



QUEENSLAND
COURTS

Office of the State Coroner

Annual report 2013–2014



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19 December 2014

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

Section 77 of the *Coroners Act 2003* requires the State Coroner to provide to the Attorney-General at the end of each financial year a report for the year on the operation of the Act. In accordance with that provision I enclose the report for the period 1 July 2013 to 30 June 2014.

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

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

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

Yours sincerely

Terry Ryan
State Coroner

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State Coroner's Overview

This report gives an overview of the work of the Queensland coronial system during 2013–14.

At the outset, I would like to acknowledge the contribution made by the staff of the Office of the State Coroner (OSC), including administrative and investigation officers, and counsel assisting. Every working day they encounter the loss and grief experienced by families following the sudden and unexpected death of a relative. Without their dedication, the successful work of the Office would not be possible.

I extend in particular my thanks to the Office's departing Director, Ms Brigita Cunnington, for her support and leadership of the Office over the past eight years. Many of the Office's achievements over that time would not have been accomplished without her enthusiasm and vision.

For the first time since its inception, the Office's administrative structures were reviewed during 2013-14. It is hoped that the outcomes of the review will enable the Office to maintain its focus on the efficient and timely investigation of reportable deaths across the State, with resources being directed to areas of most need.

The advantages of the full-time coroner model continue to be demonstrated in the efficient management of the workload of the coronial system. During 2013-14 there were 4,682 deaths reported to coroners – 80 fewer deaths than were reported in the previous year. The number of matters finalised was also slightly lower with 4,909 matters being cleared. However, a clearance rate of nearly 105 per cent was maintained.

Mr John Lock, a very experienced coroner and magistrate, was appointed for a five year term as Deputy State Coroner from 11 December 2013. I acknowledge Ms Christine Clements, the inaugural Deputy State Coroner, whose ten year term expired in December 2014. We are fortunate that we have retained Ms Clements' expertise as the Brisbane Coroner.

Ms Ainslie Kirkegaard was appointed to the position of coronial registrar in July 2013. Ms Kirkegaard continues to manage a high volume of less complex matters routinely reported to coroners, enabling other coroners in the greater Brisbane, Sunshine Coast and South West Queensland reporting catchment to focus on more complex investigations and inquests.

I express my appreciation to my fellow coroners and the coronial registrar for their continued diligence and support.

As detailed in the Report, the Office relies heavily on our partners in Queensland Health and the Queensland Police Service to deliver coronial services. The Office strives to maintain strong partnerships between the participating agencies. We meet regularly to look at ways to strengthen our combined efforts and improve the quality of services, taking into account changes in the operating environment affecting each agency.

The forensic pathologists, coronial nurses, scientists, counsellors and government medical officers from Queensland Health's Forensic and Scientific Services, and their colleagues in regional Queensland, are pivotal to the daily delivery of coronial services.

Coronial counsellors are specialists who work alongside coroners in dealing directly with people facing the sudden and unexpected death of a loved one. They are often the sole point of interface between the bereaved and the system.

Coroners also benefit from the clinical expertise provided by the Clinical Forensic Medicine Unit. Managing a range of demands from other parts of the justice system, the medical officers from that Unit are able to provide speedy advice based on a review of clinical records that informs the coroner's assessment of a reported death, particularly those reported through the Form 1A process in hospital settings.

The high quality of the advice received frequently allows a decision to be made that a death is not reportable, and a death certificate can be issued. The advice can enable the coroner's investigation to be finalised within a few days. This results in significant savings in terms of fewer deaths proceeding to autopsy. Families also benefit in not having the death of a relative subject to a potentially long and invasive coronial investigation.

It is vital that services such as these are resourced at an appropriate level in order to ensure that families continue to be responded to in a dignified way, and death investigations are concluded at the earliest opportunity.

I also extend my thanks to the Queensland Police Service Coronial Support Unit, and members of the QPS who assist coroners in responding to reportable deaths across the State each day. The Coronial Support Unit has reviewed and streamlined police procedures across the State.

A simplified approach to dealing with Forensic Crash Unit investigations has been implemented which will improve this service to coroners and reduce costs for police. Appreciation is also extended to the QPS for allocating a dedicated officer to the Central Region to support the Central Coroner. This replicates arrangements in Cairns which have proved successful in improving turnaround times for police investigations, and in more effectively targeting police investigations with consequent reduction in work for QPS.

Office of the State Coroner

Role and achievements

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

Recent years have seen a significant increase in demand for coronial services state-wide with reported deaths increasing from 3,514 in 2007–08 to 4,682 in 2013–14. This increase is a result of a number of factors including increased awareness of reporting obligations and changes to the types of deaths that are required to be reported to a coroner. A number of significant developments have been initiated or implemented to support and enhance the delivery of coronial services in Queensland during 2013–14

Review of the Office of the State Coroner Administrative Structures

In 2013 the Director, Courts Innovation Program, Magistrates Court Service, conducted a review of the OSC. The review's objectives included the examination of the OSC's staffing structure and method of regional service delivery to ensure the office is best placed to continue to provide high quality coronial services into the future. The review team consulted full time coroners, OSC staff and coronial partners QHealth and QPS.

The report of the review was presented in March 2014 and implementation of its recommendations approved by the then Acting Director-General. The primary recommendation is that the administrative work associated with supporting regional coroners to process daily reported deaths should be reallocated to Brisbane, allowing regional administrative resources to focus on supporting regional coroners in more complex investigation and inquest matters.

On 19 May 2014 the OSC commenced a trial of this structure which continued into the 2014–15 financial year. An evaluation of the trial in the first half of 2014–15 will determine the further implementation of this recommendation.

The report contained a number of other recommendations, three of which were implemented in March 2014; the re-classification of the position of counsel assisting the State Coroner from PO5 to PO6 (with added responsibilities concerning mentoring and professional development of OSC lawyers); the re-classification of the position of counsel assisting the Northern Coroner from PO4 to PO5 to achieve consistency with the other counsel assisting roles; and the appointment of an AO7 Executive Manager (Jason Schubert has been appointed to this role).

The implementation of the remaining recommendations concerning team structures and names, the re-classification of the position of Coordinator (State Investigation Team) from AO4 to AO5, the review of the name of the Office and its Mission Statement will occur 2014-15.

In March 2014, the OSC's long-time and well respected Director, Brigita Cunnington, left the Office to lead a project in another area of the Department and ultimately to take up the position of Director of the Courts Innovation Program. Robert Walker, formerly Commissioner for Body Corporate and Community Management and prior to that, Assistant Director with the Crime and Misconduct Commission, has been appointed Director.

Coroners' investigations

Purpose of coronial investigations

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

Autopsies

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

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

Although family members may not prevent an autopsy being undertaken if a coroner considers it necessary, a coroner who wishes to override a family's concerns must give the family reasons. The coroner's decision can then be judicially reviewed. No such review applications were received in 2013–14 and family concerns have been able to be assuaged with the assistance of coronial counsellors from Queensland Health Forensic and Scientific Service (QHFSS).

Data from 2010–11 to 2013–14 about autopsies is provided in Tables 1 and 2.

During 2013–14, there was again a reduction in the number of autopsies performed overall. This is likely to be due to the increasing use of the Form 1A process to report deaths in a medical setting. It is also attributable to the increased focus on exploring all options for obtaining a cause of death certificate for apparent natural cause deaths and the application of the registrar's triage process.

There was also an increase in the proportion of external autopsies ordered.

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

Type of autopsy ordered	2010–11	2011–12	2012–13	2013–14
External autopsy	16.42%	20%	23.01%	28.97%
Partial internal autopsy	19.83%	23%	29.09%	24.16%
Full internal autopsy	63.75%	57%	47.90%	46.87%
Order on cremated remains	0%	0%	0%	0%

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

Type of autopsy ordered	2010–11	2011–12	2012–13	2013–14
External autopsy	473	544	629	717
Partial internal autopsy	571	639	795	598
Full internal autopsy	1,836	1,559	1,309	1160
Order on Cremated Remains	0	0	0	0
Total	2,880	2,742	2,733	2475

Measuring outcomes

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

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

Clearance rate

There has been a significant growth in demand for coronial services since the enactment of the *Coroners Act* in 2003. From 2004–05 (the first full financial year of reporting under the new legislation) to 2011–12 reported deaths increased by 47 per cent from 3,043 to 4,461. In 2012-13 there was a more modest increase with deaths reported increasing by only 6.75% to 4,762. In 2013–14 there was a slight decrease with deaths reported decreasing by 2% per cent to 4682.

