

Office of the State Coroner

Annual Report 2007 – 2008



QUEENSLAND
COURTS



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14 May 2009

The Honourable Cameron Dick MP
Attorney-General and Minister for Industrial Relations
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Dear Attorney

Section 77 of the *Coroners Act 2003*, provides that at the end of each financial year the State Coroner is to give to the Attorney-General a report for the year on the operation of the Act. In accordance with that provision I enclose that report for the period 1 July 2007 to 30 June 2008.

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 and Appendix 4 contains guidelines used by me under section 14 of the Act. I advise that in the reporting period there were no directions given under section 14 of the Act.

Yours sincerely

A handwritten signature in black ink, appearing to read 'M Barnes'.

Michael Barnes
State Coroner

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Michael Barnes, State Coroner

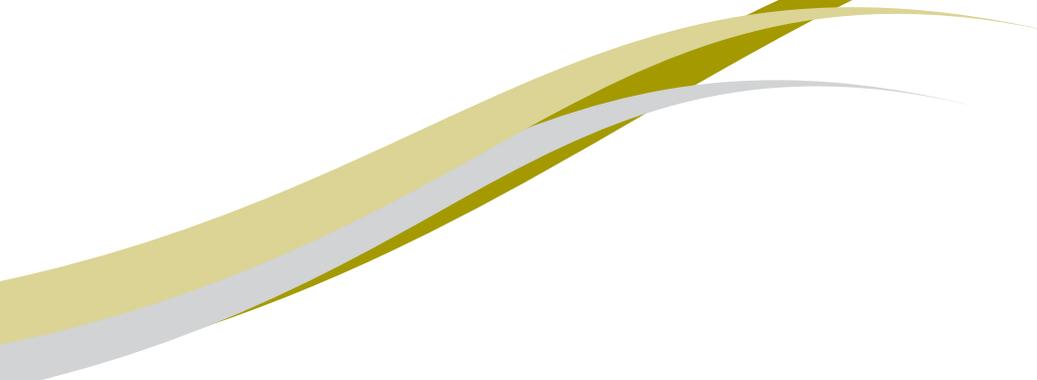
State Coroner's overview

The reform of the Queensland coronial system initiated by the introduction of the *Coroners Act 2003* continued this year. In particular, the appointment of three more full time coroners to Brisbane, North Queensland and the Gold Coast means that approximately two-thirds of reportable deaths are now investigated by specialist coroners. The statistics evidencing improvements in timeliness and more focussed investigations are detailed in other parts of this report. Among other statistics, they show that in the last year Queensland coroners finalised a greater proportion of their matters than did coroners in any other state.

There have also been qualitative improvements flowing from greater integration between the various stakeholders contributing to coronial investigations. Better case management has resulted in quicker gathering of evidence and a reduction in wasteful routine inquiries (often conducted out of habit, rather than for cause).

During the year the development of a custom built case management database continued. When commissioned in 2009, the new system will lead to further efficiencies.

There has been emphasis on ensuring families receive meaningful consultations and quick answers to their questions where possible. Given the distressing nature of coronial investigations, it is not possible to satisfy all family members in all cases. With the assistance of specialist grief counsellors from Queensland Health Forensic and Scientific Services, we have endeavoured to ensure the concerns of bereaved relatives are understood and their views carefully considered when making decisions about autopsies and other matters.



Other specialists also make vital contributions to the coronial system. Forensic pathologists and doctors from the Clinical Forensic Medicine Unit assist coroners to understand the medical aspects of deaths. Queensland Police Service officers and investigators from agencies such as the Mines Inspectorate and Workplace Health and Safety Queensland gather evidence and produce reports. Coroners depend on constructive collaboration and input from independent experts in a variety of fields. I acknowledge with gratitude the willingness of numerous agencies and individuals to assist coroners all over the state.

Prevention of death and reduction of danger are the focus of coroners' inquiries. In the last year, Queensland coroners made numerous recommendations concerning public health and safety, the administration of justice and ways to reduce the likelihood of similar deaths recurring. Most agencies to whom recommendations are directed respond constructively. Agencies often contribute to the development of recommendations through submissions by their lawyers at inquest. However, there is no statutory obligation on government agencies to make any response to coroners' recommendations. After the State Ombudsman raised concern about this in a 2006 report, the State Government required all departments to report their responses to the Department of Justice and Attorney-General. The Attorney will table responses in Parliament annually. I welcome this initiative and anticipate it will both contribute to more constructive responses and improve the quality of recommendations made by coroners.

The coronial system also contributes to prevention by making its data available to approved researchers. As detailed in this report, 26 individuals or organisations have utilised coronial reports in their work to investigate matters that range in diversity from suicide to scuba diving accidents. The Office of the State Coroner has been directly involved in some of this work through Australian Research Council funded projects involving academics and other industry partners.

Finally, I wish to acknowledge the contribution of Queensland's four other full time coroners and the local coroners in areas where magistrates have to balance their court work with coronial work. It is a privilege to work with such dedicated professionals.

Our people

Registrar's report

The Registrar's responsibilities include managing the financial and administrative arrangements for the Office of the State Coroner, overseeing coronial operations in regional registries across the state and managing the interface between the Office of the State Coroner, the state Coroner, the deputy state coroner and other judicial officers.

Growth of the Office of the State Coroner

In 2007-08, the Office of the State Coroner received additional recurrent funding to:

- establish a new coronial support team to support the appointment of an additional full time coroner in Brisbane (\$199 814). An additional \$147 300 of administered funding was provided to establish the new Brisbane coroner's position
- establish a new coronial support team to support the appointment of the new northern coroner (\$156 909). An additional \$400 000 was provided to the Department of Justice and Attorney-General for accommodation of the northern coroner and his Office in the Cairns Court Complex.

The new coronial support teams each comprise a legal officer and three administrative officers. Recruitment processes for these vacancies were completed within the first quarter of 2008, with both teams in place by March 2008.

The appointment of the Brisbane coroner, the northern coroner and their dedicated coronial support teams is discussed in detail in the section 'Coroners and their support staff – roles and responsibilities'. The appointment of a dedicated southern coroner and coronial support team in 2008-09 was foreshadowed during the 2007-08 financial year.

In June 2007, Ms Julie Wilson was appointed as in-house counsel assisting the state coroner. This position was created for a trial period of one year to allow an assessment of its effectiveness in reducing legal costs by alleviating the need to brief private counsel, except in the most complex cases. The position has since been extended to February 2009. It is part of a broader strategy to reduce legal costs for inquests, including the development of a scale of fees for private counsel and increased use of the legal officers to perform the counsel assisting role in appropriate cases.

