Brisbane Coroner. The Deputy State Coroner finalised 642 investigations including six following an inquest.

Brisbane Coroner

The Brisbane Coroner, Mr John Lock, was appointed as a full-time coroner in January 2008. Mr Lock assists the Deputy State Coroner to investigate deaths reported in the greater Brisbane area. The Brisbane Coroner finalised 735 investigations including three following an inquest.

Northern Coroner

Mr Kevin Priestly was appointed as the full-time Northern Coroner in March 2008. The Northern Coroner is based in Cairns and is responsible for investigating deaths in the Far Northern region spanning from Cairns, south to Proserpine, west to Mount Isa and north to the Papua New Guinea border. The Northern Coroner and his support staff moved into newly refurbished accommodation in the Cairns Magistrates Court in November 2009.

During the reporting period 625 deaths were reported in the region and 488 matters were finalised including six following an inquest.

Southern Coroner

Mr John Hutton was appointed as the full-time Southern Coroner in August 2008. The Southern Coroner is based in Southport and is responsible for investigating deaths in the area covering Rochedale, south to the border of New South Wales, Beenleigh, Logan City and Beaudesert.

During the reporting period 613 deaths were reported in the region and 524 matters were finalised including one following an inquest.

Local coroners

The Coroners Act provides that every magistrate is a coroner. Other than deaths in custody, which must be investigated by either the State Coroner or Deputy State Coroner, police report deaths to the coroner nearest to the place of death.

Coronial work requires the development of specialist expertise (especially for medical matters) and coroners must liaise regularly with police, families and medical practitioners. In recognition of the challenges this can pose for regional coroners who must also perform general magistrates court duties the Chief Magistrate allocated an additional Brisbane Magistrate to assist regional coroners from December 2009 to March 2010. This significantly improved the backlog of cases in Bundaberg and Toowoomba.

During the reporting period 1,267 deaths (30 per cent of all Queensland reportable deaths) were reported in the regions and 1,113 matters were finalised. Local coroners conducted 25 inquests.

Coroners' investigations

Reportable Deaths

The Coroners Act provides that reportable deaths, as defined in section 8 of the Act, must be reported to a coroner. Section 7 of the Act requires anyone becoming aware of an apparently reportable death to report it to the police or a coroner.

Section 8 defines the categories of reportable deaths as deaths where:

- the identity of the person is unknown
- the death was violent or otherwise unnatural
- the death happened in suspicious circumstances
- the death was a 'health care related' death

- a cause of death certificate has not been issued and is not likely to be issued for the person
- the death was a death in care
- the death was a death in custody or
- the death happened in the course of or as a result of police operations.

Unidentified persons

Even if there is nothing suspicious about the death, unless the identity of the deceased can be established with sufficient certainty to enable the death to be registered, the death must be reported to a coroner. Various means such as fingerprints, photographs, dental examinations or DNA are used to identify the person.

Violent or unnatural

Car accidents, drownings, electrocutions, suicides and industrial and domestic accidents are reported to coroners under this category. The coroner investigates the circumstances of death to determine whether it should be referred to a prosecuting authority or whether an inquest is warranted with a view to developing recommendations to reduce the likelihood of similar deaths.

Suspicious circumstances

Suspicious deaths are reported to coroners to enable their circumstances to be further investigated. If police consider there is sufficient evidence to prefer criminal charges in connection with the death they may do so and the inquest must be postponed until those charges are resolved.

Health care related deaths

The 2009 amendments to the Coroners Act clarified the circumstances where medical deaths are reportable and in particular that a failure to provide health care is captured. Section 8(3)(d) which required the reporting

of a death that *was not reasonably expected to be the outcome of a health procedure* was replaced by a new s8(3)(d) which requires the reporting of health care related deaths. Health care related death is defined in s10AA of the Act.

Health care has a broad definition and means a health procedure or any care, treatment, advice, service or goods provided for the benefit of human health. A health procedure includes any dental, medical, surgical, diagnostic or other health related procedure, including giving an anaesthetic or other drug.

A death is health care related if the health care caused or contributed to the death and before the health care was provided an independent person would not have expected the person to die. A failure to provide health care is health care related if the failure to provide care caused or contributed to the death and when the health care was sought an independent person would have expected health care to be provided.

Deciding whether a death that occurs in a medical setting should be reported and if so determining how it should be investigated poses considerable challenges for a coroner.

Cause of death certificate has not issued and is not likely to be issued

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

Deaths in care

Deaths of certain vulnerable members of society (namely children in the care of the Department of Communities, the mentally ill and the disabled) are reported to a coroner, irrespective of their cause.

The OSC now has an arrangement with the Office of Fair Trading, Disability and Community Care Services and Queensland Health to provide a list of the residential disability services that fall within the meaning of section 9(1)(a)(i), (ii) and (iii) of the Coroners Act. This information is updated regularly and posted on the OSC intranet site for use by magistrates and registry staff. This information is also forwarded to the QPS and Queensland Health facilities to assist with determining if a death is reportable.

The OSC would once again like to acknowledge the assistance provided by the staff of the Community Visitor Program. The partnership, which has developed between the two agencies, has been invaluable in monitoring the reporting of deaths in this category. During the reporting period, 98 deaths in care were investigated.

Deaths in custody

This term is defined in section 10 of the Act to include those who are at the time of their death actually in custody, trying to escape from custody or trying to avoid being placed into custody. 'Custody' is defined to mean detention under arrest or the authority of a court order or State or Commonwealth legislation (excluding the *Education (General Provisions) Act 2006* and the *Mental Health Act 2000*).

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

During the reporting period, 17 deaths in custody were reported. However, findings in relation to 21 deaths in custody were finalised. It is mandatory for an inquest to be held for deaths in custody.

Deaths that happened in the course of or as a result of police operations

Deaths occurring in the course of or as a result of police operations will include an innocent bystander killed while police are attempting to detain a suspect. During the reporting period five such deaths were reported. These deaths can only be reported to the State Coroner or Deputy State Coroner and an inquest must be held unless the coroner is satisfied that the circumstances do not require an inquest.

Indigenous remains

The Coroners Act recognises the sensitivity of Indigenous remains. When dealing with Indigenous burial remains, a balance must be struck between the need to ensure the death was not a homicide and the need to avoid the unnecessary disturbance of the remains. As soon as it is established that remains are Indigenous burial remains, the coronial investigation must cease and management of the site is transferred to officers from the Indigenous Cultural Heritage Unit of the Department of Environment and Resource Management and representatives of the traditional owners of the land where the remains were found.

Once a coroner has established the remains are in fact Indigenous burial remains, section 12 of the Act precludes a coroner from investigating further, unless the Minister directs.

During the reporting period, coroners investigated five matters where the remains were confirmed as Indigenous burial remains.

Purpose of coronial investigations

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

Autopsies

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

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

Although family members may not prevent an autopsy being undertaken if a coroner considers it necessary, a coroner who wishes to override a family's concerns must give the family reasons. The coroner's decision can then be judicially reviewed. No such review applications were lodged during 2009-10 and family concerns have been assuaged with the assistance of coronial counsellors from QHFSS.

The CCMS reporting functionality has improved the accuracy of data for autopsies ordered. In previous years precise figures have not been available and a sample analysis has been performed. Available data from 2007-08 to 2009-10 about autopsies ordered is included in this report in the tables below.

During 2009-10 there was a reduction in the number of autopsies performed overall. This is likely to be due to the increasing use of the Form 1A process to report deaths in a medical setting. The State Coroner encourages medical practitioners and coroners to use the Form 1A process where appropriate. There was also an increase in the proportion of external autopsies ordered. The State Coroner has issued guidelines encouraging coroners to order external autopsies so that bodies are not transported and invasive autopsies performed unnecessarily. The increase is also attributable to the availability of a CT scanner at QHFSS that uses specialist x-ray and computer technology to produce three-dimensional images of the internal organs. This greatly improves the information available without resorting to an internal autopsy.

Percentage of orders for autopsy issued by type of autopsy to be performed

Type of autopsy ordered	2007-08	2008-09	2009-10
External autopsy	10.1%	6.58%	11.64%
Partial internal autopsy	19.54%	15.57%	12.54%
Full internal autopsy	70.32%	77.82%	75.82%
Order on cremated remains	0.03%	0.03%	0%

Number of orders for autopsy issued by type of autopsy to be performed

Type of autopsy ordered	2007-08	2008-09	2009-10
External autopsy	314	208	349
Partial internal autopsy	608	492	376
Full internal autopsy	2,187	2,459	2,274
Order on Cremated Remains	1	1	0
Total	3,110	3,160	2,999

Measuring outcomes

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

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

Clearance rate

There has been a significant growth in demand for coronial services. From 2004-05 to 2006-07 there was a steady 3 per cent annual increase in deaths reported. However, the annual increase has been higher in ensuing years. In 2007-08 the number of reportable deaths increased by 9.2 per cent from 3,149 to 3,514. During 2008-09 there was increase of 6.57 per cent with reported deaths reaching 3,745. In 2009-10 there has been a 13.64 per cent increase in deaths reported bringing the number of deaths reported to 4,256.

Although finalisations have also increased over this period (finalisations increased by 2.4 per cent during 2009-10) they have not kept pace and the number of pending cases has grown. At the end of 2009-10 the clearance rate was 88 per cent, which is short of the Report on Government Services target of 100 per cent.

There are a number of reasons for the increase including increasing population and changing demographics and increasing awareness and expectations of the coronial jurisdiction. The increase also coincides with the period following the Queensland Public Hospitals Commission of Inquiry and the introduction of the Health Quality and Complaints Commission Review of Hospital-related Death Standard on 1 July 2007 (this standard mandates a review of hospital deaths and deaths in the community within 30 days of a hospital admission). Clinicians are now more aware of the obligation to report certain

deaths to the coroner. There are also heightened public expectations of health care and a greater willingness to scrutinise treatment provided.

The flow-on effect has been that treating clinicians are more likely to report deaths following health care to the coroner and doctors generally may be less willing to issue death certificates for their patients without coronial authorisation.


The increase in medical matters reported to the coroner since 2007-08 can be tracked by looking at the increase in Form 1As, which are used by medical practitioners to report deaths to coroners. The table below shows a state-wide increase of 133 per cent since 2007-08 and a 73 per cent increase in 2009-10 alone. The bulk of these matters are reported to Brisbane coroners where the major tertiary hospitals are located.

Form 1As

Financial year	Form 1As state-wide	Form 1As Brisbane
2007-08	314	223
2008-09	423	295
2009-10	732	482

Part of the increase during 2009-10 is also due to the fact that all deaths reported (including those that are found to be not-reportable) are recorded in the CCMS. This system commenced operation on 1 July 2009 – previously these deaths weren't uniformly recorded in QWIC in all registries across the state.

These matters are included in the lodgement figures on the basis that the coroner performs work in considering whether a death certificate can be authorised which may involve obtaining medical records using the powers under the Coroners Act, discussing the matter with treating clinicians and obtaining advice from doctors at the Clinical Forensic Medical Unit (CFMU), discussing treatment with family members and liaising with funeral directors. Significant time is often involved with these matters. Of the 3,745 matters finalised during the



reporting period 735 were found not to be reportable deaths within the meaning of s8(3) of the Coroners Act.

Backlog indicator

Coroners are aware that delays in finalising coronial matters can cause distress for family members and therefore constantly strive to conclude matters expeditiously. However, as is explained below, coroners are dependent upon other agencies completing their parts of the investigative process. Further, coroners must balance the benefits of timeliness against the risks of taking shortcuts.

As at 30 June 2010, 7.57 per cent of pending matters were more than 24 months old down from 10.1 per cent in 2008-09. This figure exceeds the national benchmarking target of 0 per cent largely due to the increasing number of lodgements and the more rigorous investigation required under the Coroners Act. The finalisation of a coronial investigation depends on the finalisation of autopsy and toxicology reports and the outcome of police or other expert investigations. In addition the coronial investigation is postponed pending the outcome of any criminal proceedings.

At the end of the reporting period, of the 205 matters that were older than 24 months, 52.7 per cent (108 matters) were waiting for police or other expert investigations or the outcome of criminal proceedings. Excluding outstanding reports (police and others) and criminal prosecutions, 97 matters i.e. 3.58 per cent of pending matters are older than 24 months.

Appendix 2 shows the lodgements and finalisations during the reporting period.

Coronial investigators – a multi-agency approach

The QPS Coronial Support Unit co-ordinates the management of coronial processes on a state-wide basis within the QPS. Four police officers located within the OSC in Brisbane provide direct support to the State Coroner, Deputy State Coroner and Brisbane Coroner as well as assisting regional coroners as required. Officers located at the QHFSS facility at Coopers Plains attend autopsies and assist in the identification of deceased persons and preparation of documents for autopsy. This unit also liaises with coroners, investigators, forensic pathologists, mortuary staff and counsellors. These officers bring a wealth of experience and relevant knowledge and are actively involved in reviewing policies and procedures as part of a continuous improvement approach.

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

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

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

The QPS Coronial Support Unit, the CFMU, the Coronial Counselling Service and QHFSS are integral parts of the coronial process. The dedication, commitment

and professionalism of these agencies are greatly appreciated by the OSC, as well as the families of the deceased.

Monitoring responses to coronial recommendations

When a matter proceeds to inquest a coroner may make recommendations aimed at preventing similar deaths in the future. Important and highly publicised recommendations made during 2009-10 included the State Coroner's recommendations about the QPS pursuit policy and the Brisbane Coroner's recommendations about public awareness of inadequate deck construction methods.

In 2006, the Ombudsman released his report on the Coronial Recommendations Project concluding that the ability of the Queensland coronial system to prevent death and injury would be substantially improved if public sector agencies were required to report on their responses to relevant coronial recommendations. In response the Queensland Government introduced an administrative process for monitoring these responses.

A whole-of-government report detailing responses prepared by the various Queensland Government departments responsible for considering and/or implementing coronial recommendations handed down between 1 January 2008 and 31 December 2008 was published by the Attorney-General the Honourable Cameron Dick MP in August 2009.

The report can be accessed at:

<http://www.courts.qld.gov.au/1710.htm>

Genuine researchers

The coronial system is an important source of information for researchers who in turn provide an invaluable resource for coronial systems in their preventative role. Section 53 of the Coroners Act facilitates access to coronial documents by researchers.

The following genuine researchers were approved under s53 of the Coroners Act during the reporting period:

Dr Damian Clark

Dr Clark is the Paediatric Epilepsy Fellow with the Paediatric Neurology Department at the Mater and Royal Children's Hospitals, which is responsible for the tertiary level paediatric neurology care of patients in Queensland and northern New South Wales.

Dr Clark's research is the first population-based study of sudden unexplained death from epilepsy (SUDEP) in Queensland. The study aims to clarify the incidence, demographic features and risk factors for SUDEP in Queensland from data in coroners' reports for the 5 year period 1 January 2004 to 31 December 2008.

Professor Raphael Grzebieta, Hussein Jama and Rena Friswell

Professor Grzebieta, Chair of Road Safety, Mr Jama, Associate Lecturer and Ms Friswell, Research Fellow, are from the NSW Injury Risk Management Research Centre (IRMRC).

Professor Grzebieta, Mr Jama and Ms Friswell are undertaking research for the IRMRC into motorcycle crashes into roadside barriers. The research is aimed at investigating and improving roadside barrier design.

Divers Network Alert Asia Pacific (DAN AP)

Dr Lippman is currently the Executive Director and Director of Training of DAN AP. Along with determining causes, encouraging methods of prevention of fatalities and developing better treatment methods for decompression illness, DAN also conducts research into factors such as repetitive dives, flying after diving, age and gender in order to improve the understanding and safety of recreational diving.

Michelle Hayes

A key initiative of the Queensland Government Strategy to Reduce Domestic and Family Violence 2009-2014 has

established a death review panel to better understand and assist in the prevention of domestic and family violence-related deaths. Ms Hayes is currently the Principal Researcher for the Domestic/Family Violence Strategy – Death Review Panel.

The panel's task (in consultation with the State Coroner) is to oversee a six month review of current coronial processes and practices in relation to domestic and family violence homicides.

The panel will use information generated from investigation documents to provide expert advice and recommendations in a report to the Minister for Community Services and Housing, the Attorney-General, the Minister for Police and the State Coroner.

Associate Professor Alexander Forrest

Associate Professor Forrest aims to create models of teeth and jaws from three-dimensional CT data sets scanned from routine post-mortem cases subject to dental identification. The resulting case materials will be used for disaster victim identification (DVI) training for dentists.

The use of the technology to create materials for DVI training will be reported in a peer-reviewed journal and most likely at the international conference of the ANZFSS International Symposium in the Forensic Sciences, 2012. An educational evaluation of the use of the materials may also be carried out and published in a peer-reviewed journal at a later date.

Professor Prenzler, Dr Porter, Ms Kirsty Martin and Ms Alice Hutchings

Professor Prenzler, Dr Porter, Ms Martin and Ms Hutchings are conducting research into Indigenous Deaths in Police Custody and Custody Related Operations. The aim is to identify changes in police procedures, equipment and training that will reduce the likelihood of custody and custody-related deaths.