In 2013–14 coroners finalised 4,909 matters achieving a clearance rate of 105 per cent.

The increase in medical matters reported to the coroner since 2007–08 can be tracked by looking at the increase in Form 1As which can be used by medical practitioners to report deaths to coroners. Table 3 shows a state-wide increase of 219 per cent in the use of Form 1As since 2007–08. The bulk of these matters are reported to Brisbane coroners where the state's major tertiary hospitals are located.

Table 3: Form 1As

Financial year	Form 1As State-wide	Form 1As Brisbane
2007–08	314	223
2008–09	423	295
2009–10	732	482
2010–11	880	514
2011–12	1,043	571
2012–13	1,044	699
2013–14	1,003	721

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

autopsy and further investigation. During 2013-14 of the 4,909 deaths finalised, 1,427 were found not to be reportable within the meaning of s. 8(3) of the *Coroners Act*.

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

Backlog indicator

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

As at 30 June 2013, 219 or 12 per cent of pending matters were more than 24 months old. 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 also depends on the completion of autopsy, toxicology and police reports. Coroners also await the outcome of other expert investigations and criminal proceedings.

As at the end of the reporting period, of the 219 matters that were older than 24 months, 52 per cent (113 matters) were waiting for police or other expert investigations or the outcome of criminal proceedings. Excluding these cases, 106 matters i.e. 6 per cent of pending matters are older than 24 months.

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

Managing the provision of coronial autopsy and government undertaking services

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

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

The transportation of bodies for autopsy is necessitated by the *Coroners Act* which requires an autopsy to be performed where a reportable death is investigated by the coroner. There is an exception for cases where the coroner decides to stop investigating because, although the death is reportable, the cause of death is known and no further investigation is required. This often occurs for hospital related deaths that have been reported directly by medical practitioners using the Form 1A process.

In these cases, because no autopsy is required the family can collect the body from the hospital mortuary. The State Coroner encourages the use of the Form 1A process where appropriate.

Autopsies may be performed by forensic pathologists, pathologists or government medical officers (GMOs) who are credentialed to perform autopsies. At the end of 2013–14 autopsies were performed in seven centres across the State: Cairns, Townsville, Rockhampton, Nambour, Brisbane, Toowoomba and the Gold Coast. As a rule, external autopsies can be performed by GMOs but pathologists perform internal autopsies. However, in practice all autopsies in Queensland are performed by qualified pathologists or forensic pathologists. Under the State Coroner’s Guidelines, the more complex autopsies (e.g. multiple deaths, suspicious deaths, child deaths, deaths during childbirth and deaths in custody) are required to be conducted by a forensic pathologist. Forensic pathologists are only located in Brisbane, the Gold Coast, Nambour, Rockhampton, Townsville and Cairns. Additional specialist pathologists who can perform other less complex internal autopsies are located in Cairns, Toowoomba and on the Gold Coast. An ongoing challenge for the coronial system is the availability of pathologists to perform autopsies in regional areas.

Coronial Registrar

As reported in 2012–13, the success of the coronial registrar pilot culminated in this role being established on a permanent basis, with Ms Ainslie Kirkegaard appointed as the inaugural Coronial Registrar from 27 July 2013. Prior to undertaking this role, Ms Kirkegaard had previously held the positions of Counsel Assisting the Deputy State Coroner and Director of the OSC. Ms Kirkegaard joined the OSC in 2008, bringing over 15 years experience in policy and legislation development in the health, education and justice portfolios, with specialist expertise in coronial and health regulatory law and policy.

The coronial registrar pilot was examined in a journal article, co-authored by the registrar and published in the *Journal of Law and Medicine* Volume 21/3 March 2014¹.

The registrar holds appointment under the *Coroners Act 2003* and operates under a delegation from the State Coroner which enables the registrar to investigate apparent natural causes deaths reported to police, and to authorise the issue of cause of death certificates for reportable deaths under s. 12(2)(b) of the Act and to determine whether a death referred to the coroner under s. 26(5) of the Act is reportable. In practice, this involves directing the investigation of deaths reported to police because a death certificate has not been issued; reviewing deaths reported directly by medical practitioners (using the ‘Form 1A’ process) or funeral directors; and providing telephone advice to clinicians during business hours about whether or not a death is reportable. These deaths represent the high volume, less complex range of matters routinely reported to coroners.

The registrar presents regularly at hospital and other clinical education forums including hospital Grand Rounds and professional development seminars. These

¹ *Intake rigour: Ensuring only “reportable deaths” become coroners’ cases* – Michael Barnes, Ainslie Kirkegaard and Belinda Carpenter; *Journal of Law and Medicine*, Volume 21/3 March 2014

opportunities assist not only in improving clinician education but also in developing and maintaining productive working relationships with key clinical stakeholders in the registrar's reporting catchment.

The registrar also provides assistance to the State Coroner in developing and maintaining guidelines issued under s.14 of the Act.

During the reporting period, the registrar operated within the greater Brisbane, Sunshine Coast and South West Queensland reporting catchment.

The registrar dealt with 1463 of the total 4682 deaths reported in Queensland in 2013–14 (31.25 per cent) and finalised 1537 matters within the reporting period. This represents 52 per cent of the total 2795 deaths reported within the registrar's current reporting catchment.

The registrar role continues to contribute significantly to increased efficiency of the coronial system by improving the time taken to finalise apparent natural causes death investigation and reducing the number of pending cases. A comparison of the number of coronial cases pending in 2012-2013 and 2013-2014 shows:

- reduction in the total number of pending cases (1844 down from 2069)
- reduction in the number of cases pending for 12 months or less (1329 down from 1520)
- no increase in the number of cases pending for more than 24 months.

Apparent natural causes deaths

Apparent natural causes deaths for which no cause of death certificate has issued are consistently the largest category of reportable death reported to Queensland coroners each year. These are deaths where a treating doctor cannot be located, is unavailable or unwilling to issue a cause of death certificate. Experience has shown that a significant proportion of these deaths are being reported to coroners unnecessarily because treating doctors do not properly understand their obligation to issue death certificates. Unnecessary reporting has significant implications for not only the coronial system, but more importantly for bereaved families who cannot understand why the coroner needs to be involved.

During 2013–14, 693 police reports of apparent natural causes deaths were received within the registrar's reporting catchment. This category of reported death accounted for almost 36 per cent of the registrar's workload. Proactive triaging of these deaths, with input from forensic pathologists, coronial nurses, forensic medicine officers and coronial counsellors, resulted in 287 (41.4 per cent) of these deaths being appropriately diverted from the coronial system with the issue of a cause of death certificate. When compared with the apparent natural causes death data from 2012–13, analysis of the 2013–14 data shows some interesting trends:

- a reduction in the number of apparent natural causes deaths reported to police (693 down from 744) despite the total number of deaths reported to police remaining steady
- an increase in the number of certificates issued as a result of the triage process (287 up from 256).

The reduction may well be attributed to a combination of a slight decline in the general Queensland death rate (the Registry of Births Deaths and Marriages advises there was a small drop in the number of death registrations between 2012-2013, 28959 deaths, and 2013-2014, 28494 deaths) and both proactive and reactive efforts by OSC to improve clinicians' understanding about their death certification and coronial reporting obligations.

In September 2013, the registrar released a fact sheet for medical practitioners which addresses common concerns about a doctor's ability to issue a cause of death certificate and explains when it is not appropriate for a death certificate to be issued. It also directs medical practitioners to clinical and coronial resources to help them decide whether they can or should issue a death certificate. The fact sheet *Issuing cause of death certificates for apparent natural causes deaths – a guide for Queensland medical practitioners* is accessible on the OSC website at www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications. Police, coronial nurses and OSC have been proactive in distributing the fact sheet to doctors who are approached to issue a cause of death certificate for an apparent natural causes death as this contact with the coronial system, particularly for general practitioners, is a valuable education opportunity.

The ongoing success of the apparent natural causes death triage process arguably demonstrates a multidisciplinary coronial system functioning at its cohesive best. This would not be possible without the professionalism and enthusiasm of the forensic pathologists, coronial nurses, forensic medicine officers and coronial counsellors who assist the registrar's investigation of these deaths.

Deaths reported by Form 1A or funeral directors

The registrar also receives and reviews deaths reported directly by a medical practitioner via Form 1A within the registrar's reporting catchment. This process is used in circumstances where the doctor is either seeking advice about whether a death is reportable or seeking authority to issue a death certificate for a reportable death because the cause of death is known and no coronial investigation appears necessary. It is used to report potentially health care related deaths, mechanical fall related deaths and apparent natural causes deaths in care.