In late 2007, Ms Paula Campbell was appointed as the Office Manager. Ms Campbell has been with the Office of the State Coroner since 2005.

Managing the provision of coronial autopsy and government undertaking services

The costs associated with coronial autopsies, conveyances and government assisted funerals have increased significantly since 2003-04.

The Registrar's responsibilities include management of the government undertakers' contracts and the Burials Assistance Scheme administered under the *Burials Assistance Act 1965*. The undertaking services provided under these contracts involve the transportation of deceased persons' bodies to and from a mortuary for the purpose of a coronial autopsy and the conduct of government assisted burials and cremations. The Registrar manages 67 contracts with 46 government undertakers throughout the state.

Costs associated with the transport of deceased persons for coronial autopsy have increased significantly due to several factors. Firstly, the increasing number of deaths reported to coroners each year. Secondly, the distances travelled to convey a person's body to a doctor who is suitably qualified to conduct the autopsy. Thirdly, the impact of rising fuel costs on mileage and charter costs (particularly in regional, rural and remote areas).

There has also been a marked increase in the number of government assisted funerals conducted since 2003-04. This is attributable to Queensland's population growth and demographic, the current economic climate, local Indigenous authorities no longer paying for funeral services and increased public awareness of the Burials Assistance Scheme.

All government undertaker contracts are due to expire on 30 November 2008. Contractors have an option to extend their contract for a further two year period. In January 2008, the Office of the State Coroner wrote to all contractors seeking advice about whether they wished to extend their contract. All but one contractor sought an extension and many sought to increase their fees to accommodate increases in the consumer price index and the impact of rising fuel costs. Arrangements to conduct a closed tender process for the Moranbah/Clermont boundary in the first quarter of 2008-09 were underway as at 30 June 2008.

The Office of the State Coroner also pays for coronial autopsies performed by Government Medical Officers (GMOs) and pathologists who are not employed by Queensland Health Forensic and Scientific Services. Queensland Health sets the fees for services provided by these GMOs and pathologists. In addition to a steady increase in the number of autopsies performed by GMOs, there was an above CPI increase in GMO fees from 1 March 2008.

In order to meet the increasing costs associated with the provision of these services, the Office of the State Coroner received additional capped recurrent funding of \$758 000 through the mid year budget review process.

Development of the Coroner's Case Management System

In 2005-06, the Information Management Committee of the Department of Justice and Attorney-General allocated funding of \$310 000 (comprising \$135 000 capital and \$175 000 expense) for the system design, development and testing of a purpose-built coronial case management system (CCMS). This system is designed to significantly

improve the management of coronial files, to provide more detailed and accurate information about these files and to interface with the National Coroners Information System.

In July 2007, the project manager/business analyst carried out an extensive analysis and requirement gathering. It was determined that additional funding was required to undertake the necessary system design, development and testing. Consequently, the department's Information Management Committee allocated an additional \$75000 capital to enable thorough user acceptance testing (to be conducted by staff of the Office of the State Coroner) and \$59 000 expense to enable the development and provision of comprehensive training prior to implementation.

As at 30 June 2008, 65 per cent of the system build had been completed. The new system is to be implemented in 2008-09. A staff member of the Office of the State Coroner was seconded to the department's Courts Capability Development Unit from 9 June 2008 to develop a comprehensive training package. Training will be delivered to all staff of the Office of the State Coroner and staff from regional registries managing coronial files. A two day training course is proposed for Brisbane, Cairns and Southport.

Review of approved forms

In 2007-08, the Office of the State Coroner reviewed and substantially revised the Form 1A – Medical Practitioner Report of a Death to the Coroner and the combined Form 20/28 – Record of Coroner's Findings and Comments and Notification of Completion of Coronial Investigation.

The state coroner approved a new version of the Form 1A on 4 February 2008. The new version was revised substantially to ensure that the coroner receives sufficient information about the circumstances of the person's death and the treatment they had received leading up to

the death. It also provides comprehensive instructions about when and how the form is to be used by medical practitioners. Coroners have experienced a significant improvement in the quality and extent of information provided to them through this form, which has greatly assisted their determination of whether the death is reportable and if so, whether any further investigation is warranted.

The Office of the State Coroner developed four new forms to replace the combined Form 20/28, which was considered cumbersome and not very reader-friendly, especially for bereaved families. Separate forms have been developed for findings in respect of suspected deaths and deaths that proceed to inquest:

- Form 20A – Coroner’s findings and notice of completion of coronial investigation
- Form 20B – Coroner’s findings – suspected death and notice of completion of coronial investigation
- Form 28A – Coroner’s findings at inquest and notice of completion of coronial investigation
- Form 28B – Coroner’s findings at inquest – suspected death and notice of completion of coronial investigation.

The state coroner approved new forms on 1 July 2008. Visit the Queensland Courts website www.courts.qld.gov.au to access the new forms.

Communication, stakeholder relations and business improvement initiatives

In June 2008, the state coroner initiated a review of how the progress of coronial investigations is communicated to bereaved families. As at 30 June 2008, the Office of the State Coroner was developing a range of strategies to deliver more timely and appropriate communication with, and support for families during the course of a coronial investigation. Strategies to be implemented in 2008 2009 include:

- a more systematic and informative approach to keeping families up to date on the progress of an investigation

- the provision of more comprehensive information about the coronial process at the time of the coroner’s initial contact with the next of kin
- continuing liaison with the Coronial Counselling Service to identify and support families who are having difficulty coping with the loss of their loved one
- the attendance of coronial counsellors at inquest hearings to support the family.

The Office of the State Coroner web pages were revised in November 2007, as part of the update to the general Queensland Courts website. The pages now carry a current list of inquest matters and is updated on the first business day of each month. Enhancements have significantly improved communication with the media about upcoming matters of public interest. Visit www.courts.qld.gov.au to view the Office of the State Coroner web pages.

In May 2008, the Office of the State Coroner published substantially revised Burials Assistance Guidelines for registrars who assess burials assistance applications at local Magistrates Courts registries. Guidelines contain comprehensive instructions on the burials assistance process and are available to all Queensland Courts registry staff through the department’s intranet. The Office of the State Coroner also published a new Burials Assistance factsheet for members of the public. Visit www.courts.qld.gov.au to access the Burials Assistance factsheet.

The Office of the State Coroner has also participated in regular forums with key stakeholders including Queensland Health, the Queensland Police Service and representatives of the funeral industry, with a view to improving communication and interaction with our coronial partners.