These new researchers brought to 46 the number authorised to access coronial documents. The full list of these researchers can be found at Appendix 4.

Research projects

In addition to assisting external researchers by allowing controlled access to coronial documents, the OSC has also been involved in undertaking research into coronial issues. Two projects have been funded by grants from the Australian Research Council (ARC) and further applications are under consideration.

Details of the current projects are set out below.

Investigating family concerns about internal autopsies

Prior to December 2003, there was an almost total reliance on full internal autopsies for coronial findings as to cause and circumstance of death. Under the *Coroners Act 1958*, very scant information was provided in the initial report of the death from police and there was no mechanism to families to voice any concerns they might have about an internal autopsy.

This changed with the introduction of the *Coroners Act 2003*. Now coroners are obliged to consider any such concerns before making an order for an internal autopsy.

The State Coroner was concerned coroners might have difficulty reconciling these obligations to families with their duty to ensure all relevant evidence is gathered. To help address this he joined with a criminologist from the School of Justice Studies at QUT and the Chief Forensic Pathologist to investigate ways coroners have been handling these issues. The project is funded by the ARC to the extent of \$225,000 over three years and aims to develop guidelines to assist coroners make autopsy orders that respect family concerns without jeopardising the coronial investigation.

Two peer reviewed articles have been published and draft guidelines developed.

Preventing Suicide: a psychological autopsy study of the last contact with a health professional

Suicide accounts for more of the deaths reported to coroners than any other category of non-natural causes. In an effort to contribute to the prevention of these deaths the State Coroner has joined with researchers from the Australian Institute for Suicide Research and Prevention (AISRAP), Queensland Health, the New South Wales Department of Health, the Black Dog Institute, Lifeline and others, to investigate the frequency and effectiveness of suicide risk assessments undertaken by medical practitioners with patients objectively identified as being psychologically distressed. The study is funded by the ARC to the extent of \$391,000 over four years and some of the industry partners are also making cash contributions.

This study aims to: determine the degree of psychological morbidity recognised by health care professionals (HCP) in their last contacts with suicide victims; ascertain whether there were any known behavioural cues for suicide or other non-specific unusual features of the last contact; establish whether this last contact would have provided opportunities for prevention; consider opportunities for education of HCP concerning recognition of suicidal potential, as well as recommendations for better health service delivery.

Data collection finished in 2008. In total 277 suicide and 183 sudden death next-of-kin interviews have been completed, and 213 suicide and 93 sudden death HCP interviews have been completed.

This is the first research project in Australia to examine the last contact of suicide victims with HCP. Significant results include:

- Mental health problems were the reason for the contact with HCP in 51 per cent of suicides.
- During the last contact with a HCP, the main predictors of suicide were symptoms of depression

and anxiety, sleeping problems, statement of hopelessness, worries or recent life events.

- Histories of suicidal and risk-taking behaviours, mental illness or taking psychotropic medications were also risk factors.
- Statements about changing the will or disposing possessions were rarely expressed to HCPs but often to relatives. It may be worthwhile for HCPs to ask this in the future.
- The strongest suicide predictors in middle-age were relationship events, such as break-ups, separation, infidelity and serious arguments. In the older age group, the strongest predictor was decreased income.
- Suicides received less social support (practical and moral) than they needed from family and friends. This was especially the case with moral support.

The outcomes of the study indicate a need to enhance existing HCP guidelines and training. There is also a need for collaboration between GPs and Mental HCP as well as families in suicide prevention.

Following the next-of-kin interviews (Psychological Autopsy interviews), another important outcome was identified. The survivors who participated in the interview often reported its therapeutic benefits to their bereavement process by discussing the suicide and their experience.

When a partner/parent/child dies by suicide, the relatives are vulnerable to long-term psycho-social dysfunction and isolation due to negative community reactions and stigma around suicide. Consequently, they are often reluctant to talk about their experiences and feelings resulting from the event. This project reinforces the importance of reducing the stigma surrounding suicide as well as providing counselling and support for survivors to help their bereavement process.

Inquests

This section contains a summary of coronial investigations into all deaths in custody, as required by s77(2)(b) of the Act, and other inquests of note conducted during the reporting period. The complete inquest findings are posted on the Queensland Courts website at: www.courts.qld.gov.au/1680.htm

Deaths in custody *(21 in total)*

Tony John Stanford

On 19 September 2006, Tony John Stanford was found hanging in the cell he occupied alone at the Arthur Gorrie Correctional Centre (AGCC). He had been in remand since 1 June 2006 and had been identified as being at risk of self harm. At the time of his death, Mr Stanford was the subject of a risk management plan requiring two hourly observations by Corrective Services Officers. At inquest, the acting State Coroner, Christine Clements considered whether Mr Stanford received appropriate mental health treatment and examined the reasons behind the failure to maintain his observation schedule. Concern was also expressed about Mr Stanford's ability to make a hanging point undetected.

It was found that the Health Risk Assessment Team responsible for monitoring and assessing Mr Stanford's mental health had provided adequate care and acted appropriately in advising two hourly observations.

The investigation determined that Mr Stanford had not been observed for approximately three and a half hours before being found deceased.

A systemic defect in adhering to the monitoring schedule during the hours immediately after evening lockdown was identified. This was due to several factors including the timing of lockdown, inadequate communication between day and night shifts, and the impact of late arrivals at reception.

The acting State Coroner found that AGCC staff had followed medical emergency and death in custody protocols on finding Mr Stanford in his cell and that Queensland Ambulance Service officers acted appropriately.

No recommendations were made as prison management had already provided evidence of new search procedures, staffing and accommodation arrangements. The coroner accepted that these measures were sufficient to reduce the risk of a similar death occurring at the AGCC in the future.

Randall John Coleman

Randall John Coleman died at Kingaroy Hospital on 18 January 2007 after deliberately ingesting strychnine while at the Kingaroy watch house. Mr Coleman had been taken into custody two days previously for a breach of bail conditions under a domestic violence order. He received mental health counselling and despite denying suicidal intentions was identified as presenting a moderate risk of self harm.

The police investigation revealed Mr Coleman had concealed a vial of strychnine on his person before being taken into custody on 16 January 2007. Although two pat-down searches were conducted that day, the poison was not discovered. The investigation also determined that there had been non-compliance with policies relating to search procedure and record keeping.

The acting State Coroner, Christine Clements accepted that although police had failed to remove Mr Coleman's socks while conducting their search, this may not have been significant as the vial had possibly been concealed internally and that a more invasive search process was not justified. It was noted that insufficient records were obtained with respect to Mr Coleman's health, medication and personal details at the time of his admission to the watch house. This was found to be initially due to the extreme tiredness Mr Coleman was experiencing as a side effect of his anti-depressant

medication and was compounded by the police officer responsible for completing this duty not delegating the task to another officer before leaving the Kingaroy watch house. The coroner acknowledged that even if appropriate records had been taken and Mr Coleman had received professional psychiatric help as a result, it was unlikely that his suicide would have been prevented.

The acting State Coroner noted that police had acted promptly and appropriately once Mr Coleman informed them that he'd ingested strychnine.

A recommendation was made to change the allocation of resources at Kingaroy police station to allow for more effective monitoring of prisoners. The inquest heard that funding for a new Kingaroy watch house and police station was soon to be provided.

Ronald Thomas Oram

Ronald Thomas Oram was 49 years of age when he died of a coronary artery occlusion while in custody at the Capricornia Correctional Centre (CCC). He had complained of upper gastric pain on the evening of 5 January 2008 and subsequently received treatment for indigestion. Mr Oram was last seen alive during a routine inspection at 11.00pm and was found deceased in his cell at 2.05am on 6 January 2008.

The State Coroner was satisfied that the investigation into Mr Oram's death was appropriately conducted in terms of confirming no third party involvement. However, the investigation did not critique the quality of care given to Mr Oram following his complaint of chest pain.

The inquest found that the routine medical assessment of Mr Oram after his arrival at the CCC was adequate, given the procedures in place at that time, but could have been improved by requiring a detailed medical history. Although Mr Oram had no known cardiac conditions and a medical history would not have assisted his diagnosis, in other cases it may bring important information to the attention of medical staff.

The State Coroner accepted the policy has since been revised with a detailed medical history taken upon arrival.

The medical treatment afforded to Mr Oram following his complaint of upper gastric pain was less than ideal. However, even if his complaint had been diagnosed and treated as cardiac related, it is unlikely that his death could have been prevented. The State Coroner accepted that procedures regarding the management of chest pain were under review by Queensland Health.

The State Coroner made two recommendations relating to the actions of Corrective Services staff and the fact that it took approximately eight minutes for them to enter Mr Oram's cell after it was first suspected that he was not breathing. These recommendations were that the Department of Community Safety:

- review its policy governing responses to medical emergencies to require an appropriate response as soon as an emergency is reasonably thought to exist
- review its policy stipulating cell doors cannot be opened at night except in the presence of the officer in charge.

Barry Gordon Hadlow

Barry Gordon Hadlow died of an acute myocardial infarction on 13 July 2007 at the Princess Alexandra Hospital's (PAH) corrective services facility. Mr Hadlow was 65 years old and had been a prisoner at the Wolston Correctional Centre (WCC) since 1991. He was known to have several pre-existing medical conditions that increased his risk of cardiac arrest and had been transferred to hospital after complaining of chest pain on the day of his death.

The police investigation determined that Mr Hadlow's health had been in decline and raised no concerns as to the nature of his death. A medical review was conducted by a doctor from the Queensland Health Clinical Forensic Medical Unit to investigate the management of Mr

Hadlow's health care in the two months prior to his death.

The State Coroner was satisfied that no third party played any part in Mr Hadlow's death. It was found that he had received adequate treatment at the WCC and PAH. No recommendations were made.

Luong Bang Nguyen

Luong Bang Nguyen was a prisoner at the Arthur Gorrie Correctional Centre (AGCC) when he died on 6 March 2008 at the Princess Alexandra Hospital (PAH) Emergency Department after suffering a brain haemorrhage. The police investigation into Mr Nguyen's death established that he had been a chronic intravenous drug user and autopsy results confirmed that this was a contributing factor to his death.

It was found that Mr Nguyen's cell mate had woken at 10.30pm on the night of 5 March 2008 to find him fitting on the floor. The cell mate attempted to alert prison authorities to the situation via the cell's intercom but failed to effectively activate the intercom. This delayed the commencement of Mr Nguyen's medical treatment.

Autopsy results determined that Mr Nguyen had contracted a bacterial infection from intravenous drug use, which had caused a mycotic aneurysm and resulted in a subarachnoid haemorrhage. The intensive care specialist who treated Mr Nguyen upon his arrival at hospital considered that the haemorrhage was un-survivable even if medical treatment had been immediately provided. The State Coroner was satisfied that the response to Mr Nguyen's collapse had been timely and appropriate and that he had received an appropriate standard of medical care. The brain injury that caused Mr Nguyen's death was deemed to have been a spontaneous event that was unable to be prevented, predicted or treated. No preventative recommendations were made.

Roy Barnes

Roy Barnes was taken into custody at the Southport watch house on 6 February 2008. Two days later he was found semi-conscious in his cell and taken to Southport Hospital where he was diagnosed with a ruptured cerebral blood vessel. His condition was deemed inoperable and he received palliative care until he passed away on 12 February 2008. At the time of his death, Mr Barnes was suffering from acute heroin withdrawal, hepatitis C and coronary atherosclerosis.

Mr Barnes was arrested and transported to the watch house shortly after midnight on 6 February 2008. On reception, he provided no indication of ill-health or drug addiction in response to the Health Questionnaire Observation Checklist and was accordingly classified as a mainstream prisoner.

Neither of the arresting officers, nor any other police officer who dealt with Mr Barnes considered him to be in any way intoxicated or suffering from drug or alcohol withdrawal. Nonetheless, at approximately 3.00pm that day he presented to the watch house nurse stating that he was suffering from heroin withdrawal. Mr Barnes was assessed as suffering from opiate withdrawal syndrome and was prescribed 10 milligrams of diazepam three times a day.

In accordance with standard watch house procedures designed to prevent the administration of additional sedatives to prisoners who may still be experiencing the effects of drugs taken prior to arrest, it was advised that his initial treatment not be administered until 8.00am on 7 February 2008 (the '24 hour rule'). Mr Barnes received his first dose of diazepam at the scheduled time; the second dose was not administered although his evening dose was received at the appropriate time.

At 7.45am on 8 February 2008, watch house staff found Mr Barnes semi-conscious in the doorway of his cell. He was examined by a nurse and at 8.06am Queensland Ambulance Officers arrived and transported him to the Gold Coast Hospital. It was determined that he had

suffered an inoperable brain haemorrhage and given palliative care.

Post mortem examination found no indication of any trauma or violence. Toxicological tests showed only the presence of therapeutic levels of diazepam and its metabolites, which were found not to have contributed to the death. It was concluded that the increased heart rate and possibly transient high blood pressure associated with opiate withdrawal symptoms, combined with coronary artery disease, could have led to the fatal event.

The State Coroner found that Mr Barnes had died suddenly of natural causes and that the response to his collapse had been timely and appropriate. Despite this, the State Coroner determined that there were aspects of the operation of the Southport watch house that required further comment. These issues related to the inspection of prisoners and the quality of electronic monitoring equipment, as well as the provision of nursing care and the management of heroin withdrawal.

The QPS Operational Procedures Manual (OPM) requires watch house managers to ensure that inspections of prisoners are conducted regularly at intervals of no greater than one hour. It became apparent during the investigation that some of the entries in the Southport watch house's Prisoner Inspection Register had been fraudulent with respect to the observation of Mr Barnes. While the failure to perform the required inspections did not contribute to Mr Barnes' death, the practice was nevertheless disturbing. In the absence of any convincing explanation for these failures, the State Coroner found that the approach of senior officers at the Southport watch house was redolent of habitually poor practice.

The inquest heard that since Mr Barnes' death, the Assistant Commissioner, South-East Region had addressed the problems. Disciplinary action had been taken against relevant officers and the OPM obligations had been reinforced to all staff in the region. An alarm was also installed in the Southport watch house control

room, which activates a blue strobe light and sounds an alarm every 30 minutes to ensure prisoners are regularly checked. The State Coroner noted that these were appropriate responses but recommended that the position of alarm's switch in the watch house be reviewed to ensure its placement is most conducive to ensuring compliance with the obligation to inspect prisoners.

While the unexplained failure to administer Mr Barnes' second dose of diazepam on 7 February 2008 was found to have not contributed to his death, the State Coroner noted the total amount of medication Mr Barnes received in custody had been too little and too late. In light of the doubts raised by the inquest's expert medical witness to the advisability of refraining from administering medication to a watch house prisoner for 24 hours, the State Coroner recommended the '24 hour rule' be reviewed.

The management of heroin withdrawal was acknowledged to be a frequent challenge dealt with by watch house staff; however there are currently no adequate clinical guidelines or protocols about how it should be managed in a watch house. The State Coroner recommended that Queensland Health collaborate with QPS, as a matter of urgency, to develop guidelines to assist doctors in the management of prisoners suffering from heroin withdrawal. The State Coroner also recommended that the nursing needs of the Brisbane and Southport watch houses be reviewed.

Peter Shishko

Peter Shishko died of natural causes while on remand and under an involuntary treatment order at The Park Centre for Mental Health (The Park) on 18 June 2006. He was 47 years old.

Mr Shishko had been in custody since 27 February 2006. On 2 June 2006 he was transferred to The Park as a result of mental health issues identified during his incarceration.

Mr Shishko exhibited aggressive behaviour throughout his admission and was placed in seclusion on numerous occasions. He had been put in an isolation room shortly before 11.00pm on the night of his death and was subject to 15 minute visual observations. Mr Shishko was seen to be alive during the scheduled check at 1.45am but had stopped breathing by the 2.00am observation. Resuscitation was commenced immediately and sustained until Queensland Ambulance Service officers took over at 2.14am. Resuscitation attempts were unsuccessful and he died at 3.00am.

The police investigation report concluded there was no third party involvement. However, despite numerous requests and directions, the report was not provided to the Office of the State Coroner until two years and two months after the death occurred. The State Coroner considered the investigation to be seriously inadequate and was concerned with the lack of analysis given to issues such as the quality of care given to Mr Shishko during his time in custody. While appreciating the difficulty police officers face when attempting to investigate deaths occurring in a medical setting, he concluded that the matter had not been given appropriate attention. The State Coroner acknowledged the apology received by the Assistant Commissioner, Metropolitan South and was advised that the progress of coronial files in the region was to be audited and monitored in future.

The State Coroner specifically addressed whether Mr Shishko's prescription drugs had contributed to his death and sought to establish whether the dosages and combinations he had been receiving were appropriate. The State Coroner also considered whether a reported incident of swelling in Mr Shishko's feet and lower limbs on 15 June 2006 was appropriately responded to, as this can be an indication of heart failure.

Independent advice on Mr Shishko's psychiatric management was obtained from a consultant psychiatrist and it was found that while some aspects of Mr Shishko's medication regime were not ideal, there was no evidence that the medications administered

to him played more than an indirect role in his death. The psychiatrist did state however, that Mr Shishko's medical condition was not sufficiently monitored during his admission and that the indication of possible cardiac failure was not sufficiently attended to.