Not surprisingly given the location of the State's major tertiary hospitals, the bulk of the deaths reported by Form 1A occur within the registrar's reporting catchment:

Coronial reporting catchment	Deaths reported via Form 1A
Brisbane	721
Northern Coroner	74
Central Coroner	75
Southeastern Coroner	133
	1003

The 721 Form 1A reports were received in the registrar's reporting catchment during 2013-2014 comprised:

- 303 potentially health care related deaths
- 367 mechanical fall-related deaths
- 32 apparent natural causes deaths in care

- 10 apparent natural causes deaths

Compared with the previous reporting period, this represents a small decrease in deaths reported by the Form 1A mechanism (1044 down to 1003). This may be attributable to ongoing efforts to improve clinicians' understanding of coronial reporting obligations and encouragement to seek advice about how to report these types of deaths rather than reporting them straight to police.

Form 1A reviews represent another triage process which involves collating and reviewing all relevant medical records with the assistance of a forensic medicine officer and liaising with family members with the assistance of a coronial counsellor, where required. If satisfied there is no need for further coronial involvement, the death certificate will be authorised and the coronial process ends. In most cases, the Form 1A investigation can be completed within 24-48 hours of the death being reported. During 2013–14, the Form 1A process diverted all but 16 deaths reported via Form 1A in the registrar's reporting catchment from full coronial investigation.

A similar approach is applied to the review of deaths reported by funeral directors. Most of the deaths reported directly by funeral directors are identified by independent doctors engaged by the funeral industry to issue cremation permissions under the *Cremations Act 2003*. These doctors are required to consider not only whether there is a cremation risk but also whether the death is reportable under the *Coroners Act 2003* and if so whether the death has been reported to the coroner. During 2013–14, 40 funeral director referrals were received in the registrar's reporting catchment, the bulk of them being potentially mechanical fall-related deaths or potentially health care related deaths. Doctors who certified deaths that should have been reported before the certificate was issued are now routinely sent a letter reminding them of their death certification and coronial reporting obligations.

Review of reporting and investigation of fall-related deaths

In 2013–14, the registrar examined the reporting and coronial investigation of fall-related deaths. These deaths are reportable under s. 8(3)(b) of the Act as a subcategory of violent or otherwise unnatural death.

The registrar's review demonstrated:

- the vast majority of fall-related deaths reported to coroners are the consequence of age or infirmity related mechanical falls (as opposed to accidental falls from height or where environmental factors caused the person to fall). Most of these occur in the elderly deceased person's home or aged care facility. A small number are hospital in-patient falls
- mechanical fall-related deaths have come to represent nearly one-third of all violent or otherwise unnatural deaths reported to coroners (with the next most reported subcategories including suicides and transport related deaths)
- the vast majority of mechanical fall-related deaths are reported directly by hospitals, nursing home, general practitioners and funeral directors
- coroners receive more reports of mechanical related deaths reported than health care related deaths
- only a small number of mechanical fall-related deaths proceed to full coronial investigation, with the vast majority raising no falls risk prevention issues or concerns.

With an ageing population and considerable work having been done over the past decade in both the health and aged care sectors around falls risk prevention, and with increasing pressures on finite coronial resources, it is perhaps timely for the value of coronial scrutiny of mechanical fall related deaths to be re-examined. This policy issue is currently under consideration by the Department of Justice and Attorney-General.

Future directions

Despite ongoing efforts to improve clinician education about death certification and coronial reporting obligations, there is still scope for reducing the number of apparent natural causes deaths reported to coroners. The registrar is well placed to work with Queensland Police Service Coronial Support Unit to examine ways to reduce unnecessary conveyances to coronial mortuaries pending the outcome of first response officers' enquiries with treating doctors.

The registrar is currently working with the Queensland Police Service Coronial Support Unit and Queensland Health Forensic Scientific Services to examine ways to improve police attendance at hospitals, particularly for infant and child deaths, and to streamline the way in which deaths initially reported by Form 1A but warranting further coronial scrutiny are transitioned to the full coronial investigation process.

The registrar role has been identified as an important element in improving the efficiency of Queensland's coronial system. In this regard it is noted that the Operational Review of the Office of the State Coroner identified value in future consideration of a second registrar to service the regional reporting catchments and potential expansion of the registrar role to other less complex reportable death investigations such as simple transport-related deaths.

Coroners and their support staff – roles and responsibilities

At the end of June 2014 there were seven full time coroners: the State Coroner, Deputy State Coroner, two Brisbane Coroners, Northern Coroner, Southeastern Coroner and Central Coroner.

State Coroner

The State Coroner, Mr Terry Ryan, was appointed on 5 July 2013 for a period of five years. The State Coroner is responsible for coordinating and overseeing the coronial system to ensure it is administered efficiently, and that investigations into reportable deaths are conducted appropriately.

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

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

During 2013–14, 38 matters were reported to the State Coroner. The State Coroner conducted 11 inquests and finalised 13 investigations without proceeding to inquest. The former State Coroner, Mr Michael Barnes finalised findings in three inquests.

Deputy State Coroner

Similarly, Deputy State Coroner Christine Clements, diligently fulfilled the full 10 year term on 10 December 2013 before stepping aside and taking on the role of Brisbane Coroner. On 11 December 2013, Deputy State Coroner John Lock was appointed to take up the role. The Deputy State Coroner conducted 10 inquests.

Brisbane based coroners

The Deputy State Coroner, Mr John Lock, and two Brisbane Coroners, Ms Christine Clements and Mr John Hutton, are based in Brisbane. Prior to 1 October 2012, the Brisbane based coroners were responsible for investigating deaths in the Greater Brisbane area including Caboolture, and Redcliffe. From 1 October 2012 with the state-wide extension of the full time coroner model the reporting catchment increased to include the Sunshine Coast region north to Gympie and South West Queensland. Coroner Clements conducted three inquests. Coroner Hutton conducted four inquests.

In 2013–14, 2,795 matters were reported to the Brisbane based coroners and the registrar. 2,908 investigations were finalised, including 31 following an inquest.

Northern Coroner

Deaths in the area from Thursday Island to Proserpine, north to the Papua New Guinea border and west to the Mt Isa district are reported to the Northern Coroner, Ms Jane Bentley, who is based in Cairns. In 2013–14, 653 deaths were reported in the region and 773 matters were finalised, including seven following an inquest. The former Northern Coroner, Mr Kevin Priestly finalised five inquests. Also Cairns Coroner Alan Comans finalised one inquest.

Southeastern Coroner

The Southeastern Coroner, Mr James McDougall, investigates deaths in the area covering Rochedale South to the border of New South Wales, Beenleigh and Logan. In 2013–14, 678 deaths were reported in the region and 651 matters were finalised.

Central Coroner

The Central Coroner, Mr David O’Connell, investigates deaths reported in the Central Queensland region which covers an area from Proserpine to Gayndah. In 2013–14, 556 deaths were reported in the region and 571 matters were finalised including two following an inquest.

Support staff

At the end of June 2014, the OSC comprised 42 staff members with 30 based in Brisbane, four in the Northern Coroner’s office in Cairns, four in the Southeastern Coroner’s office in Southport and four in the Central Coroner’s office in Mackay.

In-house counsel assisting at inquests

Each of the full time coroners is assisted by a legal officer. These legal officers are increasingly performing the role of counsel assisting and during 2013–14 assisted in

35 inquests. Having in house counsel assisting is beneficial as coroners are supported by lawyers with specialised skills and experience in the jurisdiction and inquest costs are kept to a minimum.

Domestic and Family Violence Death Review Unit

Situated within the Office of the State Coroner, the Domestic and Family Violence Death Review Unit (DFVDRU) provides assistance to coroners in their investigations of homicides, murder suicides and suicides identified as being related to domestic and family violence. For a significant proportion of these types of deaths there have been key predictors of a heightened risk of harm as well as missed opportunities for intervention prior to the death. There are also often similar themes, issues and identifiable risk factors that recur in many of these deaths, which is why there is a benefit to a systematic review process.

The unit provides assistance to coroners in their investigation of domestic and family violence related deaths, by ensuring that information about the broader context within which the death occurred is gathered and examined. The unit also assists with the identification of any systemic shortcomings and in the formulation of preventative recommendations for those matters that proceed to inquest. The implementation of this unit aligns Queensland with other jurisdictions that have dedicated positions focused specifically on preventing future deaths and meets relevant priority areas under the *National Plan to Reduce Violence against Women and their Children 2010-2022*.