The Office of the State Coroner also assisted the state coroner to provide input to the development of operational amendments to the *Coroners Act 2003* during the reporting period.

Coroners and their support staff – roles and responsibilities

State Coroner

The State Coroner, Mr Michael Barnes, was reappointed on 30 June 2008 for a further five year term. The state coroner is responsible for coordinating and overseeing the coronial system to ensure it is administered efficiently and investigations into reportable deaths are conducted appropriately.

In order to discharge the coordination function, the state coroner has issued guidelines of general application which inform the way coroners manage coronial matters across the state. Visit www.justice.qld.gov.au/courts/coroner/publications.htm to view the guidelines online. The state coroner also provides daily advice and guidance to coroners in relation to specific cases and liaises with other professions and organisations involved in the coronial process (e.g. police, pathologists and counsellors).

In order to discharge the monitoring function, the state coroner reviews all reportable deaths as they are reported and once local coroners have finalised their investigation and findings. In performing this function the state coroner is careful not to impinge on the judicial independence of local coroners.

Only the state coroner or deputy state coroner may investigate deaths in custody. The state coroner also conducts inquests into more complex deaths that if dealt with by a local coroner, would take him or her out of general court work to the detriment of the local court diary.

During the reporting period, the state coroner sat in Brisbane, Maroochydore, Mt Isa, Cairns, Thursday Island, Kowanyama and Townsville. During 2007-08, the state coroner conducted 31 inquests and finalised 57 matters without proceeding to inquest.

Deputy State Coroner

The Deputy State Coroner, Ms Christine Clements, was appointed on 8 December 2003. Along with the state coroner, the deputy state coroner may investigate deaths in custody and acts as the state coroner when required.

Prior to the appointment of the Brisbane coroner in January 2008, the deputy state coroner was solely responsible for investigating reported deaths in the greater Brisbane area. This involved managing a caseload in excess of 1000 deaths per annum, representing one-third of the deaths reported statewide and double the caseload identified as reasonable for a full time coroner. A significant proportion of these were complex medical deaths reported from the major tertiary hospitals in Brisbane.

The deputy state coroner conducted eight inquests and together with the Brisbane coroner finalised 1250 investigations in 2007-08.

Appointment of additional full time coroners and dedicated coronial support teams

In his Annual Report for 2005-2006, the state coroner called for the appointment of full time coroners throughout the state as a means of improving the quality, timeliness and efficiency of coronial investigations across Queensland.

“Coronial investigations and inquests are functions very different from the general work of a magistrate. In the initial stages of a coronial investigation, liaison with police, pathologists and family members is frequently necessary at very short notice. This is very difficult for magistrates to interweave with their court work. Increasingly, coroners are expected to lead interdisciplinary investigations that seek to unpack complex causes of death and develop remedial strategies. These functions require coroners to develop

close working relationships with other professionals involved in responding to unnatural deaths. They may also need coroners to analyse extensive technical information and generate responses to the dangers revealed by that analysis. It is difficult for magistrates who only infrequently fill the role of coroner to develop sufficient expertise to perform these functions effectively. The appointment of full time coroners throughout the state would address these difficulties.” Annual Report of the State Coroner 2005-2006, p.5.

Since 2004-05, there has been a 13.4 per cent increase in reported deaths across the state. The increase has been more concentrated in South East Queensland (Brisbane, Beenleigh and Southport) and in Far North Queensland. Over the period 2004-05 to 2006-07, there was a 17.29 per cent increase in reported deaths in South East Queensland and a 17.4 per cent increase in reported deaths in Far North Queensland.

In recognition of the significant growth in demand for coronial services in these regions, two additional full time coroners and dedicated coronial support teams were appointed during 2007-08. The appointment of a dedicated southern coroner was also approved with the actual appointment to follow in 2008-09.

Brisbane Coroner

Mr John Lock was appointed as the full time Brisbane coroner in January 2008. The Brisbane coroner assists the deputy state coroner to investigate deaths reported in the greater Brisbane area. The Brisbane coroner is supported by a legal officer and three administrative staff. The appointment of the Brisbane coroner and his dedicated coronial support team was made possible through the provision of additional funding through the mid year budget review process.

The appointment of the Brisbane coroner and his support team has already made an appreciable impact on the timeliness of coronial investigations in Brisbane. In 2007-08, 1149 deaths were reported to the deputy state coroner and the Brisbane coroner and 1250 deaths were finalised. This represents a clearance rate of 109 per cent. Compared to the first half of 2007-2008 during which

456 Brisbane deaths were finalised, together the deputy state coroner and the Brisbane coroner finalised 772 deaths over the second half of 2007-08 (including three matters that went to inquest).

Northern Coroner

Mr Kevin Priestly was appointed as the full time Northern Coroner in March 2008. The northern coroner is based in Cairns and is responsible for investigating deaths in the Far Northern region spanning from Cairns, south to Proserpine, west to Mount Isa and north to the Papua New Guinea border.

The northern coroner is supported by a legal officer and three administrative staff. The northern Coroner was appointed through a reallocation of existing resources in the region by the Chief Magistrate. The appointment of his dedicated coronial support team was made possible through the provision of additional funding through the mid year budget review process for the legal officer and team leader and a reallocation of existing resources for two administrative officers. Additional funding was also provided for accommodation of the Northern Coroner's Office in the Cairns Court Complex. This was complemented by the appointment of a full time Queensland Health Forensic and Scientific Services forensic pathologist in Cairns.

Prior to Mr Priestly's appointment, deaths were investigated by local Magistrates at Bowen, Proserpine, Cairns, Innisfail, Atherton, Mareeba, Mossman, Cloncurry, Mt Isa and Townsville, in addition to their general court duties. Around 300 pending coronial files were transferred from these registries to the northern coroner when his office commenced operation in March 2008.

The appointment of the northern coroner and his support team has already made an impact on the processing of deaths reported in the Far Northern region. In 2007-08, 546 deaths were reported in the region and 512 matters were finalised, representing a clearance rate of 94 per cent. The northern coroner's appointment in March 2008 assisted in increasing the average number of matters finalised in the Far Northern region from 34 to 45 per month.

The northern coroner's appointment immediately relieved pressure on local magistrates' court diaries, notably in Townsville, resulting in non-coronial matters being listed more expeditiously. The Townsville coordinating magistrate has indicated this has been so effective, that they will no longer need the week per month assistance they had been receiving from Cairns, allowing more circuits of the Cape.

Local coroners

The *Coroners Act 2003* provides that every magistrate is a coroner. Other than deaths in custody, which must be investigated by either the state coroner or deputy state coroner, police report deaths to the coroner nearest to the place of death.