The Director of Clinical Services of Queensland Health conceded that greater attention should have been paid to Mr Shishko's medical care and advised that The Park had since implemented changes to address the specific systemic failures identified in the psychiatrist's report. A root-cause analysis had been conducted and further training given to staff to ensure that patient observation is more closely linked to necessary follow-up action. The State Coroner was satisfied that the issues of concern had been addressed by the relevant authorities and made no recommendations.

Anthony Gayle Costelloe

Anthony Gayle Costelloe was 37 years old when he died on 25 October 2002 while in custody at the Wolston Correctional Centre (WCC). He had been playing touch football with other inmates when he suffered a cardiac arrest. Despite prompt medical attention from prison staff and the Queensland Ambulance Service he was unable to be revived and died.

Mr Costelloe's health records had been acquired and an independent report commissioned from the Deputy Director of Government Medical Officer Services for Brisbane and Ipswich, to assess the medical care afforded to Mr Costelloe while he was in custody.

Mr Costelloe had been to the prison medical centre complaining of chest pain the day before his death. The registered nurse who attended to Mr Costelloe's complaint noted that his temperature, blood pressure and pulse were normal. Mr Costelloe was unaware of any history of heart disease in his family and advised that his pain had eased during the brief consultation. Despite Mr Costelloe's Aboriginal ancestry and a number of physical characteristics that indicated a heightened risk heart disease, no firm diagnosis was made and he

received no treatment. An appointment was made for Mr Costelloe to see the doctor during his next scheduled visit in four days.

The State Coroner noted that the medical centre possessed the equipment to assess Mr Costelloe's heart function and had it been used, he was likely to have been diagnosed and appropriate treatment made available. The nurse's failure to diagnose the event was viewed to be based on flawed information about the patient's history and a lack of understanding as to how to deal with patients presenting such symptoms. It was concluded that Mr Costelloe had received inadequate care after seeking medical attention.

The Nursing Director of Queensland Health's Offender Health Services gave evidence that reforms were being implemented to remedy the shortcomings apparent in this case. The management of reports of chest pain to prison health staff was under review to assist nurses in making a more informed diagnosis. Screening processes were also being improved to ensure all that relevant health information was elicited from new prisoners. All staff members were to undergo regular cultural awareness training, designed among other things to make communicating with Indigenous prisoners more effective. The State Coroner considered that these reforms addressed the inadequacies in Mr Costelloe's care and made no recommendations.

John Martin Heywood

John Martin Heywood, a 68-year-old prisoner of the Borallon Correctional Centre, died at the Secure Unit of the Princess Alexandra Hospital (PAH) on 20 July 2006. Mr Heywood's health had been progressively deteriorating due to the effects of a number of medical conditions. These conditions precipitated a fatal cardiac arrhythmia and he died despite having received a high standard of medical care.

Mr Heywood was last seen alive during a routine nursing check at approximately 3.00am on 20 July 2006. He was found to have stopped breathing when the next

inspection took place an hour later. The two nurses conducting the check were aware that a medical directive had been obtained from Mr Heywood stating he was not to be resuscitated and secured the room until investigating police attended. No signs of disorder were found and there did not appear to be any unexplained marks on the deceased's body.

The State Coroner concluded that Mr Heywood's medical records clearly demonstrated that he had received a high standard of health care. No recommendations were made.

Michael James Miller

Michael James Miller died from a self-inflicted gun shot wound on 25 May 2008 while attempting to avoid being taken into custody by police. A warrant had issued for Mr Miller's arrest and he had been evading police for more than two years. He had informed a close friend that he would rather take his own life than go to jail. He had been residing on a yacht moored near the Town of 1770 and was questioned by water police conducting a boat licence and registration check. Mr Miller provided the officers with an alias, and when they returned to verify his identity he anticipated that he would be detained and took his own life.

The State Coroner commended the professionalism of the police officers who witnessed the event. The integrity of the relevant evidence had been maintained as well as was possible and the investigation was thorough. The State Coroner noted that the early involvement of investigators from the Ethical Standards Command was appropriate and beneficial.

The inquest heard that the patrol by water police was conducted in a small rigid hull inflatable boat (RHIB) which, due to its size, necessitated that the officers' firearms be stored in a watertight case on the floor of the vessel to prevent them getting wet. Police were therefore unarmed when they approached Mr Miller's yacht to request his licence and registration details. The RHIB was then carried downstream while

the information provided by Mr Miller was verified with police communications. It was soon found that the particulars Mr Miller had provided were false and the officers returned to the yacht to seek further clarification of Mr Miller's identity.

When the RHIB again pulled alongside Mr Miller's vessel, police informed him that their databases held no reference to the name he had given. Mr Miller then produced a pistol and proceeded to threaten the police. Attempts were made to calm him and he was advised that the officers were unarmed, seeking nothing more than to confirm his identity and then depart. Mr Miller subsequently moved to the edge of his yacht in order to inspect the officers and verify that they were carrying no weapons. He then raised the pistol to his head, fired a single shot and his body and the pistol fell into the water. The officers then contacted their immediate superiors and set about securing Mr Miller's body.

The State Coroner considered the fact that the police officers were operating unarmed and from an unstable platform. It was noted that section 14.9 of the QPS OPM states that officers should carry loaded, concealable firearms when on duty unless specifically directed not to. The officers involved in the incident however, were working under an operational order that allowed individuals the choice of wearing their firearms.

The State Coroner acknowledged that water police often work in conditions where the standard hip holster is unsuitable and concluded that this was the case for the officers conducting the patrol in the RHIB. The inquest heard that alternative means of carrying firearms had since been investigated and that the use of thigh holsters had been adopted. The State Coroner was satisfied that this was an adequate response to address the unique problems faced by water police. However, it was noted that the size and design of the RHIB was not conducive to the safe use of firearms even if thigh holsters were used. The State Coroner heard that the boat was no longer used and that the vessels now employed were adequately designed for the wearing of firearms.

The State Coroner accepted that while an element of discretion needed to be retained in relation to wearing firearms, the discretion should be exercised by those in a supervisory position applying recognised principles; not by junior officers on an *ad hoc* basis. It was therefore recommended that the QPS remind officers of the OPM section 14.9 and consider whether guidelines should be developed to assist officers when applying discretionary power to direct subordinates not to wear firearms.

Robert Hayes Myers

Robert Hayes Myers died of natural causes on 14 October 2005 while in custody at the Wolston Correctional Centre. Mr Myers was 63 years old and had a long history of heart disease. The inquest found that although the death was not suspicious, the investigation into the incident had encountered some issues with the potential to negatively impact upon its integrity. The State Coroner addressed these issues and recommended the Department of Community Services review the relevant policy to ensure that future investigations conducted under similar circumstances would not be adversely affected.

The police investigation into the death was conducted by members of the Corrective Service Investigation Unit (CSIU) and established that no third party was involved. Mr Myers had been participating in an active game of table tennis but had been advised to rest by a Corrective Services Officer (CSO) who was aware of his heart condition. He returned to his cell and was found unconscious by another CSO a short time later. Medical staff members were immediately alerted and commenced resuscitation. Despite resuscitation attempts Mr Myers was unable to be saved.

The investigation found that Mr Myers had been moved from his cell to the corridor to give medical staff more room to work during the resuscitation attempt. After Mr Myers was declared life extinct his body was returned

to his cell at the direction of the prison manager. The prison manager believed that Mr Myers' cell was the scene of death and that replacing his body not only restored the crime scene but also preserved the deceased's dignity and avoided undue distress to other prisoners. The State Coroner considered that unnecessary entry to the cell had the potential to contaminate evidence and that returning the body was a contravention of the relevant policy.

A further matter of concern involved the debriefing of correctional staff before police interviewed them. The policy in place at the time detailed that operational debriefing or counselling could not commence until police had interviewed all persons with direct involvement. However, while police were in the process of obtaining witness statements, prison management determined that a critical incident stress debrief should occur for all staff involved before they completed their shifts. The investigating officers did not believe the death to be suspicious and therefore reluctantly agreed to this course of action. The State Coroner found the actions of prison management and the acquiescence of the investigators to be understandable, but not in accordance with best practice. He recommended that the Department of Community Safety review the policy to ensure that staff members are interviewed before debriefing occurred.

The State Coroner found that the health care provided to Mr Myers was adequate. Concern was raised during the course of the inquest as to whether health services in correctional facilities had sufficient procedures in place for managing chronically, seriously ill prisoners. It was found that the relevant Queensland Health policy contained adequate provisions and that consideration was being given to developing a more comprehensive method of documenting prisoner's ongoing health management requirements. The State Coroner was satisfied that no further comment needed to be made.

Andrew James Cockshutt

On 3 July 2008, 33-year-old Andrew James Cockshutt was found hanging in his cell at the Lotus Glen Correctional Centre (LGCC). Mr Cockshutt had been in custody from the time he was 19 years old and had a history of self-harm. He was not diagnosed as suffering from any psychiatric disorder and not all Corrective Services Officers (CSOs) at LGCC were aware of his history.

The QPS Corrective Services Investigation Unit conducted the investigation into Mr Cockshutt's death and Scenes of Crime officers performed a thorough forensic examination of the cell. The investigation concluded that there was no evidence to suggest another person's involvement in the death. The State Coroner found that the investigation had been thoroughly conducted and that all sources of relevant information had been accessed and analysed.

A Queensland Corrective Services (QCS) investigation was also conducted into the death. The investigation produced an extensive report, which was tendered at the inquest. The State Coroner noted that the investigation had been conducted impartially and that the recommendations were appropriate and useful.

Mr Cockshutt was found hanging from bed sheets tied to a towel rail in his cell. The rail was a permanent fixture attached to the wall 150cm above the ground. Mr Cockshutt had recently experienced the break down of a relationship with another prisoner and deliberately took his own life.

The State Coroner was satisfied that the medical response to the discovery of Mr Cockshutt's body was adequate and that the staff at LGCC acted appropriately. While Mr Cockshutt was known to have previously committed acts of self harm, the circumstances on 3 July 2008 were not such that any staff member at the LGCC ought reasonably to have been aware that he was likely to take his own life that day.

The State Coroner noted that two aspects of the case warranted consideration from a prevention perspective, namely, the monitoring of intra-prison relationships and the presence of hanging points in cells.

It was noted that the QCS 'At-Risk' procedure in place at LGCC in July 2008 required that self-harm/suicide risk assessments be undertaken in circumstances of relationship break down where QCS officers are aware that this constitutes a 'Period of Critical Risk' for the prisoner. The State Coroner examined why the policy was not implemented in the case of Mr Cockshutt, and found that many CSOs had no knowledge of his prior episodes of self-harm. While this information was stored on Mr Cockshutt's large custodial file, it was not flagged in the Integrated Offender Management System (IOMS), which would have made the relevant information immediately clear to any inspecting CSO. It was found that the IOMS contained only incidences of self-harm that occurred after the implementation of the system in late 2006. However, a process had commenced after the death of Mr Cockshutt in which all IOMS self-harm information had been updated to fully reflect custodial records. The State Coroner was satisfied that these policy responses obviated the need to make further recommendations about this issue.

The State Coroner expressed concern about the unnecessarily high positioning of the towel rail, but accepted the argument that it would be futile to eliminate such potential hanging points while the older cells at LGCC continued to contain windows covered by horizontal bars. It was accepted that the removal of hanging points from cells at LGCC was a priority, albeit one subject to unavoidable delays due to financial and operational constraints.

As in previous inquests, the State Coroner again urged the Department of Community Safety (DCS) to take the steps required to render cells safe. The State Coroner stressed that notwithstanding the efforts now being made, numerous prisoners have died due to a failure to implement the Royal Commission into Aboriginal Deaths in Custody's recommendations on the elimination of

hanging points 20 years after the State Government accepted them. Recognising that the DCS is aware of the importance of this issue, the State Coroner refrained from making any further recommendations, acknowledging that doing so would not speed up the process of removing hanging points.

Lawrence Edward Jeffrey

Lawrence Edward Jeffrey was 63 years old when he died on 11 May 2008 as the result of lung cancer. Mr Jeffrey died at the Mareeba Hospital while in the custody of the Department of Corrective Services and had spent the last four and a half years as an inmate at the Lotus Glen Correctional Centre (LGCC). Although he had been treated for various chronic medical conditions his terminal condition remained undiagnosed until shortly before he died.

The investigation into Mr Jeffrey's death was conducted by a police officer from the Corrective Services Investigation Unit (CSIU). It was concluded that no other person had caused Mr Jeffrey's medical deterioration. The investigating officer also found that the standard of medical care afforded to Mr Jeffrey prior to his death was acceptable. The State Coroner noted that the investigation had been professionally conducted and that the evidence was sufficient to enable him to make his findings.

The State Coroner found that the health care provided to Mr Jeffrey while he was in custody at the LGCC was adequate. It was noted however that prison staff did not adequately address a request made by Mr Jeffrey to see the visiting medical officer on 23 March. The State Coroner deemed that had Mr Jeffrey been examined by a doctor at that time his fatal condition was likely to have been discovered some weeks earlier than it was. However, this would have made no difference to the outcome as the cancer was well advanced.

On 1 July 2008 Queensland Health became responsible for the provision of health care services to prisoners. In the course of investigating numerous deaths in custody

the State Coroner noted that he had been provided with evidence relating to changes to policy and practice since that time. He was satisfied that those changes addressed the origins of the suboptimal health care detailed in this case and made no recommendations.

Elles John Pont

On 15 June 2007, Elles John Pont, 69, was standing outside his cell at the Wolston Correctional Centre (WCC) when he collapsed suffering severe chest pains. He was taken by ambulance to the Princess Alexandra Hospital (PAH) and despite revival attempts, his condition continued to deteriorate and he died later that afternoon. Autopsy results later confirmed that Mr Pont had died of natural causes, namely an acute myocardial infarction due to severe coronary atherosclerosis.

The incident was investigated by the Corrective Services Investigation Unit (CSIU). The police investigation found there was nothing to indicate the death was suspicious.

The State Coroner was satisfied that the investigation had been conducted thoroughly but noted that an apparent anomaly concerning Mr Pont's medication had not been sufficiently examined. The matter was addressed at the inquest where it was established that the medical documentation on Mr Pont's prison file showed no record of him having been given any medication after 6 June 2007.

The apparent failure to administer Mr Pont's medication in the last nine days of his life led to a suspicion that this may have contributed to his death. However, toxicological analysis showed that the levels of medication in Mr Pont's blood were indicative of recent ingestion of the appropriate doses of the prescribed drugs. It was speculated that Mr Pont's medical records may have been seized before his medication dose signing sheet had been added to the file. The State Coroner accepted that appropriate medication had been provided despite the absence of relevant notations in Mr Pont's file. It was noted that all documents relating

to a deceased prisoner must be collated as soon as possible after a death to maintain accurate records.

The State Coroner acknowledged that WCC staff had followed medical emergency protocols and CSOs, QAS paramedics and PAH staff did all within their power to provide assistance and resuscitation. It was concluded that nothing could have been done to save Mr Pont's life and there was no need for any preventative recommendations to be made.

William Elliot Preston

On 2 May 2007, 60-year-old William Elliot Preston collapsed and died of coronary artery atherosclerosis while in custody at the Arthur Gorrie Correctional Centre (AGCC).

Mr Preston's death was investigated by the Corrective Services Investigation Unit (CSIU). There was no evidence of third party involvement and the autopsy examination and toxicology results did not suggest anything suspicious. The State Coroner found that the investigation had been thoroughly and professionally conducted.

It was established that Mr Preston suffered from a combination of alcohol-related illnesses for which he had refused treatment in the months prior to his death.

The State Coroner found that the medical care provided to Mr Preston was appropriate as was the response to his collapse. Some anomalies were found to exist in the recording of medications administered to Mr Preston. However, the State Coroner was satisfied that this played no part in the death and accepted that changes to the reporting system at AGCC have since addressed these concerns. No recommendations were made.

Allan Clive Millard

Allan Clive Millard was 63 years old and serving a four month custodial sentence at the Darling Downs Correctional Centre (DDCC) when he was found deceased in his cell on 11 December 2007. Mr Millard was found to have died suddenly from heart disease.

The QPS Corrective Services Investigation Unit (CSIU) conducted the police investigation.

It was established that the deceased was a heavy drinker and smoker. He declined medical examination on reception at the DDCC; didn't seek medical assistance during his time in custody and did not complain of illness.

The State Coroner noted that while the majority of the evidence gathered by the investigating officers had been collected in a professional and timely manner, the report was not finalised until almost two years after Mr Millard's death.

The Office of the State Coroner supplemented the police investigation by following up on Mr Millard's medical history. This information, along with the prison health records was reviewed by the Director, Clinical Forensic Medicine Unit to assess whether Mr Millard was given appropriate treatment.

Independent medical review confirmed that Mr Millard had appropriate access to medical treatment and confirmed the adequacy of the medical emergency response to the discovery of Mr Millard's body. The State Coroner was satisfied that Mr Millard's death was due to natural causes and made no recommendations.