The DFVDRU is a multidisciplinary review team, consisting of a Principal Researcher and Coordinator role, and the recent addition of a Senior Advisor position that has responsibility for providing specialist advice and assistance to coroners in relation to child protection systems, policies and practices. This role was developed as part of the whole of government response to recommendations made by the Child Protection Commission of Inquiry, which resulted in new child death review processes being implemented from 1 July 2014.

Cases are referred to the DFVDRU for review based on an assessment of whether the death occurred within a relevant relationship as defined by the *Domestic and Family Violence Protection Act 2012*; which covers intimate partner, family and informal care relationships. The DFVDRU uses the national definition of domestic and family violence homicide developed and endorsed by the Australian Domestic and Family Violence Death Review Network.

The DFVDRU maintains a dataset of homicides identified as related to domestic and family violence to assist in the monitoring and identification of any patterns or trends in these types of deaths. In Queensland approximately 45% (n=180) of all homicides between 1 January 2006 and 31 December 2013² occurred within an intimate partner or family relationship. Factoring in multiple homicides, a total of 167 offenders were responsible for these deaths. Of these, 82.03% (n=137) were male, 15.57% were female (n=26) and 2.4% (n=4) of the incidents involved both a female and male offender.

² As this data includes both open and closed coronial matters it may be subject to change, pending the outcomes of any further investigations

Intimate Partner Homicides

During that 8 year time period, 56.67% (n=102) deaths occurred within an intimate partner relationship. This includes people who were married, in a de-facto relationship, people who had a child together or who resided together as a couple. This category also covers persons engaged to be married as well as couples that were separated or divorced.

Of the total number of domestic and family violence related deaths, women were more likely to be killed in an intimate partner relationship whereas men had a higher propensity to be killed within a family relationship. Of the total number of deceased killed within an intimate partner relationship, 79.41% (n=81) were female and 20.59% (n=21) were male. Three deceased males were killed by their male intimate partner whereas all female deceased were killed by a current or former male partner.

Homicides within a Family Relationship

Within the DFVDRU, the definition of family relationships covers those that exist between persons who are related either biologically or through marriage including parents, children, siblings, cousins, aunts, uncles or nephews. During this time period 38.89% (n=70) of deaths occurred within a family relationship. Of the total number of deceased persons killed within this type of relationship 42.86% (n=30) were female and 57.14% (n=40) were male.

Bystander Homicides and Murder Suicides

The unit also conducts reviews on ‘bystander homicides’ where the death has occurred within a domestic violence context, however there is no direct intimate partner or familial relationship between the deceased and the offender. This may include for example a separated spouse’s new partner. There were eight such deaths during this time period (representing 4.44% of total deaths), all of which occurred within the context of intimate partner violence.

Of the total 180 deaths 13.33% (n=24) were murder suicide victims. This includes cases in which the offender has attempted suicide within short proximity of the homicide but has survived the attempt; predominantly as a result of medical intervention.

Case Characteristics

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

In addition to demographic statistics, the unit also collates data on a broad range of other information on these types of deaths including situational and relationship characteristics. As this information is more nuanced, a significant proportion of it only

becomes apparent once the investigation into a death has substantially progressed. Consequently the following information is reported for the time period 1 January 2006 through to 31 December 2012.

Consistent with international findings there are a number of key characteristics or risk factors found to be present in the relationship between the deceased and the offender prior to the death. This includes such factors as a prior history of domestic and family violence, controlling behaviour displayed by the offender, jealous or obsessive behaviour displayed by the offender and actual or impending separation. Consistency in these case characteristics was substantially more prevalent in intimate partner homicides than those that occurred within a family relationship, the latter being far more heterogeneous in nature.

Previous History of Domestic and Family Violence

Of the 89 intimate partner homicides in this time period, there was evidence of domestic and family violence between the deceased and the offender in 67.41% (n=60) of the cases. Although no female deceased (n=72) had a history of being a perpetrator of domestic violence, of the 17 male deceased killed within the context of intimate partner violence, 52.94% (n=9) had a prior history of being a perpetrator of domestic violence. Of the 64 homicides that occurred within a family relationship there was evidence of domestic and family violence in 46.87% (n=30) of the cases.

In 42.70% (n=38) of the intimate partner homicides, there was a prior police history of domestic violence between the deceased and offender. In the overwhelming majority of these cases 89.47% (n=34), this history was in relation to physical violence. In contrast, of the 64 homicides that occurred within a family relationship between 2006 and 2012, only 28.13 % (n=18) of the cases had a history of domestic violence reported to police between the deceased and offender. Similar to the intimate partner homicides however, 83.33% (n=15) these police reports were related primarily to physical violence.

For 26.97% (n= 24) of the intimate partner homicides there was a protection order between the offender and the deceased at the time of the death. In only 10.94% (n=7) of the homicides within a family relationship a protection order was in place between the deceased and the offender.

Escalation of Domestic and Family Violence

In 40% (n=24) of the 60 intimate partner homicides where a previous history of domestic and family violence was evident, there was a notable escalation in either the prevalence or incidence of domestic and family violence between the deceased and offender within the twelve months preceding the homicide. For the 30 homicides within a family relationship where there was a known history of domestic and family violence between the deceased and offender there was a notable escalation of domestic and family violence in only 16.67% (n=5) of the cases.

Previous Criminal Justice System History (Offender)

In 57.30% (n=51) of the intimate partner homicides, the offender had a previous criminal justice system history. In 48.44% (n=31) of the homicides within a family relationship the offender had a previous criminal justice system history. This history was in relation to a range of violent and nonviolent offences.

Actual or Intended Separation

Periods of relationship separation within an intimate partner relationship, including when a victim has expressed the intent to leave the relationship, may increase the risk of harm for victims of domestic violence. Of the 71 female deceased who were killed by a male intimate partner, 43.05% (n=31) of the deaths occurred during a period of actual or intended separation. In contrast only 3 males (n=17.65%) were killed during a period of relationship separation.

Controlling Behaviour displayed by Offender

Where a female deceased was killed by her male intimate partner there was evidence of controlling behaviour displayed by the offender in 36.11% (n=26) of cases. Broadly speaking this included behaviour intended by the offender to exert power over the deceased, for example restricting access to finances or employment opportunities or attempting to isolate them from their social support systems. When a male deceased was killed by their intimate partner, there was no evidence of controlling behaviour exhibited by any of the offenders.

Of the 64 homicides within a family relationship there was evidence of controlling behaviour displayed by the offender towards the deceased in only one case.

Jealous or Obsessive Behaviour displayed by Offender

For 30.56% (n= 22) of the cases in which a female was killed by her male intimate partner, there was evidence of jealous and obsessive behaviour displayed by the offender towards the deceased. This category covers a range of behaviours in which the actions of the offender demonstrated an intense preoccupation with the deceased, or they continuously suspected or accused the deceased of infidelity.

In contrast, of the 17 deceased males there was evidence of jealous or obsessive behaviour displayed by the offender towards the deceased in only one death.

As would be expected there was no evidence of any jealous or obsessive behaviour displayed by an offender towards a deceased in any of the homicides that occurred within a family relationship.

Monitoring responses to coronial recommendations

When a matter proceeds to inquest, a coroner may make recommendations aimed at preventing similar deaths in the future. This is one of the most important objectives of a modern coronial system. Many of the recommendations made by coroners during 2013–14 are highlighted in the Inquests section in this report.

In 2006, the Ombudsman reported that the capacity of the coronial system to prevent deaths would be improved if public sector agencies were required to report on responses to coronial recommendations. In 2008, the Queensland Government introduced an administrative process for monitoring responses to recommendations involving government agencies reporting to the Attorney-General about implementation of recommendations and compilation of an annual report.

The first report considering recommendations made during the 2008 calendar year was released in August 2009. The most recent report in relation to 2012 recommendations was published in March 2014.

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

Communication and stakeholder relations

During 2013–14, the OSC continued to engage successfully with its major partners: the QPS whose officers investigate on behalf of the coroners and QHFSS, which provides forensic, pathology, mortuary and counselling services for coroners. Each of these agencies is represented on the Interdepartmental Working Group (IWG), chaired by the State Coroner, which meets to review and discuss state-wide policy and operational issues. The IWG also includes other Queensland Health representatives from CFMU, the Patient Safety Unit, and the Mental Health Alcohol and Other Drugs Branch (MHAODB).