As at 30 June 2008, deaths were being reported to local magistrates at Beenleigh, Bundaberg, Caboolture, Caloundra, Charleville, Cunnamulla, Dalby, Emerald, Gayndah, Gladstone, Gympie, Hervey Bay, Ipswich, Kingaroy, Mackay, Maroochydore, Maryborough, Murgon, Nanango, Redcliffe, Rockhampton, Roma, Southport, Toogoolawah, Toowoomba and Warwick.

Unless the file is transferred to the state coroner, the local coroner is responsible for investigating the death. There are many steps involved in a coronial investigation some of which can be very time consuming. The coroner must consider the initial police report (the Form 1) and consider any family concerns before ordering an internal autopsy. The coroner is in control of and directs the coronial investigation. Police and other investigative agencies and experts engaged by the coroner prepare complex reports which must be considered before making a decision to hold an inquest and before findings in relation to the death are made. Family members are consulted before

it is decided whether an inquest is needed. Due to the many steps involved in the process, coronial work demands time which is not always available, considering the workload and schedule of a busy magistrate.

The appointment of full time coroners and dedicated coronial support teams enhanced justice service delivery by taking the pressure off local magistrates. It also increased the quality and efficiency of coronial services and access to justice for residents of regional areas. Having full time coroners and support teams assisted in the development of productive working relationships with local police and hospitals, in turn improving efficiency of the coronial system.

Office of the State Coroner

The role of the Office is to support the state coroner in delivering a more consistent and efficient coronial system across the state. The Office maintains a register of reported deaths, supports Queensland's involvement in the National Coroners Information System and provides ongoing legal and administrative support to the state coroner, deputy state coroner, Brisbane coroner, northern coroner, local coroners and court registry staff in Magistrates Courts across the state. The Office also ensures information is accessible to the public and provides a central point of contact for coronial matters.

At the end of the reporting period, there were 29 officers employed by the Office to provide legal and administrative support to coroners, court staff and coronial clients throughout the state. Of these, 25 were based in Brisbane and four were based in the Northern Coroner's Office in Cairns.

Coroners' investigations

Reportable deaths

Under the *Coroners Act 2003* reportable deaths (as defined in section 8 of the Act) must be reported to a coroner. Section 7 of the Act requires anyone becoming aware of an apparently reportable death to report it to the police or a coroner.

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

- the identity of the person is unknown
- the death was violent or otherwise unnatural
- the death happened in suspicious circumstances
- the death was not reasonably expected to be the outcome of a health procedure
- a cause of death certificate has not been issued and is not likely to be issued for the person
- the death was a death in care
- the death was a death in custody.

Unidentified bodies

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

Violent or unnatural

Car accidents, drownings, electrocutions, suicides and industrial and domestic accidents are all reported to coroners under the category of violent or unnatural deaths. The coroner investigates the circumstances of death to determine whether or not it should be referred to a prosecuting authority or an inquest warranted with a view to developing recommendations that will reduce the likelihood of similar deaths.

Suspicious circumstances

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

Not reasonably expected to be the outcome of a health procedure

A death must be reported to a coroner if it was not reasonably expected to be the outcome of a health procedure. Deciding whether or not to report deaths that occur in a medical setting and determining how they should be investigated, pose a considerable challenge for a coroner.

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

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

Deaths in care

Deaths of categories of vulnerable members of society (namely children in the care of the Department of Child Safety, the mentally ill and the disabled) are reported to a coroner irrespective of their cause. The current database used for gathering statistics (QWIC) is not capable of accurate reporting on the numbers of deaths in this category. This problem will be addressed with implementation of the new Coroner's Case Management System.

The Office of the State Coroner now has an arrangement with the Office of Fair Trading, Disability Services Queensland and Queensland Health to provide a list of the residential disability services that fall within the meaning of section 9(1)(a)(i), (ii) and (iii) of the *Coroners Act 2003*. This information is updated regularly and disseminated to magistrates and registry staff, the Queensland Police Service and Queensland Health facilities to assist them in identifying reportable deaths under this category.

The Office would like to acknowledge the assistance provided by the staff of the Community Visitor Program. The partnership developed between the two agencies has been instrumental in increasing the number of deaths reported in this category and has enabled coroners to more effectively assess the quality of care provided to the deceased person.

Deaths in custody

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

- detention under arrest
- the authority of a court order
- an act by a police officer or Corrective Services officer, court officers or other law enforcement personnel.

This definition covers detention in watch-houses and prisons but also extends by reference to the legal context which makes the physical location of the deceased irrelevant. For example, a sentenced prisoner who is taken to a doctor or a hospital for treatment is still in custody for the purposes of the *Coroners Act 2003*.

During the reporting period, 10 deaths in custody were reported. Findings in relation to six deaths in custody were finalised. It is mandatory for an inquest to be held for deaths in custody.

Indigenous remains

The *Coroners Act 2003* recognises the sensitivity of Indigenous remains. When dealing with Indigenous burial remains, the coroner must strike a balance between ensuring the death was not a homicide and avoiding unnecessary disturbance of the remains. As soon as it is established that remains are Indigenous burial remains, the coronial investigation must cease. Management of the site is then transferred to officers from the Cultural Heritage Coordination Unit of the Department of Natural Resources and Water and representatives of the traditional owners of the land where the remains were found.

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

During the reporting period, coroners investigated 21 matters in which the remains were confirmed as Indigenous burial remains.

Purpose of coronial investigations

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

Autopsies

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

Under the previous coronial regime, full internal autopsies were ordered in almost all cases and the views of family members were not considered when ordering autopsies. The *Coroners Act 2003* requires a coroner 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. It also recognises that many members of the community have strong objections (sometimes based on religious beliefs) to performing invasive procedures on the bodies of their deceased loved ones. The *Coroners Act 2003* requires coroners to consider these concerns when determining the extent of the autopsy ordered.

Although family members cannot 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 also be judicially reviewed. No review applications were lodged during 2007-08. Family concerns have been assuaged with the assistance of coronial counsellors from Queensland Health Forensic and Scientific Services.

Table 1: Percentage of Orders for Autopsy Issued by Type of Autopsy to be Performed a sample analysis of autopsies conducted within the reporting period. It indicates that during the reporting period, full internal autopsies were conducted in 70.32 per cent of cases, partial internal autopsies were conducted in 19.54 per cent of cases and external examinations were undertaken in 10.1 per cent of cases.