Barry John Hockey

Barry John Hockey was 58 years old and serving a custodial sentence at the Wolston Correctional Centre (WCC) when he died of lung cancer at the Princess Alexandra Hospital (PAH) Secure Unit on 29 December 2007.

The QPS Corrective Services Investigation Unit (CSIU) conducted the investigation into Mr Hockey's death. The State Coroner considered the police investigation could have progressed in a more timely manner, given that it was not finalised by the CSIU until nearly two years after Mr Hockey's death.

The Office of the State Coroner supplemented the findings from the police investigation by obtaining the

WCC medical records. The Director, Clinical Forensic Medicine Unit reviewed this material and the PAH medical records to assess whether Mr Hockey was given appropriate medical treatment.

The State Coroner found that Mr Hockey had received an appropriate standard of medical care, both at WCC and the PAH Secure Unit. Despite evidence of elevated levels of oxycodone and paroxetine in the deceased's blood, the State Coroner accepted the opinion of the Director, Clinical Forensic Medicine Unit that there was no evidence to suggest Mr Hockey was given inappropriate levels of these drugs during the course of his treatment, or that he was suffering from either opiate or paroxetine toxicity. The State Coroner made no recommendations.

George Edgar Challis

George Edgar Challis was on remand at the Woodford Correctional Centre (WCC) when another prisoner assaulted him on 1 July 2006. He died on 12 July 2006 at the Princess Alexandra Hospital (PAH) from head injuries sustained during the assault. The inquest could not proceed until the criminal charges brought against the prisoner responsible were dealt with.

The QPS Corrective Services Investigation Unit (CSIU) investigated Mr Challis' death and a detailed report was compiled. An independent investigation into the incident was also commissioned pursuant to the Corrective Services Act 2000, and the State Coroner noted that the subsequent report thoroughly reviewed the relevant policies and procedures.

At approximately 1:49pm on 1 July 2006, Mr Challis participated in a heated argument with a fellow prisoner in the WCC's exercise yard and had been punched twice in the face. CSOs in the officer's station adjoining the exercise yard witnessed the incident and, without leaving their station, directed the two prisoners to return to their cells. Although the men left the exercise yard they did not return to their cells and at approximately 1:52pm Mr Challis's assailant was seen to seize him by his clothing and drag him several metres

along the floor. The two CSOs left the officer's station to separate the men but they did not arrive in time to prevent the assailant from bringing his foot down on Mr Challis' head.

The CSOs immediately called a code blue and again directed the perpetrator of the assault to his cell. Prompt assistance was obtained from other CSOs and two registered nurses and the Queensland Ambulance Service (QAS) was contacted at 1:58pm. The CSO supervisor organised for preservation of the scene and ordered that Mr Challis' assailant be handcuffed and escorted to the WCC health centre for examination. The aggressor was strip searched and his clothes bagged as evidence; he was then taken to the detention unit, where the State Coroner noted that, remarkably, he was allowed to shower.

The Careflight helicopter was requested for emergency medical evacuation. By the time the Careflight helicopter arrived at 2:38pm Mr Challis was unconscious. On arrival at the PAH Mr Challis underwent a CT scan and was found to have sustained a fractured skull and several small brain haemorrhages. He was operated upon and managed in the intensive care unit over the course of the next few days. By 5 July the neurosurgical opinion was that no further operative intervention was suitable. On July 12, Mr Challis developed sudden haemodynamic instability and following consultation with his family and a full independent medical review, ongoing therapy was suspended and he died at 6:30pm.

It was concluded that Mr Challis died as a direct consequence of the assault. The perpetrator was convicted of manslaughter and sentenced to 12 years imprisonment.

The State Coroner found that the medical attention Mr Challis received after the attack was appropriate and that nothing could have been done to prevent death once the injuries were sustained. Despite this, the State Coroner identified two issues that warranted further consideration; namely, the adequacy of the CSO's

response to the initial assault and the procedures for the preservation of evidence following the incident.

The State Coroner was satisfied that the CSOs who had witnessed the initial incident had been trained and instructed to physically intervene in similar situations. It was noted that if the CSOs did not deem a physical intervention to be appropriate, it was incumbent on them to call a code yellow. However on 1 July 2006, they did neither. The State Coroner concluded that had the CSOs responded in an appropriate manner, they would have been able to discourage further conflict and may have been able to prevent the second assault. On this basis, the State Coroner determined that the failure of the officers involved in this case was not simply failing to call a code yellow immediately (or indeed at all) but failing to take any action that could reasonably be expected to resolve the situation.

The inquest heard that management at the WCC had addressed the issue of allowing CSOs an element of discretion in calling a code yellow and that subsequent changes to procedures now ensured that a code yellow is required on all occasions where an altercation occurs between two or more prisoners. The State Coroner heard evidence from the then General Manager of the WCC relating to a training regime put in place after Mr Challis' death in which he personally oversaw an increase in code yellow practice drills. Despite noting that the training concentrated on the response to code yellow calls, rather than on when such calls were to be made (the issue in the case of Mr Challis), the State Coroner was satisfied that the training program was adequate and made no recommendations on this issue.

In the minutes following the assault, some of the CSOs failed to follow procedures designed to ensure the preservation of evidence. While it was acknowledged that the integrity of the investigation had not been compromised in this case, failure to follow the procedures had the potential to jeopardise future cases.

The lack of recent training in such matters was evidenced by the deficiencies in the CSOs crime scene

and evidence preservation skills and the poor first officer response to the initial assault. Issues identified in the preservation of evidence in this case included the poor communication between supervisors, who had acted independently of each other in the aftermath of the incident, as well as the failure to preserve evidence by allowing Mr Challis' assailant to shower. The placement of Mr Challis's assailant in a detention unit without supervision and without considering self-harm or suicide indicators was of significant concern.

The WCC's General Manager at the time acknowledged that the management of the crime scene in this case had been less than ideal and advised the inquest of the current regime of training for CSO's and those in supervisory roles in crime scene management and the preservation of evidence. The State Coroner heard that a localised training package, devised by prison intelligence officers and members of the CSIU, now exists for each correctional facility and is conducted several times a year. The State Coroner was satisfied of the training program's adequacy and made no recommendations in relation to this issue.

The State Coroner noted that the Department of Community Safety had made a public apology to Mr Challis' family and that disciplinary action had been taken against two officers peripherally involved in the fatal incident. The apology was taken to be implicit acceptance that those officers could have responded to the incident more effectively and perhaps prevented the death and was commended by the State Coroner.

Fay Cramb

Fay Cramb was a long-term prisoner in the care of the Department of Corrective Services when she died at the Townsville Hospital on 27 May 2008. Ms Cramb died three weeks after emergency cardiac surgery.

The QPS Corrective Services Investigation Unit (CSIU) conducted the investigation into Ms Cramb's death and a detailed report was compiled. It found that there was no evidence to suggest that any other person

had caused or contributed to Ms Cramb's medical deterioration. The State Coroner found the investigation had been professionally conducted but shared the investigating officer's concern about the tardiness of some Queensland Health employees in response to repeated requests for statements. It was noted that this was an ongoing problem and that greater attention needed to be paid to the obligation to assist those responsible for investigating patient deaths.

Ms Cramb suffered from a number of chronic medical conditions. She became particularly unwell on 3 May 2008 and was transferred to the prison medical unit at the Townsville Correctional Centre (TCC). The QAS attended and Ms Cramb was transported to the emergency department at the Townsville Hospital. Her condition improved and she was considered sufficiently well to be transferred back to TCC later that evening.

On 5 May 2008 Ms Cramb again reported to TCC staff that she was feeling unwell and was having difficulty breathing. She was transported to Townsville Hospital again. The General Manager of TCC and his staff made several unsuccessful attempts to contact the next of kin, Ms Gunton to advise her of the situation.

On arrival at the Townsville Hospital Ms Cramb was attended by a senior consultant cardiologist who considered that emergency surgery was required. Although Ms Cramb was unconscious and unable to consent to treatment, it was judged that the proposed intervention was an emergency, life preserving treatment that a medical practitioner is entitled to undertake without a substituted decision maker's consent. Further attempts were made to contact the next of kin.

Due to the urgency of the situation, the treating doctor decided to proceed with the operation despite being unable to obtain consent. During the procedure Ms Cramb began to show signs of respiratory distress. A medical emergency team was called but her condition continued to deteriorate and she developed respiratory and acute renal failure. She was transferred to the

intensive care unit (ICU) and later that evening was placed on mechanical ventilation and renal dialysis. She was diagnosed as suffering from multiple organ failure and was receiving drug therapy for her heart, lung and kidney functions. Ms Cramb was managed in the ICU until 25 May 2008 by which time she had improved slowly and been able to cease mechanical ventilation and dialysis. She was transferred to a medical ward on 26 May 2008.

On 27 May 2008 Ms Cramb complained of a build up of secretions in her airway. Nurses attempted to clear the blockage but a fault with the suctioning equipment delayed the process. Ms Cramb stopped breathing and a medical emergency team was called. Her wish not to be resuscitated in such circumstances was respected and she died within minutes.

The State Coroner found that the TCC's management of Ms Cramb's health care had been appropriate and reasonable. Ms Cramb's acute health care needs were expertly attended to by staff of the Townsville Hospital on 5 May 2008 and thereafter. The State Coroner determined that the faulty suctioning equipment did not cause the death, which was found at autopsy to be due to a haemorrhage precipitated by long standing coronary atherosclerosis.

Apart from initial difficulties in contacting and verifying the authority of Ms Cramb's next of kin, the State Coroner found that decisions concerning the withholding of life sustaining measures had been appropriately negotiated, recorded and acted upon. Any delay in contacting Ms Gunton had no impact on the course of treatment provided to Ms Cramb. It was noted that Ms Cramb's wishes not to receive involuntarily emergency care or invasive procedures to sustain her life were frustrated by her not having an advance health care directive (AHCD) which could have prohibited the emergency intervention.

The inquest heard that Ms Gunton had approached a registrar of the Townsville Hospital on 6 May 2008 to ask that Ms Cramb be taken off all life supports.

Ms Gunton claimed that in response to her request, she was told that Ms Cramb was to be kept alive until she could be questioned about outstanding crimes. The State Coroner found no evidence to support this claim, nor any evidence to suggest that decisions regarding Ms Cramb's health care or treatment had been influenced by any criminal investigation priorities. The suggestion that Ms Cramb was being kept alive for these purposes was not consistent with the clear notations in Ms Cramb's medical notes from 7 May 2008 onwards that she was not to be resuscitated.

The State Coroner considered that several issues were raised by the circumstances of Ms Cramb's death which warranted further comment; namely the policies relating to a prisoner's consent for treatment, their end of life decisions and the communication of this information between prisons and hospitals.

The State Coroner considered the *Powers of Attorney Act 1998* (PAA) and the *Guardian and Administration Act 2000* (GAA) which create a legal framework to regulate the administering of emergency treatment and the withholding of life sustaining measures. A health provider can give urgent, life saving treatment without consent, provided the patient has not indicated in an AHCD that they do not wish to receive the treatment and this is known to the health provider.

As Ms Cramb did not have an AHCD in place she underwent treatment she was likely to have declined had she been in a position to be asked.

The State Coroner accepted Queensland Health's submission that it would not be appropriate to suggest to all prisoners that they should consider creating an AHCD but noted that it should be offered in some circumstances. It was recommended that the primary provider of health care to the prison population facilitate the creation and periodic review of AHCD's for prisoners reasonably in need of such a mechanism.

When addressing the issues of a prisoner's consent for medical treatment, the State Coroner noted that the relevant policy did not provide for reference to the

prisoner's statutory health attorney as a source of consent when the prisoner's capacity is impaired. The policy was therefore considered not to be consistent with the legislative regime set out in the GAA and PAA and the State Coroner recommended that it be amended.

Mulrunji Doomadgee

Mulrunji was found dead in a cell of the Palm Island police station on 19 November 2004, after having been arrested and taken to the watchhouse by Senior Sergeant Christopher Hurley earlier that morning. The immediate cause of his death was determined at two separate autopsies to be due to blood loss as a result of his liver bleeding into his abdominal cavity. The underlying cause of this was the rupture of his liver consequent upon severe blunt compressive force injury to his upper abdomen.

The inquest into his death, originally conducted by the Acting State Coroner, Christine Clements, found that Senior Sergeant Hurley had caused the fatal injuries by inflicting a number of punches to Mulrunji's abdominal region. However in June 2009, the Court of Appeal affirmed a decision of the District Court to set aside the Acting State Coroner's findings relating to how he died. On 1 October 2009, Coroner Brian Hine was appointed to re-open the inquest.

Coroner Hine accepted the whole of the evidence, both transcript and exhibits, of the original inquest. Given the effluxion of time Coroner Hine concentrated, wherever possible, on the initial responses of witnesses to obtain the most accurate and uncontaminated accounts of the incident.

The evidence, from medical experts and eye witnesses, was conclusive that although Mulrunji was severely affected by alcohol, he was not suffering from any injuries when he arrived at the Palm Island police station. Mulrunji had resisted Senior Sergeant Hurley when he was extracted from the back of the police van and a fairly violent struggle had ensued as the pair

proceeded to the watchhouse. The struggle culminated in a sudden stumbling fall into the police station, soon after which Mulrunji ceased resisting and was dragged, unresponsive to the cell. The time from when he was extracted from the back of the police van to the time that he was put in the cell was a matter of tens of seconds and his death occurred less than an hour later.

It was established that Senior Sergeant Hurley had imparted force with such violence as to cause Mulrunji's fatal injuries during, or soon after falling through the doorway of the police station. Coroner Hine noted that his efforts to determine whether the injuries were inflicted deliberately or accidentally were made considerably more difficult by witnesses describing conflicting versions of events and much of the circumstantial evidence against Senior Sergeant Hurley being suspect or highly qualified.

Coroner Hine noted that the absence of skin surface injuries or bruising on the deceased's abdomen implied that there had been no use of direct force, such as punching, kicking or stomping and suggested that the force had been applied by or through a softer surfaced object. Medical experts agreed that the injury could have been caused by the application of a knee, shoulder or elbow while the deceased was on a hard flat surface. Coroner Hine judged that Senior Sergeant Hurley had fabricated his claim that he had landed beside, not on top of, Mulrunji after the fall but was unable to find evidence to prove that he had made a conscious choice to apply that force.

While an accidental cause for the injuries could not be excluded, the Coroner also found sufficient compromising material to allow for the possibility that Senior Sergeant Hurley's actions had been intentional. Therefore, after extensive re-examination and analysis of the evidence Coroner Hine concluded that it was not possible to ascertain whether Mulrunji's injuries had been deliberately inflicted or accidentally suffered.

The police investigation into Mulrunji's death was deemed to have been conducted unsatisfactorily and

was flawed in terms of transparency, independence and thoroughness. Coroner Hine viewed that this not only undermined the credibility of the investigation and negatively impacted upon its appearance of impartiality, but also caused the coronial fact finding process to be substantially compromised.

Issues that were identified as undermining the investigation's integrity included the inappropriate conduct of the police who investigated the death and the strong evidence of collusion between Senior Sergeant Hurley and his colleagues. The perception of the effectiveness of the investigation was also viewed to have been compromised by the appointment of the same legal representative to Senior Sergeant Hurley and the two other police witnesses who were present at the Palm Island police station. Coroner Hine noted that from the point of view of the administration of justice, the combined legal representation failed to ensure the integrity of independent versions of events as the testimony of one police officer may have inadvertently influenced the account of another because of an unwitting disclosure by the common legal representative.

Coroner Hine made two recommendations. The first recommendation was that future investigation of deaths in police custody, which exhibit indicia of unnatural causes or which have occurred in the context of police actions or operations, be undertaken solely or primarily by the CMC as the specialist misconduct and anti-corruption body for the State of Queensland. To enable this to occur, the Coroner recommended that the CMC be resourced and empowered to undertake this role. The second recommendation was that the CMC in future cases give closer consideration to ensuring separate legal representation of police witnesses in serious or contentious matters where evidence may be in conflict.

Coroner Hine noted that communication between legal representatives and Aboriginal witnesses had been unclear on occasions. He acknowledged the communication difficulties that may be experienced between Aboriginal and non-Aboriginal people and

supported recommendations made on behalf of the Palm Island Aboriginal Council (PIAC). The PIAC recommendations proposed that counselling services are offered to witnesses involved in the coronial process, and that Indigenous witnesses should be questioned in the presence of members of the Community Justice Group. Investigative officers should be trained in the appropriateness of indirect questioning and alerted to the nuances of silence, gratuitous concurrence and avoidance of eye-contact when questioning Indigenous witnesses.

Brett Andrew Irwin and Craig Anthony Semyraha

Constable Brett Irwin died on 18 July 2007 after being shot by Craig Semyraha while attempting to execute a warrant for his arrest. Mr Semyraha then attempted to take his own life and died in hospital the following day.