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

Coronial investigators – a multi-agency approach

The CSU coordinates the management of coronial processes on a state-wide basis within the QPS. Four police officers located within the OSC in Brisbane provide direct support to the Brisbane based coroners as well as assisting regional coroners as required. A permanent Detective Senior Sergeant position was established in Cairns in 2012 to assist the Northern Coroner. Officers located at the QHFSS facility at Coopers Plains attend autopsies and assist in the identification of deceased persons and preparation of documents for autopsy. The OSC also supported a submission by the QPS CSU to have a dedicated police officer located in the Mackay Courthouse to support the Central Coroner. The submission was successful and the officer commenced on 18 November 2013.

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

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

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

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

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

Queensland Suicide Advisory Group

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

State Coroner's Guidelines

One of the State Coroner's functions is to issue guidelines about the investigation of deaths and other matters under the *Coroners Act*. Guidelines are issued under s.14 with the objective of ensuring best practice in the coronial system. The State Coroner must consult with the Chief Magistrate before issuing any directions or guidelines.

At the time the 2013 guidelines were published, Parliament was considering amendments to the *Coroners Act* to enable coroners to release investigation documents in the public interest and to publish non-inquest findings. The proposed amendments also clarified arrangements for access to inquest exhibits. The amendments were passed and commenced operation in August 2013, and the State Coroner subsequently issued revisions to Chapters 2 (The Rights and Interests of Families), 8 (Findings) and 10 (Access to coronial information) to reflect those amendments.

The State Coroner's Guidelines can be accessed at:

<http://www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications>.

Research

Genuine researchers

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

Generally, researchers may only access coronial documents once the investigation is finalised. However, the State Coroner may give access to documents on open files if the State Coroner considers it appropriate having regard to the importance of the research and the public interest in allowing access before the investigation has finished.

The *Coroners Act* requires the names of persons given access to documents as genuine researchers to be noted in the annual report. The following genuine researchers were approved under s. 53 of the *Coroners Act* during the reporting period:

- Associate Professor Ben Mullins & Mr Jason Selman - Curtin University
- Megan Seeley, Prof Peter Ellis, Dr Nathan Milne & A/Prof Alex Forrest – Queensland Health Forensic and Scientific Services
- Nicholas Nuttall, Tracey Woolford – Qld Bone Bank
- Dr Gerald Lawson – Independent researcher

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

Inquests

This section contains a summary of coronial investigations into all deaths in custody, as required by s. 77(2)(b) of the Act, and other inquests of note conducted during the reporting period. The complete inquest findings are posted on the Queensland Courts website at: <http://www.courts.qld.gov.au/courts/coroners-court/findings>

Deaths in custody

During the reporting period, the State Coroner conducted one inquest into deaths that occurred in the context of an attempted intercept by police:

Ronald Anthony Ellison and Jacqueline Sylvester

Ronald Ellison, 46 and his long term partner Jacqueline Sylvester, 40, were killed when they were struck by a vehicle while walking adjacent to Chambers Flat Road at Park Ridge on 4 December 2009. That vehicle was driven by Brett Glenbar and he was later sentenced to 10 years imprisonment for the manslaughter of Mr Ellison and Ms Sylvester. The inquest was delayed while the criminal proceedings, including an appeal against sentence, were finalised.

An inquest conducted by the State Coroner heard that Mr Glenbar left a social function on Logan Reserve Road, Park Ridge at around 7pm. He set off in a Holden Statesman hire vehicle towards the house of his front seat passenger and friend, Phillip Chang. Mr Glenbar's blood alcohol limit was in excess of the legal limit and he was speeding as he drove along Chambers Flat Road. Police officers in a marked vehicle travelling in the opposite direction detected the Statesman travelling at 134km/h and signalled to the other driver by activating their vehicle's emergency lighting. The Statesman did not stop and the police officers performed a u-turn before setting off in an attempt to intercept the Statesman. Mr Glenbar accelerated from his already high speed and when he came to a right hand curve in the road was unable to maintain full control. The Statesman entered a 'yaw' with the rear of the vehicle travelling off the road surface to the left hand side. It struck Mr Ellison and Ms Sylvester. Both were killed instantly.

The State Coroner found that the officers in the police vehicle were not in a position to see the collision with the two deceased. The inquest heard that the attempted intercept continued with the Statesman striking another vehicle and then continuing for a further 1.2km before Mr Glenbar lost control for a final time. The State Coroner considered the adequacy of the investigation by officers from the QPS Ethical Standards Command and found it to be thorough and appropriately conducted. He found that the actions of police were reasonable, and complied with QPS policy, to the extent that the attempted intercept of the Statesman was justified and events had not evolved into a pursuit at any time (and certainly not at the relatively early stage that the two deceased were struck). It was clear that this was not a case where a pursuit could have been justified under QPS safe driving policy.

The State Coroner did find that the speed of the police vehicle, determined to be 186km/h (+/- 7 km/h) from CCTV footage, was so fast as to have been unreasonable and did not comply with the QPS safe driving policy despite the good road conditions and the experience of the police officer driving. As that issue had already been appropriately addressed by the QPS disciplinary system no referral pursuant to section 48 was made.

The State Coroner and Deputy State Coroner conducted two inquests during the reporting period into deaths that occurred in the course of a person being detained and/or restrained by police or custodial officers:

Scott Matthew Taylor

Scott Matthew Taylor was a 37 year old man who stabbed himself repeatedly in the chest with a knife shortly after five police officers attended his home to speak to him about a rape allegation on 14 January 2012. Police deployed a Taser twice in an effort to stop him from inflicting further self-harm. He then collapsed. Police handcuffed him and administered first aid pending the paramedics' arrival. Mr Taylor was transported to hospital but despite continued resuscitation efforts, he was unable to be revived.

A full internal autopsy and external examination performed by an experienced forensic pathologist revealed the cause of death to be stab wounds to the chest, some of which caused significant internal organ injury and haemorrhage. Toxicological analysis detected alcohol (0.111%) but no other drugs.

Mr Taylor's death was investigated by the QPS Ethical Standards Command (ESC) as a death in custody. Pending arrival of ESC investigators, local police secured the scene and the involved officers were issued with a direction not to discuss the matter. The ESC investigation involved forensic examination of the scene, interviews with witnesses and video re-enactments with the attending police officers. The Taser was seized and downloaded. Audio exhibits and photographs were also obtained. Enquiries were made about whether Mr Taylor had a mental health history. The State Coroner was satisfied the investigation was comprehensive and independent.

The State Coroner found that:

- Mr Taylor died as the result of self-inflicted stabs wounds
- application of the Taser did not contribute to the death and was necessary in order to stop Mr Taylor from committing further acts of self-harm
- the decision by police to enter Mr Taylor's home in order to stop him from avoiding arrest once he was seen to run towards the back of the residence was lawful.

The State Coroner did not make any comments or recommendations.

Elliott John Coulson

Elliot John Coulson was a 32 year old man who died from injuries sustained in a fall from the balcony of his hotel room on the 26th floor of the Marriott Hotel, Surfers Paradise on 24 April 2013. The fall occurred shortly after members of the Queensland and New South Wales police services entered the room to execute a search warrant in connection with the investigation into the suspicious death of Mr Coulson's former girlfriend in New South Wales.

Mr Coulson's death was investigated by the QPS Ethical Standards Command as a death in custody. The ESC investigation involved separating the involved officers and obtaining breath and urine samples for testing. The officers were interviewed and participated in a re-enactment. The officers' digital voice recorders were examined. The Deputy State Coroner was satisfied the investigation was performed thoroughly, competently and promptly and in compliance with the QPS Operational Procedures Manual requirements.

An external examination and toxicology was performed by an experienced forensic pathologist. Toxicological analysis detected a high level of alcohol but no other drugs.

The Deputy State Coroner found that:

- the Queensland and New South Wales police investigation, surveillance, obtaining and execution of the search warrant was undertaken and performed lawfully
- Mr Coulson deliberately climbed over the balcony perimeter fence and then let go of the rail in order to avoid being placed in police custody. He was significantly affected by alcohol at this time and aware he was facing criminal charges in relation to his former girlfriend's death.

The Deputy State Coroner did not make any comments or preventative recommendations.

During the reporting period, the State Coroner conducted one inquest into the death of a person in a siege situation

Peter Alan Sutcliffe

Peter Alan Sutcliffe was a 39 year old man who took his own life during police negotiations at his home in Edmonton, south of Cairns, on the evening of 25 January 2011. His former partner had contacted police with concerns for her safety due to his behaviour. When police arrived, he took position in a large semi-enclosed backyard shed and threatened to kill police if they approached. This prompted the deployment of specialist negotiators and police from the QPS Special Emergency Response Team (SERT). After about half an hour of attempted negotiations failed to elicit a response from Mr Sutcliffe, police discovered him hanging from an internal beam. He was unable to be revived.