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

Type of autopsy	1/12/03 to 30/06/2004	2004-05	2005-06	2006-07	2007-08
Order for external autopsy	11.7%	6.3%	7.12%	9.84%	10.1%
Order for internal autopsy – partial	16.3%	25.2%	27.73 %	22.51%	19.54%
Order for internal autopsy – full	71.4%	68.3%	65.11%	67.62%	70.32%
Order on cremated remains	0.5%	0.2%	0.04%	00.03%	0.03%

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

Type of autopsy	1/12/03 to 30/06/2004	2004-05	2005-06	2006-07	2007-08
Order for external autopsy	107	145	198	296	314
Order for internal autopsy – partial	149	575	771	677	608
Order for internal autopsy – full	653	1559	1810	2034	2187
Order on cremated remains	5	5	1	1	1
Total	914	2284	2780	3008	3110

Measuring outcomes

New performance measures have been introduced for the coronial jurisdiction, which align to the national benchmarking standards outlined in the Report on Government Services.

Coronial performance is now measured by reference to a clearance rate (finalisations/lodgements) and a backlog indicator (the percentage of matters more than 24 months old).

The clearance rate replaces the former performance measure of number of coronial inquests held. The latter was an unreliable measure of performance for two reasons. Firstly, the vast majority of matters proceed to findings without an inquest. Secondly, the number of inquests able to be finalised each year varies depending on the complexity of each matter.

The backlog indicator has been changed to extend the pending caseload period from 12 to 24 months. The national standard for coroners' courts is that no lodgements pending completion are to be more than 24 months old.

Number of deaths reported

In recent years, coroners have observed a steady annual increase in the number of deaths reported. In 2007-08, 3514 deaths were reported to coroners across Queensland – up 8.4 per cent from 2006-07 (3219 reported deaths).

Finalisation of coronial cases

Coroners are aware that delays in finalising coronial matters can cause distress for family members. Coroners strive to conclude matters expeditiously.

For the first time, the Queensland coronial system achieved a clearance rate (104 per cent) which exceeded the clearance rates of all other Australian jurisdictions. The appointment of additional full time coroners and dedicated coronial support teams has been a significant contributor to this success.

As at 30 June 2008, 25.5 per cent of pending matters were more than 12 months old. Compared to other Australian jurisdictions, Queensland ranked fourth behind the Australian Capital Territory, Victoria and New South Wales. Last year Queensland ranked fifth behind the Australian Capital Territory, Western Australia, New South Wales and Tasmania.

As at 30 June 2008, 9.6 per cent of pending matters were more than 24 months old. Compared to the other Australian jurisdictions, Queensland ranked fourth behind the Australian Capital Territory, Victoria and New South Wales, with no change in ranking from 2006-07.

Although this measure has not reached the Queensland target of 7 per cent, it is important to acknowledge several factors peculiar to the coronial jurisdiction that impact on a coroner's ability to finalise investigations within 24 months.

- Coronial matters are increasingly more rigorously investigated to enable coroners to fulfil their preventative role under the *Coroners Act 2003* in commenting on matters such as public health and safety and the administration of justice.
- The complexity of coronial investigations is increasing, particularly with the notable increase in reporting of health procedure-related deaths. Complex death investigations involve the preparation of expert reports from external agencies.
- For certain types of deaths, there are multiple investigative processes that may be invoked and these processes generally inform the coronial investigation. For example, the Department of Child Safety reviews the deaths of children who have had contact with the department. The Division of Workplace Health and Safety investigates many industrial accidents. In most cases, it is appropriate for the coroner to wait for the deliberations of other agencies in order to recommend preventative measures in addition to determining the cause of death. In many cases, the specialist agencies are best placed to devise such reforms and the coroner need then only note the changes that have been mooted, adding his or her voice to the call for improvement if appropriate.
- The *Coroners Act 2003* halts a coronial investigation in circumstances where a person has been charged with an offence in relation to the death, until the offence proceedings are completed. Of the matters that are older than 24 months, 15.3 per cent relate to ongoing criminal prosecutions.

Appendix 2 shows the finalisation rates achieved during the reporting period.

Coronial investigators – a multi-agency approach

The Coronial Support Unit (CSU) coordinates the management of coronial processes on a statewide basis within the Queensland Police Service. The officers located within the Office of the State Coroner provide direct support to the State Coroner, Deputy State Coroner and Brisbane Coroner. They also assist regional coroners when required. Officers at the John Tonge Centre help prepare documents for autopsy, attend autopsies and assist in the identification of deceased persons. This unit also liaises with coroners, investigators, forensic pathologists, mortuary staff and counsellors. Officers bring a wealth of experience and relevant knowledge to the Office of the State Coroner. They are actively involved in various research projects and proactively review policies and procedures as part of a continuous improvement approach.

Clinical expertise provided by the Queensland Health Clinical and Forensic Medicine Unit (CFMU) has greatly assisted full time Brisbane-based coroners and the Northern Coroner. Government Medical Officers are made available on an as needs basis to assist the coroner's preliminary assessment of a reported death (particularly deaths which occur in clinical settings). They review the report of the death and the deceased person's medical records, alerting the coroner to any clinical issues requiring follow up or independent clinical expert opinion. Having this expert advice available during the preliminary stage of a coronial investigation is extremely valuable. It focusses the investigation on the relevant issues – issues which can be quite complicated in complex medical matters.

Queensland Health Forensic and Scientific Services (QHFSS) is responsible for providing a coronial autopsy service and a specialist pathology and toxicology investigation service to the Office of the State Coroner.

The Coronial Counselling Service based at the John Tonge Centre provides information and counselling services to relatives of the deceased. This service is staffed by experienced professional counsellors who play an important role in explaining the coronial process to bereaved families. Counsellors help families work through their objections to autopsy and organ/tissue retention and support them during inquest hearings. In 2007-08, the Coronial Counselling Service produced a booklet called 'A guide to coping with unexpected death'. The booklet is distributed to next of kin at the time the death is reported to a coroner. Feedback from families suggests that the booklet has been an extremely helpful resource.

The Coronial Support Unit, CFMU, the Coronial Counselling Service and QHFSS are integral parts of the coronial process. Each agency is represented on the interdepartmental working group chaired by the state coroner, which meets on a bimonthly basis to review and discuss operational issues. The Office of the State Coroner and families of the deceased greatly appreciate the dedication, commitment and professionalism of agencies involved.

The changing landscape of medical death investigations

Increased reporting of health procedure related deaths

There has been significant increase since the events leading to the Queensland Public Hospitals Commission of Inquiry, there has been a marked increase in the reporting of health procedure related deaths under section 8(3)(d) of the *Coroners Act 2003*.