A comprehensive investigation was conducted. It was established that Constables Brett Irwin and John Edwards arrived at Mr Semyraha's residence at 10.43pm on 18 July 2007, intending to execute an arrest warrant for his failure to appear at the Brisbane Magistrates Court in June 2007. Constable Edwards was unable to elicit a response from the occupants by knocking on the front door and Constable Irwin proceeded to the rear of the property and entered via the back door. Constable Irwin encountered Mr Semyraha and there was a verbal exchange, a brief struggle and a shot fired. Constable Edwards heard Constable Irwin say he'd been shot and retreated to his patrol car to call for assistance at 10.47pm.

A siege developed as numerous police crews converged on the scene. At 11.25pm contact was made with the house's occupants and it was agreed that Mr Semyraha's two children, his girlfriend and friend should come out. Mr Semyraha was asked if he knew where Constable Irwin was and replied in the negative.

At 11.45pm the women and children left the house and between 12.09am and 12.42am five more phone conversations took place between a police negotiator

and Mr Semyraha. Over the course of these calls the police negotiator anticipated that Mr Semyraha was becoming suicidal. Mr Semyraha was assured that he would not be harmed and encouraged to come out. He stated that he was preparing to surrender but wanted to complete writing letters to his family.

At 1.15am Mr Semyraha was heard to say that he would come out after finishing his cigarette. A gun shot was then heard and at 1.20am officers from the Special Emergency Response Team entered the house. Mr Semyraha was found alive but seriously injured with a gun shot wound to his head. The weapon was recovered and Mr Semyraha was transported to the Royal Brisbane and Women's Hospital where he was put on life support. At approximately 7.30pm on 19 July 2007 Mr Semyraha's mother agreed that his injuries were un-survivable and his life support was discontinued.

Constable Irwin was located in a dark corner of the front yard. Resuscitation was attempted but it was soon apparent he was deceased. He was found to have a gunshot wound through his chest which autopsy results later confirmed to have perforated his heart and lung and caused his death within seconds or minutes. Ballistics examination was carried out on Mr Semyraha's weapon as well as all guns carried by the officers who had entered the premises. It was established that Mr Semyraha's firearm had been used in both shootings.

The State Coroner considered the attempt to execute the warrant had been done at the wrong time of day, in the wrong manner and with an insufficient number of officers participating. Mr Semyraha had spent 11 of the last 15 years of his life in youth detention or in jail; he was known to have committed violent offences and was believed to be armed.

Although Constable Edwards had concerns about the safety of the endeavour he did not specifically articulate them. Constable Irwin had less than one year's service in the police force and was found to have made an error in judgement when he decided to enter the premises alone. The State Coroner was concerned that despite

the inexperience of the officers and the apprehension displayed, there was no discussion between the constables or their sergeant as to how they were to go about executing the warrant. It was concluded that the execution of the arrest warrant on the night in question was not urgent enough to justify exposure to the risks involved.

The State Coroner also considered whether the grounds around the house were sufficiently searched and questioned whether the officers communicating with Mr Semyraha did all they could to establish Constable Irwin's whereabouts after he was shot. The two and a half hours that elapsed between the shooting and the Special Emergency Response Team entering the house was also noted as being unduly lengthy. It was however accepted that these aspects had no impact on the outcome of the case, as even immediate medical attention could not have saved Constable Irwin.

The State Coroner recommended that the QPS review its policies and training to ensure officers are aware of the potential dangers involved in apprehending suspected offenders and the need to conduct a threat assessment and at least a verbal operational plan whenever circumstances permit. QPS policies and training should be reviewed to ensure officers recognise the paramountcy of safety and their obligation to raise safety concerns and the obligation of supervisors to support and encourage junior officers who do so. The State Coroner also recommended that the case be used to create a training scenario and QPS review all aspects of the response to the shooting of Constable Irwin to identify whether it could have been handled more effectively.

Inquests into police pursuits

Between June 2005 and July 2008, ten people died in or following a police pursuit in Queensland. Separate inquests were held into each of those deaths. In March 2010, the State Coroner delivered a report that synthesised the findings from each of the inquests in order to comment on issues of public health and

safety and the administration of justice. A number of recommendations were made to reduce the risk of further deaths without significantly compromising reasonable law enforcement. The following comprises a précis of the inquests held during the reporting period and the subsequent policy recommendations made by the State Coroner.

Matthew Raymond Cullen

Matthew Raymond Cullen was attempting to evade police when he lost control of his motorcycle and died on 26 July 2008. Mr Cullen was 21 years old and was under the influence of alcohol. He had ignored a police direction to stop at a random breath test (RBT) point and was being pursued by a police vehicle when he collided with a street sign. The investigation into the incident produced a detailed report that clearly established the events leading up to the accident.

At 10.06pm on the night of the death, a QPS officer had observed Mr Cullen negotiate his motorcycle through a roundabout at an excessive speed and without checking for traffic. The officer set off after Mr Cullen without engaging his vehicle's flashing lights or siren and followed him for less than a kilometre when he observed a fellow QPS officer attempt to stop the motorcycle at an RBT site. Mr Cullen failed to comply with the direction and the pursuing officer activated his vehicle's siren and flashing lights 50-100 metres after passing the RBT. He did not increase his speed.

After following the motorcycle for approximately 15 seconds it was apparent to the officer that he would be unable to catch up to Mr Cullen and he formed an intention to abandon the intercept. The police vehicle was an estimated 300 metres behind the motorcycle when Mr Cullen failed to negotiate a left turn, struck a traffic island and was propelled into a street sign. The police officer and two other witnesses attempted to provide Mr Cullen with first aid. He was taken to Bundaberg Hospital where he died.

The State Coroner was satisfied that the officer involved in the incident had received timely training in QPS pursuit policy and had a sufficient working knowledge of it. The policy specifically stated that failing to stop at an RBT was not a sufficient reason to justify the commencement of a pursuit. The officer however, was entitled to attempt to give Mr Cullen further direction by following at a normal speed and activating his vehicle's flashing lights and siren. It was concluded that the police officer had acted reasonably and that no breach of policy had been committed.

Caitlin Myfanwy Hanrick

Caitlin Myfanwy Hanrick was a 13-year-old high school student who died as a result of the injuries she sustained on 4 December 2006, when a stolen car being pursued by police struck her.

The coronial and disciplinary investigation was conducted by the QPS Ethical Standards Command (ESC), while a separate investigation into the criminal offences arising from the incident was conducted by officers of the Redcliffe CIB.

The State Coroner was satisfied that all sources of relevant information had been accessed and analysed and, although he was not in agreement with some of the conclusions reached by the investigating officer, found that the matter had been investigated thoroughly and professionally.

The investigation established that shortly before 1.00pm on 4 December 2006 an off-duty police officer observed a white Commodore driving erratically. The officer contacted Redcliffe police communications to check the vehicle's registration details and found that the Commodore had recently been used in both a petrol station drive-off and a break and enter and was listed as possibly stolen. A police vehicle was requested to attend. The officer's initial impression was that the vehicle contained five or six Aboriginal juveniles but this information was not relayed to the communications centre.

The officer continued to follow the Commodore and relay its location details. The driver consistently failed to indicate or give way but did not exceed the speed limit. During this time, two officers from the Redcliffe police station had been advised that the vehicle was possibly stolen and were proceeding to the area in a marked police car. Two other officers travelling in a second marked car were also directed to attend but were not made aware of the vehicle's status. The first police vehicle soon encountered the Commodore and directed it to stop by activating its siren and flashing lights. The driver ignored this direction and the pursuit commenced.

During the initial stages of the pursuit, witnesses stated that the Commodore travelled on the incorrect side of the road and negotiated several roundabouts the wrong way. However none of these manoeuvres were relayed to the officer at the communications centre who had assumed the role of pursuit controller.

The pursuit continued and the Commodore passed Caitlin's school for the first time. The second police vehicle arrived and the off-duty officer pulled over to enable the marked car to take up the position behind the leading police vehicle. The Commodore gained speed rapidly and the pursuit controller was advised that it was travelling 120km/h in a 60km/h zone. It was then relayed that the vehicle had veered onto the wrong side of the road through a gap in the median strip and made a right turn. The marked cars followed the Commodore back towards the high school and the pursuit controller was advised that it was travelling at approximately 90km/h. The officers in the lead car then sought to verify that the vehicle was in fact stolen but events intervened before they were able to confirm their suspicion. The Commodore had travelled at speed through a red light and hit Caitlin as she stepped from the median strip at the pedestrian crossing at approximately 1.03pm.

The investigation determined that the driver of the Commodore had been under the influence of cannabis during the pursuit and that the degree of impairment

was similar to that caused by a blood alcohol content of 0.10-0.15 per cent. The Commodore was found to have been stolen but had not yet been reported missing. The vehicle was in dangerous mechanical condition. Three of the four tyres had insufficient tread and the brakes were ineffective, requiring the driver to use the handbrake to slow the vehicle.

The State Coroner considered that while the driver of the stolen vehicle's dangerous and criminal behaviour directly caused Caitlin's death, breaches of QPS pursuit policy had exacerbated the risks to public safety. The pursuit controller and the senior officers in each of the pursuing vehicles were responsible for breaching the policy in a number of areas, despite having taken part in a comprehensive pursuit policy training program only three to four months before the incident.

The State Coroner found that there had been ample time, opportunity and reason for the pursuit to be terminated before the accident. It was concluded that the officers involved had demonstrated insufficient regard to the risks posed to other road users and had failed to terminate the pursuit when a reasonable officer would have deemed it unacceptably dangerous to continue.

The State Coroner then considered the adequacy of measures taken to ensure the road safety of students at Caitlin's high school. The inquest heard that no significant improvements had been made to the school's road safety infrastructure for at least 13 years and that this had been an issue of longstanding concern in the community. The school had acted to reduce the risks in a number of ways and the State Coroner was satisfied that it had done all that could be reasonably expected to manage the road safety of its students. It was noted however, that the construction of an overpass subsequent to Caitlin's death raised the question of whether the authority's previous refusals to supply such infrastructure had been reasonable.

The Department of Education and Training's lack of a road safety policy was of concern. The State Coroner

considered that although the department has no statutory or administrative responsibility for the management of road traffic around schools, it does have a duty of care to its students. Both Education Queensland and the Department of Transport provided submissions that informed the inquest of measures being taken to manage road safety around schools. The State Coroner maintained misgivings regarding the Department of Education's limited involvement in traffic management but refrained from making any recommendations about these issues.

Peter Edward Ash and Nicole Florence Ash

Peter and Nicole Ash died on 18 July 2008 in a motor vehicle accident caused by the dangerous driving of 22-year-old Samuel Bonner. Mr Bonner was affected by alcohol and attempting to evade police officers who had tried to intercept his vehicle to undertake a breath test and licence check.

The Internal Investigations Branch of the QPS Ethical Standards Command conducted the investigation. Scientific officers, officers from Scenes of Crime and the Accident Investigation Unit also attended the scene. The State Coroner was satisfied the investigation had been conducted thoroughly. The coronial investigation ran concurrently with a criminal investigation that resulted in Mr Bonner being charged with two counts of dangerous driving causing death.

Mr Bonner had attended a party and consumed alcohol and cannabis on the night of the incident. He had decided to go for a drive with a friend and due to the accentuated sound of his Mitsubishi Magna's exhaust note, had come to the attention of police conducting a mobile patrol. The officers resolved to intercept the vehicle and have the driver produce his licence and undertake a random breath test. The police were travelling in the opposite direction and after turning around, approached Mr Bonner without flashing lights or siren. The lights and siren were activated as the vehicles came up to an appropriate intercept point, however the Magna then accelerated away and overtook

a private car and a courtesy bus at a speed estimated to be in excess of 100km/h. The police vehicle increased its speed, overtaking the car and bus as it pursued the Magna. Upon seeing that the driver of the Magna was likely to continue to drive recklessly the police officers formed the intention to abandon the pursuit. However, before the lights and siren could be deactivated, Mr Bonner's Magna collided with the rear right hand side of the Ash's vehicle, causing it to be side-swiped another car, hit a power pole and tip over onto its roof. Mr and Mrs Ash were killed instantly while Mr Bonner and the other occupants of the Magna sustained minor injuries.

The State Coroner considered the police officers had received timely training in and had sufficient working knowledge of the amended QPS pursuit policy and had acted reasonably when they attempted to intercept Mr Bonner's vehicle. This was demonstrated by their decision to conclude the pursuit seconds before the fatal crash occurred. The actions of the police officers were reasonable and constituted no transgression of policy.

Report on Police Pursuits - Policy Recommendations

The State Coroner's report on police pursuits produced thirteen recommendations aimed at balancing the competing policy objectives inherent in maintaining public safety while providing effective law enforcement.

Recommendation 1 - Refocus on safety

A pursuit should only be undertaken when the suspected offender's behaviour poses a greater risk to public safety than that posed by the pursuit. The current policy directs officers to balance the safety risks of pursuing against the benefits to the community of apprehending the suspect, whether or not those benefits involve the prevention of personal injury. It was recommended that the pursuit policy be recast to stipulate that the only factor officers need to consider when deciding to commence a pursuit is whether the danger to the safety of others is increased by not immediately apprehending the suspect.

The State Coroner commented that 24 per cent of all police pursuits in 2008 were commenced for 'non-pursuit matters' and made the following recommendations to reinforce the understanding of the circumstances in which a pursuit is not justified.

Recommendation 2 - No pursuits without evidence

The pursuit of vehicles in which the officer's instinct alone is the basis for suspecting the driver or occupants of committing an offence is among the current list of non-pursuable offences. The State Coroner recommended that this prohibition be moved from non-pursuit matters to the 'pursuit policy principles' to ensure that no pursuit be commenced without evidence.

Recommendation 3 - Don't pursue drunk or drug affected drivers

Non-pursuit matters should be revised to include drivers affected by drugs and alcohol to reduce the likelihood of such drivers increasing the risk to the public.

Recommendation 4 - Pursuing stolen cars

The State Coroner refrained from recommending that the unlawful use of a motor vehicle be included in the list of non-pursuit matters on the basis of the Police Commissioner's conviction that those responsible for the crime pose a safety risk more significant than the property crime aspects of the offence. However, QPS were encouraged to review and consider the justification for the current policy.

Current policy states that once an officer is satisfied that a pursuit is justified before commencing the pursuit further risk assessment must be carried out to determine which one of three categories the pursuit belongs to. A category one pursuit is where there are reasonable grounds to believe that the driver or a passenger has or may commit a homicide or attempt to murder. Pursuit category two requires that the driver or passenger be known to have committed an indictable offence or offence involving the unlawful use of the vehicle or dangerous driving. Pursuit category three

requires a reasonable suspicion that the driver or passenger has committed an offence involving unlawful use of the vehicle.

The State Coroner considered category one was appropriately framed but held a number of reservations regarding categories two and three. The State Coroner thought the policy could be significantly simplified by abolishing category three, changing the standard of certainty to reasonable belief in category two and limiting pursuits to indictable offences.

Recommendation 5 - Abolish category 3

The current policy requires an officer who has successfully attempted an interception to weigh the evidence to determine whether a fleeing motorist is 'known' or just 'reasonably suspected' to have committed an offence. The State Coroner considered this was impracticable and recommended that the distinction be abolished by deleting category 3 from the policy.

Recommendation 6 - Reasonable belief is sufficient

The current categories refer to different offences and different levels of certainty that an offence has been committed. The State Coroner viewed it unreasonable to require officers to make such fine judgements in volatile and dynamic circumstances. It was considered that a mere suspicion is too low a threshold to justify an inherently dangerous activity but that requiring an officer to know an offence has been committed is too restrictive. It was therefore recommended that category two be amended to require that an officer have a 'reasonable belief' that a relevant offence may have been committed.

Recommendation 7 - Weighted considerations

The QPS policy stipulates that safety is paramount and then lists 11 other matters to be taken into account when determining whether to commence and/or continue a pursuit, only some of which relate to safety, with no guidance as to how they should be factored into

decision making. It was recommended that this aspect of the policy be reviewed to ensure the intention that safety is the overriding consideration be made clearer. For example, officers should be encouraged to disregard those factors that do not add to the risk.

Recommendation 8 - Consider impact of pursuing

The State Coroner recommended the policy explicitly acknowledge the likelihood that pursuing a motorist is likely to result in the other car driving more dangerously and require an officer considering pursuing to factor this into the risk assessment and the manner in which the police car is driven.

Recommendation 9- Development of best practice guidelines

It was recommended that QPS develop best practice guidelines that:

- prohibit officers pursuing, other than in category 1 pursuits, unless radio contact can be maintained and the police car contains two officers or a hands free radio
- require a pursuit to be terminated if nominated dangerous manoeuvres such as running red lights at speed, etc occur
- insist on compliance with school speed zones and other particularly sensitive road management requirements
- deem a pursuit to continue until the police car ceases to follow or otherwise maintain contact with the other vehicle.

Recommendation 10 - Commencement - reverse the presumption

The State Coroner recommended that the current definition of when a pursuit commences be amended to deem a pursuit to commence whenever a driver fails to comply with an officer's direction to stop, unless the officer has reasonable grounds for believing the driver

is unaware of the direction having been given. It was also recommended that if this definition is adopted, a corresponding amendment be made to the 'evade police' offence if necessary.