Mr Sutcliffe's death was investigated by the QPS Ethical Standards Command (ESC). The ESC investigation involved interviewing each of the attending SERT officers (from who urine samples were taken for testing) and senior police who had been involved in the overall management of the police approach to Mr Sutcliffe. Walk-through re-enactments were conducted and documents relating to the management of the siege situation were seized. The scene was preserved and forensically examined and video and audio footage taken by the attending officers was reviewed, as were ambulance radio communications and 000 call recordings. Witness statements were taken from a wide range of civilian witnesses about Mr Sutcliffe's movements that day and possible motivations for his behaviour. The investigation also obtained records relating to another siege situation involving Mr Sutcliffe and SERT at the same address in December 2008. The State Coroner was satisfied the investigation was conducted thoroughly, impartially and professionally.

An external examination and toxicology were performed by an experienced forensic pathologist, which confirmed the cause of death as consistent with hanging. Toxicological analysis detected alcohol but no other drugs.

The State Coroner found that:

- the deployment of SERT to the situation involving Mr Sutcliffe was an appropriate and proportionate response to his behaviour that day
- all police officers involved in the situation up until the SERT deployment acted professionally and did their best to resolve a volatile situation peacefully
- senior police directing the SERT officers acted reasonably when they decided to wait 30 minutes for negotiators to attempt contact with Mr Sutcliffe before either using noise distraction techniques, shining light into the shed or moving an operative into a closer position, as these measures involved risks to the safety of police officers and/or Mr Sutcliffe that could not be justified at such an early stage in the SERT deployment
- the overall command and tactical approach of the QPS officers in charge of the siege situation was reasonable and appropriate in the circumstances.

The inquest considered evidence relating to the night vision equipment available to SERT officers as the lack of depth perception in the night vision scope available to a particular operative may have contributed to his failure to see that Mr Sutcliffe was hanging, rather than standing, during the final 30 minutes of the stand off. The State

Coroner noted that more modern equipment has since been supplied to SERT teams though not all SERT operatives have access to it. The State Coroner was satisfied the night vision equipment supplied to SERT was not inappropriately outdated and, in the absence of any evidence showing a specific piece of equipment would have changed the outcome for Mr Sutcliffe, the State Coroner declined to make any recommendation on this or any other issue.

During the reporting period, the State Coroner conducted one inquest into prisoner deaths in police watchhouses:

Nathan David McGrath

Nathan David McGrath was a 35 year old man who died at the Cairns Base Hospital in the early hours of 25 June 2012. He had overdosed on methylamphetamine while being detained in a cell at the Cairns Watchhouse (CWH). On the afternoon before his death, Mr McGrath had been arrested on two outstanding warrants, one of which was for interstate drug trafficking. Pat down and property searches were conducted. A significant quantity of cash and a small amount of amphetamine were located.

In the hours before his death, Mr McGrath was seen to be behaving erratically in his cell. CWH staff attended and the Queensland Ambulance Service (QAS) was also called to attend. It was decided that Mr McGrath would require sedation before treatment could commence. Mr McGrath stopped breathing while preparatory measures relating to the sedation were occurring. Resuscitation measures commenced and Mr McGrath was transferred to the Cairns Base Hospital where he was pronounced deceased.

Upon being notified of Mr McGrath's death, the QPS Ethical Standards Command (ESC) promptly attended and an investigation ensued. The investigation was informed by statements from CWH police officers, QAS and hospital staff, interviews with fellow inmates at CWH and associates and family of Mr McGrath. An autopsy was conducted which confirmed the cause of death to be methylamphetamine toxicity. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

The inquest examined the issue of unclothed searches of prisoners and the training of CWH staff relating to the QPS guidelines for searching prisoners. Factors which might have warranted an unclothed search in this case were Mr McGrath's history for drugs, the outstanding warrant for drug trafficking, and the drugs which had been located in his wallet. Despite these factors, the State Coroner acknowledged that the relevant watchhouse officers were not obliged to order an unclothed search in Mr McGrath's case. The policy surrounding unclothed searches is subjective. Mr McGrath had not presented to be under the influence of drugs or alcohol, and he was cooperative with CWH staff throughout the process of the arrest and search.

The State Coroner was satisfied that, had Mr McGrath been subjected to an unclothed search, it was possible that the quantity of methylamphetamine would have been found and the death may have been prevented. The State Coroner commented that CWH search procedures should be amended to place greater emphasis on the QPS policy factors supporting unclothed searches. However, overall there was a lack of

evidence to substantiate the State Coroner making any recommendation to change the current QPS policy relating to unclothed searches.

The State Coroner was satisfied that, at the time the QAS was contacted, Mr McGrath's death could not have reasonably been prevented. The medical response by CWH and QAS was adequate and appropriate.

The remaining seven deaths in custody inquests examined the adequacy of the medical and emergency treatment provided to prisoners in a custodial setting:

Robert John Quartermain

Robert John Quartermain was a 67 year old prisoner from the Capricornia Correctional Centre (CCC) who died at the Rockhampton Base Hospital on 7 June 2011 after developing acute breathing difficulties and suffering a cardiac arrest.

Mr Quartermain's death was investigated by the QPS Corrective Services Investigation Unit (CSIU). The CSIU investigation involved examining and photographing the body in situ, seizing the hospital records, obtaining statements from corrections staff and prisoners who had been in contact with Mr Quartermain in the lead up to his medical emergency, obtaining statements and records of the paramedic attendance and statements from the treating hospital doctors. The Office of the State Coroner arranged for an independent doctor from the Queensland Health Clinical Forensic Medicine Unit to review the prison and hospital medical records and provide an opinion about the adequacy of the health care provided to Mr Quartermain. The State Coroner was satisfied the investigation was thoroughly and professionally conducted.

An external examination and partial internal autopsy performed by an experienced forensic pathologist revealed acute myocardial infarction as the cause of death.

The State Coroner found that:

- Mr Quartermain died from natural causes
- the medical care provided by the prison and the hospital was reasonable and appropriate – there was no record of Mr Quartermain having sought medical attention for symptoms of chest pain prior to his collapse
- the response by correctional and nursing staff to Mr Quartermain's acute breathing difficulties was timely and appropriate
- although there was a delay in an ambulance being called, this did not affect the outcome – the delay arose from events peculiar to this incident rather than as a result of a systemic problem.

The State Coroner did not make any comments or recommendations.

David Samuel Morris

David Samuel Morris was a 57 year old prisoner who was found deceased in his cell at Woodford Correctional Centre (WCC) on 19 November 2011. Resuscitation efforts were not commenced as he was obviously deceased. Mr Morris had been undergoing coronary treatment for his dilated cardiomyopathy since his incarceration in 2006.

Mr Morris' death was investigated by the QPS Corrective Services Investigation Unit (CSIU). The CSIU investigation involved examining and photographing the death scene, seizing relevant corrections and medical records from WCC and the Princess Alexandra Hospital, interviewing prisoners who lived in the same accommodation unit as Mr Morris and obtaining a statement from Mr Morris' daughter. The Office of the State Coroner arranged for an independent doctor from the Queensland Health Clinical Forensic Medicine Unit to review the medical records and provide an opinion about the adequacy of the medical care provided to Mr Morris.

An external examination and full internal autopsy performed by an experienced forensic pathologist revealed the cause of death to be severe coronary atherosclerosis. Toxicological analysis detected only low levels of blood thinning medication.

The State Coroner found that:

- Mr Morris died from natural causes – his death was sudden and could not have been prevented
- the medical care provided to Mr Morris by the prison and the hospital was reasonable and appropriate – there was indication he had complained of chest pains after his discharge from hospital on 16 November 2011

The State Coroner did not make any comments or recommendations.

Andrew John Joseph Emerton

Mr Emerton was a 43 year old prisoner who became acutely unwell in his cell at the Maryborough Correctional Centre on 2 February 2012. Despite emergency resuscitation efforts, Mr Emerton was unable to be revived.