In 2005-06, 86 health procedure deaths were reported to coroners across Queensland. This increased by 43 per cent to 123 in 2006-07 and a further 115 per cent to 265 in 2007-2008. These figures may not accurately capture

all health procedure related deaths. This is because some deaths will have been coded as other types of reportable death (e.g. a health procedure related death that is also a death in care).

Medical practitioners are encouraged to report health procedure related deaths by using a Form 1A. Form 1A is used to seek the coroner's advice as to whether a death is reportable and to report reportable deaths which may or may not need further investigation. There has been a significant increase in use of Form 1A over the period 2005-06 to 2007-08. In 2005-2006, 183 instances of Forms 1A were submitted by medical practitioners statewide (of which 148 were submitted to the deputy state coroner by medical practitioners in the greater Brisbane area). This increased by 12 per cent in 2006-2007, when 205 instances of Form 1A were submitted statewide (of which 181 were submitted to the deputy state coroner by medical practitioners in Brisbane – a 22 per cent increase for the greater Brisbane area). This trend increased sharply in 2007-08, with 314 instances of Form 1A submitted by medical practitioners statewide (of which 223 were submitted to the deputy state coroner and the Brisbane coroner by medical practitioners in Brisbane). This represents a statewide increase of 53 per cent over the period from 2006-07 to 2007-08. This increase contrasts with that of statewide reporting- up 9 per cent over the same period.

The significant increase in the reporting of health procedure related deaths is attributable to the publicity surrounding the events leading to the Queensland Public Hospitals Commission of Inquiry, which delivered its recommendations on 30 November 2005. It is also an outcome of implementation of the Health Quality and Complaints Commission (HQCC) standard for the review of hospital-related deaths on 1 July 2007.

The *Health Quality and Complaints Commission Act 2006* requires health facilities to establish, maintain and implement processes to monitor and improve the quality of the health services they provide. One of the ways health facilities can comply with this obligation is to comply with standards issued by the HQCC. On 1 July 2007, the HQCC issued a standard that requires a review of all deaths that occur in public and private hospitals in Queensland, for both admitted and non-admitted patients and of all deaths in the community where the deceased person was hospitalised within 30 days prior to their death.

The review is undertaken by the hospital and must assess whether the death was reportable to the coroner and if so, that it was in fact reported. The review also assesses the integrity of the cause of death certificate and whether opportunities for improved quality of care have been identified and addressed by the facility.

Visit the Health Quality and Complaints Commission website www.hqcc.qld.gov.au to view the Standard for the Review of Hospital-Related Deaths.

The standard is considered to have increased the hospital sector's awareness of coronial reporting obligations. Significant increase in use of the Form 1A during the reporting period supports this consideration. The Queensland Health Patient Safety Centre undertook a review of the public health sector's implementation of the standard. Outcomes of the review are expected to be made available in 2008-09. In the event the standard has not been implemented satisfactorily across all Queensland Health facilities, further work will be required to achieve compliance. Reporting of health procedure related deaths will continue to increase. As reporting increases, so will the workload for coroners and their support staff.

The advent of root cause analysis

In February 2007, the Health Minister introduced legislation that established a regulatory framework for root cause analysis (RCA) of adverse health outcomes including death or permanent harm. RCA is a quality improvement technique that examines the chain of events responsible for an adverse health outcome. Its objective is to identify systemic factors that caused or contributed

to the event and identify measures that could prevent or reduce the risk of a similar event recurring. The legislative provisions underpinning the RCA process commenced operation on 20 March 2008 (although RCAs had been introduced in the health sector some time prior to this). The RCA process is used by public sector health services, private health facilities and the Queensland Ambulance Service. It was recommended by the *Action Plan – Building a better health service for Queensland* (2005) and the *Queensland Health Systems Review Final Report* (2006).

The objective of an RCA is to understand how or why an event occurred, rather than to apportion blame or determine liability. An RCA is conducted by an independent multidisciplinary team. As the RCA process relies on voluntary participation by individuals involved in the adverse event, information and documents produced for RCA purposes are privileged. This means that information and documents cannot be used as evidence in civil, criminal, coronial or disciplinary processes.

The RCA process is intended to operate as a rapid response to adverse health outcomes. Where the adverse event results in death, the death will invariably be reportable under the *Coroners Act 2003*. The coroner will only be informed that an RCA is being conducted in respect of the death if the coroner requests confirmation of this fact from the health facility. The coronial investigation is informed by the RCA process to the extent that a copy of the final report produced by the RCA team must be provided to the coroner and is admissible in an inquest.

Coroners' experience to date suggests that the RCA report helped to identify relevant issues. It has also helped to provide facilities with an early opportunity to demonstrate their response to RCA recommendations, which may obviate the need to proceed to inquest.

Due to the privileged nature of the RCA process, coroners have limited ability to get behind the RCA report and its recommendations to satisfy themselves that it represents a comprehensive review of the incident leading to the death. This issue has emerged in several current inquests. It is hoped that ongoing improvements to the RCA process will address these concerns.

Coroners' access to independent clinical expertise

In the 2005-06 Annual Report, the State Coroner commented on the urgent need for coroners to have access to expert medical support in order to assist their investigations (particularly of health procedure related deaths). Since that comment, coroners have benefited from the valuable assistance of Government Medical Officers from the Queensland Health CFMU (as previously discussed). The state coroner and CFMU have documented the principles and procedures underpinning the provision of this assistance.

Other sources of independent clinical advice accessed by coroners include the HQCC (discussed below) and private clinicians commissioned to prepare expert reports for the coroner. The Office of the State Coroner acknowledges the valuable assistance provided by both the Queensland Health Patient Safety Centre and the HQCC in identifying qualified clinicians for this purpose.

Intersection with the Health Quality and Complaints Commission (HQCC) and other relevant investigative agencies

The HQCC was established in 2006 in response to the recommendations of the *Queensland Health Systems Review Report* (2006). The HQCC is an independent body that monitors, investigates and reports on the quality of all public and private health services in Queensland and handles consumer complaints through assessment, conciliation and investigation. The coronial investigation of a health procedure related death often raises health quality issues that also fall within the HQCC's investigative jurisdiction.

The HQCC has assisted coronial investigations through the provision of assessment reports and the identification of suitably qualified independent clinical experts. Through regular monthly meetings, the Office of the State Coroner has developed a good working relationship with the HQCC investigators. Unfortunately HQCC's ability to provide timely assessments for coronial purposes has been impacted by significantly increased demand on HQCC's limited investigative resources.