Recommendation 11 - Pursuit controller training

In view of the important role of the pursuit controller and the difficulties that can arise when the officer discharging the role is junior to the officers in the primary pursuit car, the State Coroner recommended that the QPS develop a training package specifically for pursuit controllers. It was also recommended that the project team consider whether training should be targeted at officers with more than 10 years service.

Recommendation 12 - Evade police review

The State Coroner recommended that as part of its review of the 'evade police' offence, the CMC consider recommending mandatory licence disqualification upon conviction and more flexible vehicle impounding arrangements to bolster the deterrence effect of the offence.

Recommendation 13 - Engineered safety

It was recommended that QPS continue to explore developments in technology that will reduce the need for and the risk of police pursuits.

Inquests of Public Interest

Andrew Scott Anderson

Fourteen-year-old Andrew Scott Anderson was in the care of the Department of Child Safety (now the Department of Communities) when he died at the Princess Alexandra Hospital on 25 July 2005, due to a fatal head injury caused by a self-inflicted bullet wound.

Andrew was first brought into the department's care in March 2004 following an incident in which he was assaulted by his father. He was placed into emergency care and then into the care of a foster family.

An application for a child protection order was made and Andrew's father consented to give temporary custody of his son to the department.

The department's initial response was considered timely and appropriate. However, despite the positive ground work done by Andrew's first case worker, his foster home placement failed. A lack of alternate foster families in Toowoomba led to Andrew's placement in a communal youth home but his position there became untenable. With no other options available on 13 August 2004 an arrangement was reached for Andrew to stay with his grandfather in Brisbane.

On 6 September 2004, Andrew's family services officer applied for the grandfather to be formally assessed for suitability as a 'relative carer'. The request recorded that Andrew had presented as a suicide risk but refused to attend counselling. The Deputy State Coroner considered that the report produced by the social work consultant contracted to perform the assessment was inadequate. Essential details had failed to be elicited, including the particulars of Andrew's grandfather's work schedule, his regular overseas visits and his alcoholism, while the veracity of the information that had been provided was questioned. There was no evidence to indicate that the consultant had observed any interaction between Andrew and his grandfather or had even spoken with or considered Andrew's views. This lack of information prevented the department from being able to give appropriate consideration to whether Andrew's grandfather could care for him in a meaningful way and had resulted in an inappropriate assessment and placement.

In late February 2005 Andrew's grandfather contacted the department advising that his grandson was missing. On 9 March, the grandfather advised that he was no longer prepared to care for his grandson. From this time on, Andrew had no fixed abode but stayed with his father and his grandfather on occasion.

On 22 July 2005 Andrew showed his grandfather a 25 calibre handgun he had acquired. There was no

magazine or ammunition with the gun. His grandfather told him to get rid of the weapon, but did not confiscate it. On 23 July 2005 Andrew was in telephone contact with his father throughout the day trying to negotiate with him to pick him up to have a meal together. His father was unable to provide transport and told the boy to catch a bus. Andrew rang his father again and said, "Good bye Dad", there was then a loud popping sound and the sound of a fall. The father presumed Andrew had shot himself and drove to the grandfather's residence where he found Andrew unconscious with a fatal gun shot wound to the head. Andrew did not regain consciousness and died in hospital two days later.

The Deputy State Coroner made a number of comments about Andrew's care by the department but noted that some of these issues had been addressed by the department following serious consideration and review of the case.

It was recommended the department create a system for allocating responsibility in cases where a child is 'mobile' between different offices. There was also a need to review the guidelines relating to the disappearance of a child in care. The guidelines for responding to this situation should be reviewed within the regime of the Suspected Child Abuse and Neglect system, the interdepartmental group of police, health, child safety, and education workers that consider children at risk.

The Deputy State Coroner stated the assessment process for placing children with relatives must comply with legislative requirements to ensure that the child's needs are met and that resources suitably support the placement, including physical visits where appropriate.

The Deputy State Coroner recommended priority training be developed for case workers in relation to dealing with difficult families. Early intervention resources were also considered. Although Andrew's family had attempted to the best of their ability and resources to access professional help to guide them in managing Andrew as a young child, their efforts were

unsuccessful and the family unit fractured before the final crisis which precipitated Andrew being taken into care. The Deputy State Coroner suggested greater priority be given to identifying and supporting families when the first indication of potential child safety issues arises.

The Deputy State Coroner stated that problems with Andrew's care should be considered against the background of very high case loads, insufficient foster families and a lack of other options available to the department. It was recommended the department receive priority funding to provide early intervention for families as well as to support children already in its care.

It was noted that although the department was addressing disciplinary issues with a team leader involved in the supervision of Andrew's care, the employee's suspension did not occur until immediately before commencement of the inquest, four years after Andrew's death. The Deputy State Coroner recommended a careful review of issues pertaining to the training and supervision of the department's staff.

Fraser Island Incident

Ian Davy, Concetta Dell'Angelo and Takeshi Sakai

Ian Davy, Concetta Dell'Angelo and Takeshi Sakai were young foreign tourists who lost their lives in two separate motor vehicle accidents occurring on the eastern beach of Fraser Island on 18 April and 13 December 2009. In the lead up to their deaths all three had been passengers in four-wheel drive (4WD) vehicles hired from operators in nearby Hervey Bay. Each of the vehicles was being driven by a fellow tourist driving on a beach for the first time and whom the deceased had only recently met.

The inquest found that Mr Davy and Ms Dell'Angelo died when the vehicle in which they were travelling rolled over as a result of the driver swerving suddenly to avoid a wave. They were not wearing seatbelts. At the time of the accident the vehicle was travelling between 59

and 73km/h on a section of beach suitable for driving on and a speed limit of 80km/h. Mechanical inspection of the vehicle found there were no mechanical defects contributing to the accident. The cause of the crash was due to a combination of the sudden movement of the steering wheel, the vehicle's speed, load and design limitations which increased its propensity to roll.

Mr Sakai was killed as a result of the vehicle in which he was travelling rolling over after being driven onto soft sand at an excessive speed. This view was based on the investigating officer's inspection of the scene and eye witness accounts. None of the occupants were wearing seatbelts. Mechanical inspection of the vehicle revealed no faults that could have contributed to the crash.

The State Coroner considered whether either driver should be referred to the Director of Public Prosecutions (DPP) to determine if dangerous driving charges should be preferred. In assessing the drivers' culpability the State Coroner took into account their knowledge of the conditions and instructions they had been given. The State Coroner considered that a jury would be unable to find that the driver of the vehicle involved in the deaths of Mr Davy and Ms Dell'Angelo did not have an honest and reasonable belief that the manner and speed of driving were safe. Accordingly, the driver's conduct was not referred to the DPP. The driver involved in the death of Mr Sakai was concluded to have been driving dangerously prior to the crash despite being aware of the rules regarding speed and the wearing of seatbelts. The State Coroner therefore referred that driver's conduct to the DPP.

The State Coroner noted the frequency of crashes on Fraser Island had increased from 10 incidents between 1998 and 2002, to 60 incidents between 2003 and 2007. Although the increase to some extent reflected the rapid growth in visitor numbers, driver related, vehicle related and environmental factors were found to amplify the risks involved with beach driving on the island.

Regulatory reforms undertaken as a result of a review commissioned by the Department of the Environment

and Resource Management (DERM) included the reduction of speed limits and placement of relevant signage and increased traffic enforcement activity and vehicle safety inspections. A two-stage policy initiative was also implemented and involved legislative changes requiring all 4WD hire vehicles on the island to carry no more than eight occupants including the driver. A new requirement was also introduced prohibiting the carrying of any load on the roof of a hire vehicle. Stage two of the initiative, to be implemented on 31 December 2010, requires all 4WD hire vehicles on Fraser Island to be fitted with no more than eight seats that are either rearward or forward facing and fitted with seatbelts. The Department of Transport and Main Roads (DTMR) has committed to undertaking an inspection of vehicles from 4WD hire companies in the area four times a year. An extensive publicity campaign had been put in place to advertise these new requirements and highlight safety issues including the development of a beach driving safety video and fact sheets.

'Tag-a-long' tours commenced on 1 July 2010 with the aim of increasing the safety of passengers in hire vehicles where groups had been put together by selling individual seats. The regulations require that those participating will travel as part of a group of no more than four vehicles led by a qualified, operator-appointed guide. The guide must have undergone DTMR character and experience checks prior to accreditation and the lead vehicle used in the tours must undergo mandatory six monthly inspections by DTMR. The State Coroner viewed these initiatives as worthwhile and commended the departmental officers responsible for driving the process.

The State Coroner recommended that DERM monitor the success of the 'tag-a-long' tours initiative with a view to encouraging greater participation by island visitors who are ill-equipped to undertake independent travel. The State Coroner recommended that DERM consider introducing a set of questions to accompany the application for vehicle permits, before driving on the island, to ensure first time and foreign visitors to the

island understand the crucial safety measures conveyed in the DERM video and fact sheets.

The State Coroner also recommended a review of the speed limit be undertaken to consider whether the maximum speed for hired 4WD vehicles on the island should be reduced to 60km/h. As the risk of drivers crashing reduces with age, and in view of the introduction of 'tag-a-long' tours, it was recommended that DERM consider only issuing vehicle permits to independent travellers hiring 4WD vehicles if they are over the age of 25 years. The State Coroner also recommended that DERM only issue vehicle access permits to hire vehicles that have undergone an annual safety inspection.

Goodna Rail Incident

Hayden Duncan, Glen Duncan and Reginald Fisher

Hayden Duncan, 10, his brother Glen, 8, and their cousin Reginald Fisher, 9, died when a train hit them early in the evening of 11 March 2006.

The incident was investigated by five separate agencies: the QPS; Department of Child Safety; Queensland Rail (QR), Workplace Health and Safety Queensland and Queensland Transport (QT). Each investigation focused on different aspects of the accident and produced reports that were considered during the course of the inquest.

The three boys had been playing together in their neighbourhood between noon and the early evening of Saturday 11 March. They were unsupervised, which was not atypical, and had been told to be home before dark. They had arrived at the Redbank train station at approximately 6.00pm where a QPS Railway Squad officer had observed their antics. When the officer saw two of the boys sitting on the edge of the platform she admonished them and the boys subsequently left the station.

At 6.16pm the train guard of an Ipswich bound train was advised by a passenger that three boys had been seen picking up bits of gravel in the rail corridor. The

guard radioed this information to the control centre and in accordance with QR policy, contacted the driver of the next train due through the area. The driver of this Brisbane bound train verified that he had received the information and subsequently confirmed the boys' location after slowly negotiating the area where they were thought to be.

The driver of the next train was also advised of the incident. He took steps to reduce his chances of being struck by rocks or glass fragments from shattered windows. This involved pulling mesh screens down over the side windows of the cabin and covering the two outer panels of the front windscreen with blinds while leaving enough room under the blind in the centre panel to see the track ahead. The driver did not reduce the speed of the train below 80km/h and also turned off the train's headlight in an attempt to conceal the train from the stone throwers. When he saw the boys, they were between the tracks and too close for the emergency braking to prevent the train from running over them. The boys did not hear the train approaching due to noise from the nearby freeway.

There was no evidence that any mechanical or operational defects contributed to the crash. The train driver was appropriately accredited and neither the driver nor the train controller was adversely affected by alcohol, drugs or fatigue. The State Coroner did not accept the conclusions of the QR and QT investigations that the accident would still have occurred if the train had been properly illuminated. While he could not find that the fatalities would not have occurred had the headlight been on, the State Coroner considered that driving the train at speed with the head light off increased the risk of the children being struck.

The QR policy at the time of the accident contained nothing in relation to the use of headlights in circumstances involving reports of trespassers on the rail corridor. The State Coroner found that QR's written policies relating to the response of train drivers to people being in the rail corridor were inadequate and afforded drivers too much unstructured discretion.

However, it was noted that QR had recommended a review of procedures for managing these situations. The material provided by QR and the now Department of Transport and Main Roads satisfied the State Coroner that the major policy deficiencies had been addressed and appropriately acted upon.

The relevant union identified some additional policy deficiencies. The State Coroner agreed with the submission that the meaning of the term 'proceed with caution' should be clarified. It was therefore recommended that QR develop and use in all its policies and notices to employees a standardised meaning for the terms 'proceed with caution' and 'proceed with extreme caution'.

The State Coroner considered the driver had operated the train in a dangerous manner because even though he was aware of the boys' presence in the rail corridor he turned his headlights off and proceeded at full speed. However, there was little or no likelihood of his being convicted of causing the deaths, as the Crown would not be able to prove that the driver did not have an honest and reasonable belief that it was safe to drive in the manner in which he did. No referral was therefore made to the Director of Public Prosecutions. However, the matter was referred to the CEO of QR for disciplinary action to be considered.

Annette Lee Spencer

Annette Lee Spencer died at the Royal Brisbane and Women's Hospital on 21 November 2008 due to head injuries sustained the previous day when the balcony on which she was standing collapsed. Mrs Spencer was one of 70 guests attending a function at an older style, Queensland home when part of the front balcony collapsed from a height of approximately 3.2 metres onto a tiled area on the ground level.

Experts agreed the balcony collapsed because some of the joists were not adequately recessed into the side of the balcony's front supporting bearer. At the time of construction of the deck in the early 1900s, the joists

were housed approximately 20mm into the bearer along the front of the balcony secured with only nails into the end grain and skewed nails into the side of the joists. The nails used at the time would have been non-galvanised and corroded over time. This construction method was in accordance with practices at the time.

Over time, the joists had disengaged from the front bearer. The corrosion of many of the nails and loss of embedment due to the existing separation of joist ends from the front bearer resulted in the nail fixings being the only items restraining the bearer up against the joists. The experts agreed that the joists would have been able to support the deck's load on the day of the accident if they had been fully engaged. There was no evidence to suggest the collapse resulted from insect damage or timber decay.

The inquest also considered whether the flaws in the deck's construction could have been identified during the renovations undertaken in 2001 or during the building and pest inspections carried out in 2001 and 2005. It was found that it would have been impossible to ascertain the state of the joists during the building inspections and that even a trained building practitioner may not have been immediately alarmed at the potential dangers when viewing the deck from the underside prior to its collapse.

Coroner Lock made two recommendations in relation to the method of the balcony's construction and the action to be taken by various bodies. It was recommended that occupants of residential dwellings containing a wooden deck or balcony, particularly those built before World War II, have those constructions checked for structural integrity and in particular for the construction method identified in this case. It was also recommended that the Building Services Authority, the Brisbane City Council (BCC) and other local government authorities, as well as the Building Code and Residential Building Associations disseminate these recommendations to their members, stakeholders and the general public to highlight the need for an inspection of such buildings.

Coroner Lock noted that since his preliminary recommendations were published in November 2009, the BCC had advised property owners of the recommendations. The Building Services Authority had also made specific reference to the recommendations on its website. The Building Services Authority repeated the recommendations in full and highlighted the balcony collapse in its summer 2009 edition of Building Links and conducted education sessions for home builders in relation to deck construction.

John Arthur Harvey

John Arthur Harvey was 28 years old when, on 16 August 2007, he lost control of the rental truck he was driving and died from the multiple injuries.

The road on which the accident occurred was a sealed, dual carriageway in an 80km/h zone, which was dry and in good condition with no pot holes or surface irregularities. There was no evidence to suggest that Mr Harvey had been under the influence of alcohol or drugs at the time of the accident, nor was he affected by any other physical incapacity that might have prevented him from being able to control the truck in the ordinary way. There was no evidence of any mechanical defects.

Analysis from officers of the Forensic Crash Unit determined that at the time of the accident, the truck was travelling at between 80 and 85km/h. This speed was found to be just below the vehicle's threshold for rollover at that point. When measured by Queensland Transport Vehicle Inspectors the day after the accident, the truck was also found to have been carrying an excessive load.

Coroner Springer accepted that Mr Harvey's ability to control the truck had been adversely affected by the excessive load in the vehicle coupled with the slightly higher than stipulated speed at which he was travelling.

Coroner Springer noted that although the vehicle was referred to as a three tonne truck, its maximum carrying capacity was clarified at the inquest to be only 730kg. However, there was no document given to Mr

Harvey to allow him to calculate the weight that could lawfully be carried by the vehicle and it was concluded that, through no fault of his own, Mr Harvey had been unaware of the truck's legal load limit.

The evidence indicted a common practice in the vehicle rental industry of referring to vehicles by descriptors such as 'two tonne' or 'three tonne' without clarifying what is meant by the description. Mr Harvey had misconstrued the carrying capacity of his hire truck. Coroner Springer considered that to prevent this occurring in the future customers should be provided with a clear and unequivocal explanation of the vehicle's load carrying capacity, including the weight of the driver and passenger(s).

Coroner Springer recommended that motor vehicle rental companies disclose to customers at the point of enquiry and at the time of hire, the maximum load and tare (empty weight) that the different classes of truck can carry. It was also recommended that this information be included on the rental vehicles in a visible place and clearly noted in the rental agreement. Further, Coroner Springer recommended that rental companies develop and distribute to their clients a brochure specifying average weights of household goods and containing general guidelines about the placement of loads.