Mr Emerton's death was investigated concurrently by the QPS Corrective Services Investigation Unit (CSIU) and the Office of the Chief Inspector, Queensland Corrective Services (QCS). The CSIU investigation involved a forensic examination of the scene with the body in situ, obtaining statements from relevant corrections officers, prisoners, prison nursing staff and paramedics and seizing medical records and CCTV footage and audio recordings. The QCS investigation examined compliance with policies, procedures and practices in place at the correctional centre for Mr Emerton's supervision and the response to his medical emergency. The Office of the State Coroner obtained a report from an independent doctor from the Queensland Health Clinical Forensic Medicine Unit about the adequacy of the health care afforded to Mr Emerton. The State Coroner was satisfied the investigation was thorough and independent.

A full internal autopsy and external examination performed by an experienced forensic pathologist revealed the cause of death as severe coronary atherosclerosis. Toxicological analysis detected a lower than therapeutic level of Quetiapine.

The State Coroner noted the QCS investigation findings that while the correctional centre's response to the medical emergency was timely and effective, there was scope for improved awareness of and compliance with Code Blue contingency checklists, participation in operational debriefing and crime scene preservation (particularly relating to separation and searching of prisoners and collecting their clothing). The

State Coroner noted none of the investigation recommendations addressing these issues would have changed the outcome for Mr Emerton.

The State Coroner found that:

- Mr Emerton died from natural causes
- correctional and prison nursing staff responded appropriately to Mr Emerton's distress call
- Mr Emerton received appropriate medical care during his incarceration – even though he did not receive lipid lowering medication over the three months preceding his death, this gap in his lipid lowering therapy would have been unlikely to have impacted significantly on the outcome.

The State Coroner did not make any comments or recommendations.

Kenneth Draney

Kenneth Draney was an 80 year old prisoner from the Woodford Correctional Centre who died in the Princess Alexandra Hospital Secure Unit on 30 October 2012. Mr Draney had been diagnosed with metastatic mesothelioma in early May 2012. He was transferred to hospital for palliative care on 29 October 2013.

Mr Draney's death was investigated by the QPS Corrective Services Investigation Unit (CSIU). The CSIU investigation involved examining and photographing the body in situ, seizing the hospital and prison medical records and obtaining statements from corrections staff and prisoners. The Office of the State Coroner obtained a report from an independent doctor from the Queensland Health Clinical Forensic Medicine Unit about the adequacy of the health care afforded to Mr Draney. The State Coroner was satisfied the investigation was thorough and conducted professionally.

An external examination including a post-mortem CT scan, was performed by an experienced forensic pathologist who considered the cause of death was sepsis secondary to lobar pneumonia arising from mesothelioma.

The State Coroner found that:

- Mr Draney died from natural causes
- Mr Draney received appropriate medical care in prison and in hospital and his death could not have been prevented.

The State Coroner did not make any comments or recommendations.

Desmond Arthur Sims

Desmond Sims was a 62 year old prisoner from Wolston Correctional Centre who had been a prisoner for almost six years when he died from non-small cell lung carcinoma at the Princess Alexandra Hospital on 26 January 2011.

Mr Sims' death was investigated by the QPS Corrective Services Investigation Unit (CSIU). The CSIU investigation involved examining and photographing the body in situ, seizing the hospital and prison medical records and obtaining statements from hospital staff. The Office of the State Coroner obtained a report from an independent doctor from the Queensland Health Clinical Forensic Medicine Unit about the

adequacy of the health care afforded to Mr Sims. The State Coroner was satisfied the investigation was thorough and conducted professionally.

Mr Sims' fatal condition was first diagnosed at the Princess Alexandra Hospital in February 2009 and Mr Sims was sent for a PET scan at the Royal Brisbane Hospital. That testing confirmed the diagnosis but a breakdown in administrative procedure at Princess Alexandra Hospital meant Mr Sims was not re-scheduled for a follow up appointment to discuss his treatment options. Notably, Mr Sims made no enquiry as to the outcome of the testing and nothing further was done until May 2010. At that time, and again during further consultations, Mr Sims made it clear that he did not wish to receive radiation therapy or chemotherapy, nor did he wish to undergo any further testing or examination.

The inquest heard that since Mr Sims' death a PET scanner has been installed at Princess Alexandra Hospital, no further incidents of a similar nature had occurred and changes have been made to the notification and administrative procedures involved in the transfer of prisoners to Princess Alexandra Hospital. The State Coroner noted that the unusual circumstances could only have come about in circumstances where Mr Sims made no enquiry as to the progress of his treatment as this would otherwise have prompted further review at the Princess Alexandra Hospital.

The State Coroner, relying on the findings of the independent clinical review, made no criticism of the health care provided to Mr Sims at Wolston Correctional Centre where he had been accommodated in the five years prior to his death. Having considered these matters and the changed circumstances at Princess Alexandra Hospital, the State Coroner decided against making any recommendations.

Gordon Currie

Gordon Currie was a 58 year old man who died unexpectedly from a heart attack on 22 April 2013. At the time of his death, Mr Currie was carrying out work on a banana plantation whilst in custody at the Palen Creek Correctional Centre (PCCC). He had been incarcerated at PCCC since April 2012, after being re-sentenced with regard to various property offences for which he had breached his parole. Mr Currie died three days prior to his scheduled release from PCCC.

Upon being notified of Mr Currie's death, the QPS Corrective Services Investigation Unit (CSIU) promptly attended and an investigation ensued. The investigation obtained Mr Currie's correctional records and his prison medical records. The investigation was informed by statements from all QPS personnel, relevant custodial officers at PCCC, interviews with fellow prisoners who were housed with Mr Currie and also the prisoner who was working with Mr Currie at the time of his death. An autopsy was conducted which showed the cause of death to be coronary atherosclerosis. The Deputy State Coroner was satisfied the matter was investigated thoroughly and professionally.

Mr Currie was not receiving any medication for his heart whilst in custody and had not requested any medical treatment relating to his heart. He was medically assessed upon his admission to PCCC. During that assessment Mr Currie denied any cardiac condition, including chest pain or shortness of breath. His initial assessment did not reveal any medical condition which would be problematic for management.

At the inquest, a question arose as to whether Mr Currie met the criteria for a mandatory electrocardiogram (ECG). Factors supporting a mandatory ECG were Mr Currie's age and that he was a smoker. Medical opinion was obtained which placed doubt on the ability of an ECG to detect any pre-existing heart disease.

The Deputy State Coroner accepted that the medical care during incarceration was adequate and appropriate. Mr Currie consistently denied any symptoms associated with a cardiac health problem and he was within the normal range of testing for weight, blood pressure and heart rate. The Deputy State Coroner accepted that had an ECG been performed, there was no evidence to suggest that it would have identified Mr Currie to be at risk of or suffering from ischaemic heart disease.

The Deputy State Coroner also concluded that Mr Currie received appropriate medical care on the day he died. There was no evidence to suggest his death was preventable. No recommendations were made.

Craig Steven Lingwood

Mr Craig Steven Lingwood was 45 years of age when he died in the custody of the Capricornia Correctional Centre (CCC) in Rockhampton on 10 May 2011.

Mr Lingwood first complained to his next of kin in 2005 or 2006 that a mole on his back was red, itchy and bleeding. He saw the prison doctor on 23 August 2006 and 18 December 2006. The prison doctor appears to have assessed the mole as benign.

On 6 February 2008, Mr Lingwood saw a doctor at the Rockhampton Base Hospital (RBH) Skin Clinic, who determined that the mole was a suspected melanoma. The RBH doctor referred Mr Lingwood to the hospital's Lesion Clinic for an urgent excision and wrote to the prison doctor advising him of this.

On 4 August 2008, Mr Lingwood asked to see the prison doctor after not hearing anything about his urgent referral in February 2008. Mr Lingwood saw a new prison doctor on 19 September 2008. The new prison doctor performed a punch biopsy and confirmed melanoma. She arranged for an urgent wide excision, which was performed on 24 October 2008 at the RBH. After further tests were conducted, it was determined that Mr Lingwood had a stage IIa tumour but the cancer had not spread.

Follow up and review post-operation was managed by the RBH surgical outpatients department until his discharge into the care of the prison medical service on 13 July 2009. In July 2010, Mr Lingwood noticed a lump adjacent to the original excision scar on his back. He saw a prison doctor on 13 July 2010. Mr Lingwood's lump was excised on 23 September 2010 at the RBH. It was determined that Mr Lingwood had metastatic melanoma and he received treatment for his condition until his death on 10 May 2011.

The autopsy determined that Mr Lingwood died of Metastatic malignant melanoma.

This matter was investigated by the Queensland Police Service. Their investigation identified that there had been a significant delay in the removal of the melanoma from Mr Lingwood's back. As a result, the State Coroner referred the matter to the Clinical

Forensic Medical Unit for review and then to a specialist Cutaneous Oncologist for an expert report.