In August 2007, the state coroner entered into a Memorandum of Understanding (MOU) with the HQCC, the Office of Health Practitioner Registration Boards, the Queensland Nursing Council, the Chief Health Officer, the Crime and Misconduct Commission, the Queensland Police Service, the Queensland Ombudsman and the Commission for Children and Young People and Child Guardian about the coordination of responses to serious adverse health incidents. This instrument articulates principles and procedures to encourage information sharing, interagency cooperation and coordination of concurrent investigations. To date, the MOU has assisted in clarifying lead investigative agency responsibility and resolving competing investigative priorities in complicated cross-jurisdictional matters. The MOU is in place until 2011.

Improved cooperation by the health sector with the coronial process

In addition to increasing general awareness and understanding of reporting obligations and coronial processes, coroners have experienced improved cooperation in its coronial investigations by the health sector.

On 26 October 2007, the Office of the State Coroner and Queensland Health held a Coronial System Business Process Improvement workshop involving key coronial stakeholders. The objective of the workshop was to identify opportunities to improve coronial investigations of health care related deaths. The workshop was attended by 68 people from agencies including the Department of Justice and Attorney-General, Queensland Health, Queensland Police Service, Queensland Ambulance Service, HQCC, the Office of Health Practitioner Registration Boards, the Australian Medical Association Queensland and representatives of the funeral industry.

The workshop was successful in both improving participants' understanding of the current end to end coronial process and identifying key issues impacting on the efficiency of the coronial process (as it operates in respect of health care related deaths). Following the workshop, the Office of the State Coroner and the Queensland Health Patient Safety Centre developed an Action Plan which outlines a range of strategies to address the issues identified. Strategies include:

- reviewing of approved forms
- updating and promoting the existence of Queensland Health's internal coroner's investigation guide for health service employees
- reviewing Queensland Health's internal medical summary form to improve the quality of information doctors provide to the coroner when reporting a death
- developing directives for police officers about the process of obtaining medical records from hospitals
- providing joint agency information sessions to health facilities about the coronial process
- improving the dissemination of coronial findings within the health sector.

The Action Plan was endorsed by the state coroner's Inter-Departmental Working Group in February 2008. Each agency's progress is measured against the Action Plan by the state coroner's Interdepartmental Working Group at its bi-monthly meetings.

Monitoring responses to coronial recommendations

Unlike other jurisdictions, the *Coroners Act 2003* does not mandate reporting of government responses to coronial recommendations. The Queensland Ombudsman examined this issue in his 2006 report on the Coronial Recommendations Project.

Some agencies (e.g. Queensland Health) have adopted a routine practice of providing a formal response to the investigating coroner's recommendations. Other agencies have demonstrated an inconsistent approach.

In October 2007, the Attorney-General and Minister for Justice announced the introduction of an administrative process to monitor public sector agencies' response to coronial recommendations that impact on their portfolio responsibilities. Responses will be compiled to form an annual report which will be tabled in Parliament. The report will include portfolio responses to any coronial recommendations made during the previous year. The first annual report is expected to be tabled in mid 2009.

Genuine researchers

The coronial system is an important source of information for researchers. The analyses of researchers are an invaluable resource for other coronial systems. The following genuine researchers were approved under section 53 of the *Coroners Act 2003* during the reporting period.

Dr Nathan Milne and Dr Beng Beng Ong (19 November 2007 and 20 May 2008)

Dr Ong and Dr Milne are forensic pathologists employed by Queensland Health Forensic and Scientific Services.

Their first research project is to investigate gas production in decomposed individuals. While it is known that gas production is one of the effects of decomposition, little is known about the types and quantities of gases produced.

The project will evaluate whether the time of death can be deduced by analysing gas production alone and whether the particular gases re-present in the body or are produced post-mortem.

Dr Milne's and Dr Ong's second research project is to investigate the source of traumatic subarachnoid haemorrhage, which typically arises in the context of an assault. There is currently debate about whether the source is extracranial or whether this extracranial source is concomitant with an intracranial rupture.

Dr Luke Jardine (19 November 2007)

Dr Jardine's research project is to investigate any association between babies who have died of sudden infant death syndrome (SIDS) and babies whose names appear in the Healthy Hearing database as having abnormal hearing test results. The Healthy Hearing Database is a newborn screening program.

Maritime Safety Queensland (19 November 2007)

Maritime Safety Queensland (MSQ) is an agency of Queensland Transport and is established under the *Marine Safety Queensland Act 2003*. MSQ is responsible for developing strategies for marine safety and handling the investigation process into marine incidents, including those resulting in death.

Dr Yvonne Zurynski (17 June 2008)

Dr Zurynski is the Assistant Director of the Australian Paediatric Surveillance Unit (APSU) at the Children's Hospital in Westmead, Sydney. The APSU is conducting research on children aged 12 years or under who die in traffic accidents. Research aims to identify risk factors associated with child restraint use.

Dr Whitehall and Dr Yoga Kandasamy (17 June 2008)

Dr Whitehall is the Director of Neonatology at the Townsville Hospital and Associate Professor in the School of Public Health and Tropical Medicine at James Cook University. Dr Kandasamy is a neonatologist working under Dr Whitehall at the Townsville Hospital and a senior lecturer in the School of Public Health and Tropical Medicine at James Cook University.

Dr Whitehall and Dr Kandasamy's research project is to determine whether there is any difference in the epidemiology and demography of sudden infant deaths in North Queensland over the past ten years, compared to the findings of Dr Whitehall's earlier research over the period 1990-1998.

Queensland Health Forensic and Scientific Services Human Ethics Committee

The Registrar and the Deputy State Coroner's legal officer represent the Office of the State Coroner on the Forensic and Scientific Services Human Ethics Committee. The committee operates in accordance with the National Statement on Ethical Conduct in Human Research. The committee reviews and oversees:

- research
- non-diagnostic activities involving autopsies and autopsy material
- the use of confidential information obtained by QHFSS.

If approved by the committee, the state coroner's consent is then sought before a research project involving coronial cases, documents or samples can proceed.

During the reporting period, the state coroner approved a project examining the use of portable x-ray equipment on coronial cases at QHFSS. The purpose of the project is to establish optimal operating parameters for the equipment in order to facilitate more timely screening for projectiles and shrapnel in deceased persons at the scene of death.

Research projects

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

A summary of the current projects is set out below.

Investigating family concerns about internal autopsies

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

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

The state coroner was concerned that coroners might have difficulty reconciling obligations to families with their duty to ensure all relevant evidence is gathered. To help address this issue, the state coroner joined with a criminologist from the School of Justice Studies at Queensland University of Technology and the Chief Forensic Pathologist to investigate the ways in which coroners have handled the issue. The ARC has granted funding of \$225 000 over three years. The investigation aims to develop guidelines which will assist coroners to make autopsy orders that respect a family's concerns without jeopardising the coronial investigation.