Coroner Springer also recommended legislative change to require that the tare mass of the vehicle be included on the registration label of vehicles designed to transport loads (other than passenger cars) and that the actual load carrying capacity be clearly visible on the vehicle. The recommendations were forwarded to the National Transport Commission and to motor vehicle rental companies operating in Queensland.

Jason George Elliott Blee

On 9 April 2007, Jason George Elliott Blee was working at an underground coal mine when he was involved in an accident that caused him to become trapped between the wall of the mine and a shuttle car. Mr

Blee sustained a serious pelvic crush injury during the accident and died at the scene.

The initial investigation into Mr Blee's death was conducted by police officers from the Criminal Investigation Branch (CIB), who attended the scene. Scenes of Crime officers also attended. The CIB officers undertook a brief viewing of the scene of the incident and conducted interviews with witnesses. At the conclusion of the interviews they formed the view that what had happened had been an accident and no criminal charges would be laid. Police did not conduct any drug or alcohol tests on the driver of the shuttle vehicle. The investigating officer admitted in hindsight that the testing was overlooked in the difficult circumstances of the day and it was assumed that the mine's usual regime of testing would be likely to ensure that the driver was not affected by drugs or alcohol.

An investigation was also conducted by an Industry Safety and Health Representative appointed by the Construction, Forestry, Mining and Energy Union (CFMEU) and a report provided to the coroner.

The investigations confirmed that prior to the accident Mr Blee had been operating a continuous miner, a large vehicle designed to extract coal from the underground seam and convey it to a shuttle car for transportation to the next point in the process. When the continuous miner broke down Mr Blee left his work area to verbally communicate with the shuttle car driver to move out of the area in preparation for repairs to be made. At this time Mr Blee was standing approximately one metre from the shuttle car and as the driver straightened the vehicle's path he heard Mr Blee yell. The driver, believing that he had run over Mr Blee's foot, stopped his vehicle by way of the hand brake; although he did not get out of the cab to investigate as he could see and speak with Mr Blee and there was another mine worker with the injured man at the time. The driver then manoeuvred the shuttle vehicle in an attempt to release Mr Blee but in doing so trapped him between the vehicle and the rib of the mine.

After the injuries were inflicted, Mr Blee was slumped between the rib of the mine and the rear side of the shuttle car. Mine control was immediately informed and the Queensland Ambulance Service (QAS) contacted. The mining company's rescue personnel attended the scene quickly and the earth adjacent to Mr Blee was dug away until he was freed from his entrapment. He died a short time after he was extricated.

Coroner Hennessey commended the efforts of the mine workers and QAS staff who attended to Mr Blee. The response of the workers and of the mine's management to the incident was found to be timely and the management of Mr Blee's condition was medically appropriate.

Coroner Hennessey noted that there was significant controversy about what had actually happened in this incident and found that it had been difficult to determine what movements of the shuttle car took place and when, during those movements, the fatal injury to Mr Blee occurred. It was clear that Mr Blee had been injured as he was trapped between the shuttle car and the rib after initially being pinned by the shoulders as the shuttle car moved to leave the heading as directed. It was not clear what movements of the shuttle car were made in what sequence and which of the movements inflicted the fatal injuries. The precise sequence of events remains unknown.

Coroner Hennessey found that Mr Blee had been working in accordance with usual mining procedures in a restricted zone over which he had authority. This was not a case of workers participating in aberrant behaviour but rather of an adverse incident occurring in a situation where coal mine workers had followed existing procedures and requirements. Had it not been for the breakdown of the continuous miner which put out the sequence of the place change operation, Mr Blee would not have left the safe area. The continuous miner was found to have suffered a broken track or track pin while tests conducted on the shuttle car indicated that it was operating normally. The width of the mine's heading was not unusual in this context and the floor conditions

did not appear to have contributed to the incident. The mine management system was comprehensive and, on the whole, safety procedures were in place in relation to preventing such a potential incident.

Coroner Hennessy made 18 recommendations aimed at preventing a similar occurrence in the future including that a protocol be developed regarding the notification of families in the event of a serious mining accident. Where QPS is responsible for the initial notification, this task should be given priority.

It was also recommended that serious consideration be given to amending the *Coal Mining Safety and Health Act 1999* to provide for tripartite investigations involving the coal mine operator, the Department of Mines and Energy (DME) and an appointed Industry Safety and Health Representative from the CFMEU in any fatal accident. Consideration should also be given to amending the Act to ensure that all material generated as the result of such investigations be privileged such that it cannot be used in any proceeding other than a coronial hearing.

Recommendations were made regarding drug and alcohol testing of workers involved in fatal or serious accidents and the availability of appropriate first aid and other heavy lifting equipment to assist with such incidents underground. Recommendations were also made regarding health and safety procedures at coal mines including a review of arrangements for the interaction of pedestrians and machinery. The coroner recommended the development of proximity detection devices for use underground to detect the presence of pedestrians around mobile equipment. The need for a working party to be formed to review and discuss concerns about safety issues with shuttle cars was raised. Recommendations were also aimed at improving the investigation of mining deaths by developing a memorandum of understanding between the QPS and DME Inspectorate.

Casey Andrew Frizzel

Casey Andrew Frizzel was working as a bricklayer on 10 January 2007 when he suffered from heat stroke and died as a result of damage to his heart.

Mr Frizzel had commenced his work as a bricklayer at a new housing estate on 8 January 2007. Conditions were very hot and Mr Frizzel consumed very little food over the following days. During the lunch break on 10 January, Mr Frizzel told a fellow employee that he was feeling ill and had chest pains. However, he returned to work. Mr Frizzel at 3.30pm was observed by the site owner to be working in an erratic and unco-ordinated manner. Mr Frizzel advised that he was hot and tired and was advised to rest. Approximately half an hour later, Mr Frizzel's employer asked after his well being. Mr Frizzel replied that he would be fine after a rest. A co-worker noticed Mr Frizzel lying down, apparently asleep at around 5.00pm and approached Mr Frizzel. He advised that he was fine.

The co-worker and employer checked on Mr Frizzel again at approximately 5.45pm and discovered him lying down with blood coming from his mouth. They observed an electrical lead connecting a saw to a portable power box to be lying across Mr Frizzel's chest. The employer immediately called triple 0. The operator at the call centre requested Mr Frizzle be given CPR but the employer refused stating that he was in shock, didn't have any first aid training, and that there was blood and vomit around Mr Frizzel's mouth. The operator requested that Mr Frizzel be moved onto his side to free his airway but this was unable to be accomplished due to Mr Frizzel's size and weight. Resuscitation was attempted once police and officers from the Queensland Ambulance Service (QAS) arrived but he died at the scene.

The evidence was clear that Mr Frizzel consumed very little food during the period from 7 January until his death. The independent expert confirmed that Mr Frizzel's poor nutritional status was one of the risk factors for exertional heat stress. A number of other

factors were identified as increasing Mr Frizzel's risk of heat stress, including his general dehydration, his high body mass index and the fact that he was un-acclimatised to working in hot and humid conditions.

In response to the failure of Mr Frizzel's employer to provide CPR, Coroner Muirhead made a number of recommendations aimed at addressing the issues relating to the lack of heatstroke first aid training and education on work sites. Those recommendations included that all building sites be required to post an Emergency Information Sheet at the site containing details of emergency telephone numbers, the exact site location and basic first aid instructions. Building sites should also display posters advising employees of the signs and symptoms of heatstroke and how to prevent and treat it. He also recommended that consideration be given to requiring building sites to have a person trained in first aid.

The evidence at the inquest was that the QAS officers were delayed in attending the scene due to inadequate information provided regarding the location of the incident. The initial delay was due to Mr Frizzel's employer, who was not from the area, providing mistaken information to the triple o operator. Further delay resulted from details of the address in the new housing estate being unavailable in the ambulance's GPS or in the QAS Central Region Communications Centre (CAPCOM) database. This was compounded by the fact that the ambulance officers were also relatively new to the area.

Coroner Muirhead recommended that the QAS consider implementing an orientation policy for officers new to a particular area. It was also recommended that local government authorities provide, as soon as possible, details of all development applications that have been approved by the authority to Queensland Spatial Information Council.

The issue of site security was also raised as police had run out of crime scene tape and had only been able to properly secure the immediate area where

Mr Frizzel had passed away. The electrical switchboard and surrounding area were not secured and no police officers were enlisted to guard the scene overnight. The next day an officer from Workplace Health and Safety, and an officer from the Electrical Safety Office arrived at the site to discover that an electrician was performing work on the switchboard before it had been properly tested to see whether any electrical faults contributed to the death.

Although in this case it did not interfere with the coroner's ability to make findings the coroner recommended that the importance of scene preservation be addressed in a Memorandum of Understanding that is currently being negotiated between the QPS Coronial Support Unit and Workplace Health and Safety.

Jean-Marie Jeremie Yannick Zaza

Jean-Marie Jeremie Yannick Zaza was two years and nine months of age when he drowned in a back yard swimming pool on 23 February 2008.

The QPS and the Department of Child Safety investigated Jean-Marie's death. It was established that the only adult in attendance at the time of the accident was Jean-Marie's father, who had fallen asleep on the couch and had awoken at approximately 4.00pm to discover his son face down in the swimming pool. Mr Zaza retrieved the boy and enlisted the help of some neighbours however Jean-Marie was unresponsive. The Queensland Ambulance Service transported him to hospital but resuscitation efforts were unsuccessful and he was declared deceased at 5.00pm. Both investigations determined that the death had been accidental and concluded that there were no suspicious circumstances.

The inquest heard that the Zaza family had arrived from Mauritius just two weeks before Jean-Marie's death. They were seeking to reside permanently in Australia and had been living in 'home stay' accommodation; an arrangement often used to introduce new families to the

Australian culture and facilitate their applications for residential tenancy. In this case, difficulties in locating a suitable property had resulted in the Zaza's placement in a residence where the host was absent.

Upon the family's arrival at the house, the migration agent who had organised the placement undertook an inspection of the property. The agent tested the security of the gate to the pool by pushing on it while it was locked and, satisfied that the fastening was secure, completed a form confirming the pool's safety.

The investigation determined that although the gate functioned effectively when locked, its self-closing and locking mechanisms were defective. A fault in one of the hinges was identified and multiple tests confirmed that when opened beyond a distance of 20cm the gate failed to self-close. If the gate was opened less than 20cm it was found to self-close successfully but would only latch into the locked position if pushed.

Coroner Fingleton found it was likely that the gate's failed hinge had contributed to the tragic accident. It was noted that although the fault had since been rectified, the pool's fence had not been professionally assessed for compliance with local council regulations for over four years prior to the accident.

The coroner recommended that the Queensland Government implement a mandatory ongoing periodic inspection system to guarantee that pools are inspected for safety compliance at least once every four years. Until such time as the implementation of such a system it was recommended that the relevant local council put into practice a random audit program to encourage pool owners to maintain their fences and gates.

It was also recommended that the government ensure that there is a viable monitoring process in place for pools to be inspected upon the sale or lease of a property. This included an obligation upon real estate agents to ensure that a council officer inspects a pool for safety at the beginning of each new lease and once a year for existing long leases. In conjunction with the above, it was recommended that this arrangement

apply to 'home stay' operators where applicable. Coroner Fingleton also recommended that the condition reports completed by real estate agents at the beginning and end of tenancies focus on pool safety as well as other safety issues, such as smoke alarms. It was also recommended that it be made a requirement that building inspection certifiers follow up on pool fencing approvals.

Coroner Fingleton additionally recommended that the Queensland Government embark on an immediate advertising campaign to urge pool owners to regularly check their fences and gates. In her final recommendation Coroner Fingleton stated that the relevant regional council compile a register of all pools in its area, in both owned and rented residential properties, with a view to regular inspections being carried out.

Sharon Faye Congoo

Sharon Faye Congoo died at the Cairns Base Hospital on 11 January 2007 due to bacterial septicaemia from an unknown organism.

The coronial investigation adduced considerable evidence relating to the quality of treatment provided to her from the time of her initial presentation at the Mareeba Hospital on 7 January 2007 until her death four days later. The deterioration of Mrs Congoo's health began during the first week of 2007 when she contracted an influenza type virus and suffered a bump to her shin. By 7 January she was in significant pain and presented at the Mareeba Hospital. A provisional diagnosis of viral illness was made and blood tests were ordered. Treatment was by way of fluids, paracetamol and anti-inflammatory medication. Mrs Congoo was advised to return, for possible admission, if her condition deteriorated.

On 8 January 2007, Mrs Congoo's condition worsened but she did not return to the hospital as she was told the test results would not be back until Wednesday. On Tuesday 9 January Mrs Congoo felt worse and

attended the Mareeba Hospital again complaining of flu-like symptoms together with non-specific leg pain. The results from the tests initiated on Sunday were not available and she was again treated conservatively and returned home.

Mrs Congoo again re-presented to Mareeba Hospital on 10 January and was admitted. During transfer to the ward at about 3.15pm, nursing staff noticed that Mrs Congoo's fingers were cyanosed and that she displayed other signs and symptoms of septic shock. There was a further sudden and serious deterioration in her condition and despite medical evacuation by helicopter to Cairns Base Hospital and admission to intensive care she died the following morning.

The unanimous opinion of expert medical witnesses was that Mrs Congoo had died of an overwhelming sepsis notwithstanding the fact that that diagnosis does not explain all of her presenting features or the absence of a precipitating cause or focus of infection. It was acknowledged that there was no clinical information available to the treating medical team to suggest a bacterial infection and that preliminary indications had in fact suggested the contrary. The reviewing medical experts therefore did not suggest that a different clinical path should have been taken by treating doctors.

Coroner Priestly subsequently found that there had been no missed opportunity for medical intervention upon Mrs Congoo's presentations at the Mareeba Hospital that would have prevented her death. Nothing more could have been done by way of medical intervention that would have led to earlier diagnosis and treatment of the bacterial sepsis. Coroner Priestly concluded that it was likely Mrs Congoo had initially suffered a viral illness that had lowered the capacity of her immune system and left her vulnerable to the sudden and unexpected onset of the bacterial septicaemia.

Coroner Priestly then considered potential areas of improvement in the clinical and organisational management at the Mareeba Hospital and addressed

issues relating to staffing levels, clinical record keeping, blood testing and clinical co-ordination. Coroner Priestly was satisfied that any inadequacies in these areas had been satisfactorily addressed prior to the inquest and found that there were no matters that warranted the making of any recommendations.

Timothy Gerard O'Neil

Timothy Gerard O'Neil died at the Princess Alexandra Hospital on 20 September 2007 as the result of head injuries sustained seven days earlier when the boat he was travelling in collided with the sea wall at the mouth of the Brisbane River.

The Brisbane Water Police conducted the investigation into the death. It was established that at approximately 8:00pm on 13 September 2007, Mr O'Neil was one of two passengers returning from an afternoon fishing trip in Moreton Bay in a seven-metre console fibreglass craft that was being skippered by a mutual friend. The boat was owned by a club that provided its members with access to a range of vessels. The skipper of the craft was a member of this club and the voyage of 13 September was the first time that he had solely piloted a return trip to the mouth of the Brisbane River at night. The skipper had plotted the return course with the aid of the vessel's Navman satellite navigation system and had relied on the GPS map to steer a course aimed at the mouth of the Brisbane River. He did not realise that he was in the vicinity of the rock wall until moments before the collision. Mr O'Neil was seated next to the skipper and was thrown forward on impact with the wall. The skipper of the boat faced committal proceedings arising from the incident but the charge was dismissed.

Coroner Clements identified a number of factors that contributed to the collision including the moonless night, high tide conditions and the significant backlight emanating from the Port of Brisbane that made the unlit and undeveloped rock wall difficult to see. Furthermore, the boat was equipped with an out of date version of Navman which did not show the rock wall and

which was set to a mode that did not show hazards or navigation markers.

The skipper had relied solely on the Navman and visual observations and not only did he neglect to refer to other charts but he also did not use the Navman to set a way point on the outward journey to return to the mouth of the Brisbane River in the dark. Although the skipper was aware of the North Cardinal Mark marking the northern face of the rock wall, he did not know that the sequence of flashing lights meant there was safe navigable water to the north of the beacon. He erroneously thought the beacon signalled shoals and that he would be able to safely pass it on the southern side. As he proceeded towards the North Cardinal Mark he collided with the rock wall almost at the same time as he first became visually aware of its presence.

In response to Mr O'Neil's death, Maritime Safety Queensland commissioned a risk assessment that examined the circumstances surrounding the four incidents of collision since the wall's completion in August 2004. The report determined that given the thousands of ship movements in the area each year, there was a very low probability of a recreational craft colliding with the wall. Coroner Clements noted however that the risk was very real and dangerous for recreational boat operators inexperienced in night navigation.

Coroner Clements made several recommendations pertaining to the current recreational boat licensing regime and the visibility of the rock seawall. These recommendations were aimed at educating mariners about the hazards of entering the Port of Brisbane at night (and in other conditions of limited visibility) and improving the visibility and warning of existence of the rock wall at the mouth of the Brisbane River, particularly in conditions of new moon and high tide.