The State Coroner found:

- earlier intervention (i.e. a biopsy or wide excision of Mr Lingwood's mole), either in 2006 or earlier in 2008, may have improved Mr Lingwood's prognosis and may have averted his death from melanoma.
- it was not possible to attribute any blame to the initial prison doctor for failing to take earlier action because of the lack of detail in his notes and the prison doctor had died prior to Mr Lingwood's death and the inquest.
- the policies and procedures in place at the CCC for the monitoring and tracking of medical referrals of prisoners to external service providers were inadequate prior to Mr Lingwood's death.
- from July 2009, a follow up or review plan should have been put in place by the CCC's medical service to ensure that Mr Lingwood received a check up every three to four months in accordance with the relevant Guidelines. This may have resulted in earlier detection. Earlier detection should have resulted in earlier intervention. Earlier intervention may have improved his prognosis.
- the health care provided by the CCC was inadequate in terms of the apparent failure to follow up the RBH doctor's referral of Mr Lingwood to the RBH Lesion Clinic for excision of his suspected melanoma; and failure to put in place a follow up or review plan once Mr Lingwood's primary melanoma was excised and he was discharged back into the care of the prison.
- the improvements made to the relevant policies and procedures applicable at the CCC and RBH since Mr Lingwood's death appear to have adequately addressed the deficiencies identified in this case.

Given the measures already taken by the Queensland Correction Service and the Central Queensland Hospital and Health Service in response to this incident, the State Coroner did not make any preventative recommendations.

Inquests of Public Interest

Matthew James Fuller, Rueben Kelly Barnes & Mitchell Scott Sweeney (Former State Coroner, Michael Barnes)

The former State Coroner was directed pursuant to s. 27(1) of the *Coroners Act 2003* by the Attorney General to hold an inquest into the death of Matthew Fuller. As a result it was decided that a joint inquest should be held into two other deaths also associated with the installation of insulation under the Federal Government Home Insulation Program (HIP); those of Rueben Barnes and Mitchell Sweeney.

Matthew Fuller was 25 when he collapsed in the ceiling cavity of a house at Meadowbrook on 14 October 2009. He had been laying metal based insulation sheeting as a contractor for a registered installer with whom he had been working for two weeks. His collapse was the result of electrocution and resuscitation attempts were unable to save him.

Rueben Barnes was 16 when he was electrocuted while laying fibreglass insulation in the ceiling of a property at Stanwell on 18 November 2009. Again resuscitation

attempts were in vain. He had been working with a registered installer for three weeks at the time.

Mitchell Sweeney, 22, collapsed in the ceiling cavity of a house in Milla Milla after being electrocuted while laying metal based insulation sheeting on 4 February 2010. He had been working for a registered installer for five months.

In each case the deceased person was laying insulation under the HIP. The inquest examined the implementation and administration of that program; the oversight of the State Government bodies charged with workplace and electrical safety, and the steps taken by the employer of each deceased person to provide a safe place and system of work.

The former State Coroner found that:

- Matthew Fuller's training and supervision were inadequate as was his employer's safety management system. These inadequacies contributed to his death.
- Rueben Barnes' employer had a very basic safety management system in place but it was not utilised on the job on which Rueben died. It is unlikely these inadequacies contributed to the death which was the result of a hidden trap created by another tradesman at some undetermined, earlier point in time.
- Mitchell Sweeney's employer provided no supervision or work safety system. Mr Sweeney used metal staples while laying insulation despite being instructed not to do so, however, he was not warned of the possible consequences.

The former State Coroner identified problems in risk identification by state regulatory agencies, failures by state and federal agencies to adequately communicate with each other and inadequacies with the prescribed requirements for training and supervision of employees working under the HIP. Numerous failings associated with the HIP were identified and it was noted that the Commonwealth had already acknowledged a number of these during previous inquiries and reviews.

The former State Coroner recommended that:

- the Office of Fair Trading and Safe Work Queensland undertake a review of the systems that led to their failure to proactively respond to the increased risk arising from the implementation of the HIP;
- a public awareness campaign be instigated warning of the risks inherent in entering a residential roof space; and
- the State Government assess the competing considerations and then consider implementing an expansion of the regime mandating the fitting of electrical safety switches in residential properties.

The former State Coroner referred evidence from the inquest to the Office of the Director of Public Prosecutions and the Department of Justice on the basis that he suspected a number of offences may have been committed that had not yet been the subject of prosecution.

Higher court decisions relating to the coronial jurisdiction

Leahy v Barnes (No 2) [2013] QSC 263

In 2013 the then State Coroner, Michael Barnes, delivered his findings into the 1991 deaths of Vicki Arnold and Julie-Anne Leahy. Included was a finding that the husband of Ms Leahy, Alan Leahy, should be committed to stand trial for the murder of the two women. Mr Leahy applied to the Supreme Court for a statutory order of review seeking to set aside that decision. On 27 August 2013 Justice Henry made an order to that effect.

Justice Henry found that when relying on alleged lies told by Mr Leahy State Coroner Barnes did not recite the correct test of admissibility for lies as evidence of guilt and, further, his findings indicated that the correct test was not in fact applied. His Honour upheld the complaint of Mr Leahy that the decision to commit for trial was informed by reference to an opinion that Mr Leahy had told lies, in circumstances where those alleged lies could not be admissible as evidence of guilt in criminal proceedings, and were therefore irrelevant. It was decided that this departure from legal principle was such that the general reluctance of civil courts to grant relief in respect of committal proceedings could be overcome.

His Honour did not uphold any other basis on which the application for a statutory order of review was based and noted by way of conclusion that the decision “...*does not disturb the Coroner’s other findings. The inquest’s effective overturning of the positive findings of past inquests that Ms Arnold took her own life and Ms Leahy’s still stands.*”

Goldsborough v Bentley [2014] QSC 141

Coroner Jane Bentley convened an inquest into the death of a woman at Granite Gorge in North Queensland. Following the death the Office of Fair and Safe Work Queensland (OFSWQ) conducted an investigation and made a decision not to prosecute. During the inquest the coroner directed an employee of OFSWQ to answer a question relating to the decision of that Office not to prosecute.

Legal representatives for the OFSWQ challenged the direction. The question for the Supreme Court was whether the coroner can investigate and comment upon the reasoning of the decision not to prosecute. It was argued that, in directing the question to be answered, the coroner was acting outside the scope of her powers under the *Coroners Act 2003* (Qld).

Justice McMurdo, in refusing the application, held that it was not demonstrated that the answer which the employee had been directed to provide was one which would be irrelevant to any appropriate comment by the coroner. There is no express qualification of the powers in section 46(1) of the *Coroners Act* that a coroner could never, in an appropriate case, investigate and comment upon a decision whether to prosecute.

It was further held that the coroner's task is one of investigation and if it is not presently clear that a particular line of inquiry must be futile as irrelevant for the outcome, a higher court should not intervene. There was no error, particularly any jurisdictional error, on the part of the coroner in directing that the question be answered. Further, in directing an answer to a question relating to the decision not to prosecute, the coroner did exceed her powers.

Appendix 1: Number of Coronial cases Lodged and Finalised in the 2013-14 financial year and the number cases pending as at 30 June 2014

Court Location	Number of Deaths reported to the Coroner	Number of Coronial Cases finalised			Number of Coronial Cases pending			
		Inquest held	No inquest held	Total	Less than or equal to 12 months old	Greater than 12 and less than or equal to 24 months old	Greater than 24 months old	Total
Brisbane	2795	31	2877	2908	660	151	108	919
Cairns	653	13	760	773	228	37	26	291
Gympie	0	2	0	2	0	0	1	1
Ipswich	0	1	0	1	0	0	0	0
Mackay	556	2	569	571	149	33	31	213
Maryborough	0	0	3	3	0	0	0	0
Southport	678	0	651	651	292	75	53	420
Total	4682	49	4860	4909	1329	296	219	1844

Appendix 2: Register of approved genuine researchers 2013–14

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

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

Adjunct A/Prof. George Rechner, Adjunct A/Prof Andrew McIntosh and Mr Declan Patton	Transport & Road Safety - University of New South Wales
Dr Susan Ballantyne	Director, Drugs of Dependence Unit
Associate Professor Ben Mullins & Mr Jason Selman	Curtin University
Megan Seeley, Prof Peter Ellis, Dr Nathan Milne & A/Prof Alex Forrest	QHFSS
Nicholas Nuttall, Tracey Woolford	Qld Bone Bank
Dr Gerald Lawson	Independent researcher