Joshua Leslie Hopkinson

Joshua Leslie Hopkinson was 17 years old and working as an apprentice fitter and turner when, on 21 July 2005, he died from chest injuries sustained when the nitrogen-charged cylinder he was in the process of dismantling discharged unexpectedly. The uncontrolled gas release caused the piston and flange to be rapidly expelled from the cylinder, striking Mr Hopkinson in the chest.

Coroner Risson relied on two separate reports when undertaking the coronial investigation into Mr Hopkinson's death. The first report was prepared by Mines Inspection Officers under the *Coal Mining Safety and Health Act 1999*. The second report was prepared by the Principal Inspector (Investigation) of the Department of Industrial Relations – Workplace Health and Safety Queensland, under the provisions of the *Workplace Health and Safety Act 1995*.

Mr Hopkinson had been working on a nitrogen-charged cylinder that formed part of the track tensioning system on a drill that was owned and operated by a coal mine. The cylinder had last been recharged on 16 June 2005 and because of leakage problems a decision was made to replace it when the drill rig was in for maintenance. The technician charged with performing the maintenance was experienced in the changing of cylinders on trucks and dozers but had not changed a nitrogen cylinder on a drill. Before starting the job, the technician referred to the Original Equipment Manufacturer's instructions for cylinder discharge. The technician determined that there was no gas left in the cylinder. This was confirmed by another technician. Once the cylinder had been removed from the drill, a number of other mine employees observed that its piston was retracted by the same amount as that shown by a new, uncharged cylinder. Some time after this, the cylinder was discarded, however a decision was made to refurbish it and it was sent from the mine to Mr Hopkinson's place of work on 12 July 2005.

On 21 July 2005, the production manager at Mr Hopkinson's workplace inspected the cylinder and instructed the

supervisor of the hydraulics department to have it disassembled so that a report could be prepared for a quote to be given for the refurbishment. The supervisor delegated the job to Mr Hopkinson. The explosion occurred while he was in the process of removing the last of the bolts securing the flange to the cylinder.

The evidence was that the cylinder could not have been removed from the drill rig if it had been fully charged. Coroner Risson acknowledged that both technicians had used a discharge tool to check that the cylinder was empty of gas and accepted that the cylinder appeared to be fully discharged. Despite this, Mr Hopkinson received the cylinder in a partially charged state.

Coroner Risson found that, in all probability, the failure to fully discharge the cylinder occurred because the valve was not engaged. This was believed to have been caused by the use of a modified discharge tool that resulted in the piston jamming and gave the false impression that the cylinder was not charged.

Mr Hopkinson was found to have failed to follow safe working procedures which involved progressive loosening (not removal) of each of the cylinder's 15 bolts. While Mr Hopkinson's supervisor was well aware of the correct practice he did not specifically advise the apprentice of this. Coroner Risson noted that with appropriate supervision such unsafe practices might have been detected and corrected.

Workplace Health and Safety prosecuted the employer for failing to ensure that workers were not exposed to risks arising out of the employer's conduct. The employer pleaded guilty and was convicted of that offence.

Coroner Risson made a number of recommendations aimed at improving safe handling and maintenance of stored energy equipment. Coal mine operators and others involved in the maintenance and repair of stored energy equipment used in coal mining operations were also recommended to review procedures for the safe dismantling of such equipment to ensure that no dismantling of any such equipment is commenced

before it is confirmed, by independent validation if necessary, that it is fully discharged. He also recommended that procedures be reviewed to ensure that all apprentices and others without formal trade qualifications are appropriately supervised at all times when working on such equipment.

It was also recommended that the departments responsible for the administration of *Coal Mining Safety and Health Act 1999* and the *Workplace Health and Safety Act 1995* are clear about who is responsible for any investigation and prosecution in relation to any accident relating to coal mining operations which occurs elsewhere than at a coal mine and that any legislative amendment be sought if necessary.

Sridhar Shekar

Dr Sridhar Shekar was an overseas tourist who died on 28 April 2008 as a result of head injuries he sustained during an accident involving a hired jet-ski, or personal water craft (PWC).

On 28 April 2008, Dr Shekar and his wife had hired a PWC from a business that offered unlicensed persons the opportunity to navigate the craft around a circuit in a well used Gold Coast waterway. They entered the water at approximately 10.30am with Dr Shekar in the driver's seat and his wife in pillion position. Conditions were clear and fine and the water was smooth. However, the owner of an 8.2 metre recreational motor boat had moored his vessel within the PWC circuit as he had mistakenly believed the buoys outlining the perimeter of the circuit to be mooring buoys. Although the owner of the motor boat was legally allowed to moor his vessel at that location he agreed to the PWC hirer's request to relocate his vessel soon after Mr Shekar and his wife began the circuit. While the motor boat was being readied to leave, the PWC hirer noticed that Dr Shekar was having difficulties in operating and controlling the craft. The PWC hirer beckoned Dr Shekar back to shore and reminded him of the safety requirements and also advised him that increasing the PWC's speed would assist in control of the craft.

When Dr Shekar went to return to circuit he took off at full throttle towards the still-moored motor boat. The PWC collided with the motor boat's anchor chain and Dr Shekar was propelled into the side of the boat. Dr Shekar and his wife were taken to shore where first aid was administered and the emergency services were called. Dr Shekar died as a result of his injuries.

The QPS investigation concluded that Dr Shekar lacked the necessary skills to navigate past a moored vessel and that it was his unlicensed PWC experience that had caused the accident. The Maritime Safety Queensland (MSQ) investigation found that the hire company was responsible for a number of areas of non-compliance with respect to the *Transport Operations Standard 2007*. However these deficiencies had not caused Dr Shekar's death.

The MSQ report found that many operators of PWC hire businesses in the region were not complying with legislative requirements and compliance was not being enforced by the officers of the Gold Coast MSQ. It was acknowledged that while the Gold Coast MSQ regularly interacted with local hire and drive businesses, there was no record of these interactions and their quality and regularity was therefore unknown.

Since Dr Shekar's death, an audit of PWC hire businesses had resulted in MSQ assisting operators to achieve full compliance with the existing legislation. In order to maintain this compliance, the increased monitoring of hire and drive operations had also commenced concurrently with the implementation of better record keeping practises at the Gold Coast MSQ office. Coroner Hutton accepted that these were appropriate measures to remedy the deficiencies but noted that continued random, covert and thorough monitoring was required to maintain full compliance.

It was subsequently recommended that a quality assurance program be developed for all PWC hire and drive operations and that all businesses be inspected and audited on a regular basis, including at least one annual covert audit. Coroner Hutton also recommended

that full records and documentation be maintained of all interaction between MSQ officers and PWC hire and drive operations.

Coroner Hutton considered the issue of whether the use of helmets would prevent PWC related injuries and found that, despite head injuries being a common result of PWC accidents, there was no legal requirement for helmets to be worn. Coroner Hutton therefore recommended that legislation be developed requiring all persons who use a PWC in Queensland wear appropriately designed helmets and to be licensed.

Coroner Hutton made a final recommendation that MSQ develop guidelines for all enforcement agencies to assess compliance with the *Transport Operations (Marine Safety- Hire and Drive Ships) Standard 2007* and facilitate the sharing of information between enforcement agencies.


Judicial Decision

Neale Kelson GENTNER

In September 2009 at the Maroochydore District Court, Judge J. M. Robertson heard the appeal of Neale Kelson Gentner against the State Coroner's decision not to hold an inquest into the death of his stepson, Adrian Elliott Jones.

Adrian Jones was 18 years old when, on 8 April 2006, he was killed as the result of his motor bike colliding with a station wagon. A Queensland Police Service (QPS) officer from the Accident Investigation Squad investigated the accident and it was concluded that the death had been caused by the motor bike having been driven at excessive speed by an inexperienced driver.

Mr Gentner and his family strenuously disputed the investigating officer's conclusions and in response to their concerns, the coroner to whom the matter had initially been referred, Magistrate Ken Taylor, advised that the only way in which such disputes could be thoroughly explored was at an inquest. However Coroner Taylor retired before the matter progressed any



further. Accordingly, the file remained with the State Coroner and his office undertook further investigations and reviews.

The State Coroner subsequently advised Mr Gentner that he did not intend to hold an inquest into Adrian's death. In response Mr Gentner filed an application with the District Court requesting that an inquest be held.

Judge Robertson noted that this had been the first ever application to the court regarding section 30(7) of the *Coroners Act 2003*, whereby if a coroner refuses an application to hold an inquest, the District Court may order that the inquest be held if satisfied it is in the public interest. There was therefore no developed Queensland jurisprudence to guide the judge in his decision. For that reason he considered Mr Gentner's application in the context of similar applications made to the Supreme Court in other States and Territories. It was observed however that the test applied when considering these appeals had been based on the court being satisfied that the holding of an inquest was "in the interest of justice" rather than "in the public interest" as stated by the Act in Queensland.

Judge Robertson found that in order for Mr Gentner's application to succeed there needed to be such uncertainty or conflict of evidence so as to justify the use of the judicial forensic process, and/or that the views of the deceased's family were such that an inquest was likely to assist in maintaining public confidence in the administration of justice. The judge also found that affirming Mr Gentner's application did not necessarily mean that he conclude that the State Coroner's decision was erroneous.

Judge Robertson acknowledged that an inquest into Adrian's death would be unlikely to constitute a long and resource intensive hearing and was satisfied that it was in the public interest that an inquest be held. In consequence, it was respectfully recommended that the local Coroner hold the inquest into Adrian Jones' death at the Maroochydore Magistrates Court.

Appendices

Appendix 1

Operating expenses 2009/10

	2009/2010
Autopsies	775,505
Burials/cremations	917,664
Conveyances	1,690,458
Conferences	745
Crown Law fees	134,899
Fees for private counsel	387,373
Employee related expenses	2,145,309
Expert report fees	80,856
Supplies and services - other	212,020
Travel fees	89,988
NCIS grant	87,577
Funds recovered - burials assistance contributions	-363,340
TOTALS	\$6,159,054

Appendix 2

Number of Coronial cases lodged and finalised in the 2009-10 financial year and the number cases pending as at 30 June 2010

Court location	Number of deaths reported to the coroner	Number of coronial cases finalised			Number of coronial cases pending			
		Inquest held	No inquest held	Total	< or = to 12 months old	> 12 and < or = to 24 months old	> 24 months old	Total
Beenleigh	0	0	1	1	0	0	1	1
Brisbane	1751	46	1551	1597	714	131	87	932
Bundaberg	121	2	103	105	76	11	1	88
Cairns	625	7	503	510	405	97	32	534
Caloundra	54	3	29	32	31	3	0	34
Charleville	29	1	27	28	11	4	2	17
Dalby	30	0	27	27	30	25	2	57
Emerald	29	0	41	41	12	1	0	13
Gayndah	8	0	7	7	7	0	0	7
Gladstone	60	0	47	47	32	5	2	39
Gympie	38	2	27	29	26	9	2	37
Hervey Bay	44	0	29	29	27	4	0	31
Innisfail	0	0	1	1	0	0	1	1
Ipswich	147	0	121	121	93	6	4	103
Kingaroy	33	0	18	18	21	4	0	25
Mackay	116	3	122	125	59	17	4	80
Maroochydore	170	1	140	141	75	16	8	99
Maryborough	35	0	30	30	18	4	1	23
Murgon	5	2	3	5	2	0	2	4
Proserpine	0	1	0	1	0	0	0	0
Redcliffe	0	0	1	1	0	0	2	2
Rockhampton	154	7	123	130	65	10	8	83
Southport	613	1	524	525	293	65	41	399
Toowoomba	60	1	122	123	2	5	2	9
Townsville	0	1	0	1	0	0	1	1
Warwick	134	0	70	70	80	6	2	88
Total	4256	78	3667	3745	2079	423	205	2707

Source: Coroners Case Management System (CCMS). Date prepared: 5 August 2010

Appendix 3

Presentations 2009 – 10

State Coroner

Domestic Violence death review panel inaugural meeting, “*The role of the coroner in preventing DV deaths*”, August 2009

NJCA Phoenix Magistrates Program, Welcome address, August 2009

Death investigation, Bachelor of Justice QUT, *Inquests – theory and practice*, September 2009

QPS – ATSB Aircraft crash investigation course, opening remarks, “*The unique challenges of investigating aircraft crashes*” September 2009

TressCox twilight seminar series, *Amendments to the Coroners Act of interest to medical practitioners*, September 2009

DOMSAC, *The new hospital death reporting criterion*”, September 2009

QEII Grand rounds, *the new hospital death reporting criterion*, October 2009

Hervey Bay Hospital, *The new hospital death reporting criterion*, November 2009

Princess Alexandra Hospital, *The new hospital death reporting criterion*, November 2009

North Coast Region QPS Detectives Conference, “*Working with the Coroner*”, December 2009

Mater Hospital, *The new hospital death reporting criterion*, December 2009

University of Queensland, *The Queensland coronial system*, January 2010

Bond University, *The Queensland coronial system*, January 2010

Caboolture Hospital Grand Rounds, *The new health care death criterion*, February 2010

Logan Hospital Grand Rounds, *The new health care death criterion*, February 2010

QPS Central Region District Mangers Conference, “*Working with the Coroner*”, March 2010

Greenslopes Hospital, *The new hospital death reporting criterion*, March 2010

QPS State Crime Forum, “*Working with the Coroner*”, June 2010

Deputy State Coroner

The Deputy State Coroner made several presentations to the major teaching hospitals in the Brisbane area throughout this reporting period.

Brisbane Coroner

Australian Medical Students Annual Conference 7 July 2009

Health Quality and Complaints Commission Conference 6 August 2009

Queensland Nurses Union Conference 9 October 2009

Royal Brisbane and Womens’ Hospital Health Care Symposium 14 October 2009

The Prince Charles Hospital Grand Rounds 22 October 2009

Minters Conference 29 October 2009

Princess Alexandra Hospital Psychiatric Conference 10 November 2009

Redcliffe Hospital Grand Rounds 12 November 2009


Aged Care Directors of Nursing Conference 23 April 2010

Appendix 4

REGISTER OF APPROVED GENUINE RESEARCHERS

Chairperson	Queensland Maternal and Perinatal Quality Council
Chairperson	Queensland Paediatric Quality Council
Chairperson	Committee to Enquire into Peri-operative Deaths Queensland Health
Director (Rob Pitt)	Queensland Injury Surveillance Unit
Director (Prof Diego De Leo)	Australian Institute of Suicide Research and Prevention
Director (Prof Nicholas Bellamy)	Centre of National Research on Disability and Research Medicine
Director (Assoc Prof David Cliff)	Minerals Industry Safety and Health Centre
Dr Douglas Walker	
Deputy Team Leader Safety and Education Branch	Australia Transport Safety Bureau
Director (Prof Mary Sheehan)	Centre for Accident Research and Road Safety-Queensland
Dr Charles Naylor Chief Forensic Pathologist Queensland Health Scientific Services	Australian Research Council
Dr Belinda Carpenter Criminologist QUT School of Justice Studies	Australian Research Council
Dr Glenda Adkins Criminologist QUT School of Justice Studies	Australian Research Council
Director (Assoc Prof Robert Hoskins)	Queensland Health Clinical Forensic Medicine Unit
Dr Ben Reeves	Paediatric Registrar Mackay Base Hospital
Dr Beng Beng Ong	Queensland Health Scientific Services
Dr Nathan Milne	Qld Health Scientific Services
Dr Peter O'Connor Ms Natalie Shymko Mr Chris Mylka	National Marine Safety Committee
Dr Nathan Milne	Queensland Health Scientific Services
Dr Beng Beng Ong	Queensland Health Scientific Services
Manager (Strategy and Planning)	Maritime Safety-Queensland
Dr Luke Jardine	Royal Brisbane and Women's Hospital
Dr Yvonne Zurynski	Australian Paediatric Surveillance Unit The Children's Hospital at Westmead
Director of Neonatology – Dr John Whitehall and Dr Yoga Kandasamy	Department of Neonatology Townsville Health Service District
Dr Nathan Milne	Queensland Health Scientific Services

Dr Beng Beng Ong	Queensland Health Scientific Services
Professor Ian Thomas Director of CESARE	Centre for Environmental Safety and Risk Engineering
Dr Margot Legosz	Crime and Misconduct Commission
National Manager for Research and Health Promotion (Dr Richard Charles Franklin)	Royal Life Saving
Lance Glare (Manager BCQD Building Legislation and Standards Branch)	Building Codes Queensland Division (BCQD)
Michelle Johnston	School of Pharmacy, University of Queensland
Dr Damian Clarke	Paediatric Neurology Department Mater and Royal Children's Hospital
Professor Grzebieta, Hussein Jama and Rena Friswell	NSW Injury Risk Management Research Centre - UNSW
Director - John Lippmann OAM	Divers Alert Network Asia Pacific
Michelle Hayes	Department of Communities
Associate Professor Alexander Forrest	Queensland Health Scientific Services
Professor Christopher Semsarian	Centenary Institute - Molecular Cardiology Group
Professor Tim Prenzler, Doctor Louise Porter, Kirsty Martin and Alice Hutchings	ARC Centre of Excellence in Policing and Security (CEPS)



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