The investigation is on track. Two peer reviewed articles have been published and draft guidelines developed.

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

Suicide accounts for more of the deaths reported to coroners than any other category of unnatural causes. In an effort to contribute to the prevention of these deaths the state coroner has joined with experts from the

Australian Institute of Suicide Research and Prevention and a number of other health and welfare agencies to investigate how contact with medical practitioners might affect outcomes.

The ARC has granted funding of \$391 000 over four years and some of the industry partners are also making cash contributions.

This study aims to:

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

For the first time in Australia, general practitioners, health professionals and the deceased's next-of-kin will be interviewed to determine the context surrounding the death, and the abilities of health professionals to identify warning signs and intervene prior to suicide.

Data collection finished in 2008. In total 277 suicide and 183 sudden death next-of-kin interviews were completed. A total of 213 suicide and 93 sudden death healthcare professional interviews were completed. Data analysis and interpretation will follow in 2009.

Inquests

Visit the Queensland Courts website www.courts.qld.gov.au to view the complete findings of inquests.

Deaths in custody

Nicola Jean WALKER

On 17 May 2005, Nola Walker was involved in a car crash. Ambulance officers examined Ms Walker and found no significant injuries but recommended she allow them to take her to hospital for observation and tests. She declined. Police officers took Ms Walker to the Cairns Police Station following a positive road side breath test. Ms Walker was there for about 90 minutes while the necessary paperwork was prepared and attempts were made to locate a friend to collect her. When an officer went to advise her that she could go, Ms Walker was found to be unconscious, without a pulse and not breathing. An ambulance was called but attempts to revive her failed.

The state coroner found that Ms Walker died of injuries sustained in the traffic accident and considered the adequacy of the response by ambulance officers and police. The following recommendations were made:

Recommendation 1 – Exchange of information between police and ambulance officers

The Queensland Police Service and the Queensland Ambulance Service consider ways of ensuring that information relevant to the health and safety of patients/prisoners is exchanged.

Recommendation 2 – Review of QPS training concerning intoxication

As part of its commitment to continuous improvement, the QPS review training materials and the Operational Procedures Manual in order to draw together and reinforce the medical issues associated with intoxicated and apparently intoxicated persons.

Samuel John MILLS

On 12 December 2004, Samuel John Mills was discovered hanging in the medical ward of the Lotus Glen Correctional Centre. He was 31 years of age but had struggled with schizophrenia and had accessed mental health services on numerous occasions. Mr Mills had criminal convictions relating mainly to vagrancy and dishonesty offences. At the time of his death, Mr Mills was on remand for a number of vagrancy and street type offences.

The state coroner considered that despite vigilant inquiry, the staff supervising Mr Mills had no basis to suspect that he was in imminent risk of self harming. He was also satisfied that staff responded appropriately when Mr Mills was discovered hanging and that there was nothing more they could have done to save his life. The state coroner made the following recommendations:

Recommendation 1 – Audit of paper files for at risk information

The Department of Corrective Services audit its hard copy files to ensure records of previous self harm attempts are added to the Integrated Offender Management System.

Recommendation 2 – Removal of hanging points

The State Government immediately make available sufficient funding to enable the removal of the exposed bars and other hanging points in all cells at the Lotus Glen Correctional Centre.

Recommendation 3 – Review of funding for Cairns forensic psychiatrist

Queensland Health review the funding it proposes to allocate to the new position of forensic psychiatrist Cairns with a view to increasing it to one full time equivalent.

Thomas Dion WAITE, Mieng HUYNH, James Henry JACOBS and James Michael GEAR

Thomas Dion WAITE

On 24 October 2003, 30 year old Thomas Waite was shot and killed by a police officer outside his home in Regents Park. He had suffered from mental illness for more than 10 years. Although for much of that time his illness was sufficiently controlled and enabled him to lead a relatively normal life in the months before his death Mr Waite exhibited severe symptoms that had caused him to come to the attention of police and local mental health services. Immediately prior to his death, Mr Waite was engaging in violent and bizarre behaviour. He was shot by a police officer when he lunged at the officer with a knife.

Mieng HUYNH

On 26 December 2003, Mieng Huynh, without warning or provocation, stabbed three people. Police were called and saw a man matching Mr Huynh's description a few blocks from where the earlier attacks had taken place. As police approached Mr Huynh attacked another person. The police officers attempted to disarm him with the use of OC spray. Mr Huynh regained his weapon and ignored repeated instructions to drop it. He was shot and died at the scene. At the time of his death Mr Huynh was an involuntary patient under the *Mental Health Act* but was residing in the community subject to certain conditions.

James Henry JACOBS

On 25 March 2005, two police officers responded to a complaint regarding a man causing a disturbance near the Gold Coast Hospital. As they approached Mr Jacobs and called on him to stop, he produced a knife from under his clothing and soon after was shot by one of the officers. Mr Jacobs had an extensive history of mental illness.

James GEAR

On 24 February 2006, neighbours of James Gear called police when they became concerned by his bizarre and threatening behaviour. When approached by police

in his backyard Mr Gear reacted in an aggressive and threatening manner. After a brief struggle he fled into his house. Shortly afterwards, three officers went into the house. Mr Gear ran at one with a knife and he was shot dead.

The state coroner found there was no basis on which to refer any of these matters to the Director of Public Prosecutions. The state coroner noted that each of the four men were long term sufferers of mental illness and were experiencing serious symptoms at the time of death. Their mental illness caused them to come into contact with police and led directly to their deaths. The state coroner considered the adequacy of mental health treatment received in the period leading up to the deaths, the mental health legislative regime and the police response. The State Coroner made the following recommendations:

Recommendation 1 – Standardised assessment instruments

The Director of Mental Health develop standardised processes and assessment tools that do not seek to replace clinical judgment but which introduce more objectivity into mental health assessments and address the tendency of mental health workers to give insufficient weight to relevant information other than that gathered from the patient during the assessment.

Recommendation 2 – Retention and auditing of assessment instruments

Mental health practitioners should be required to complete and retain the standardised documentation used to undertake mental health assessments and that compliance with these processes be audited as a quality measure.

Recommendation 3 – Review of assessment decisions

The processes should include mechanisms for supervision or overview so that whenever someone other than a psychiatrist decides not to order a psychiatric assessment following an examination pursuant to a Justices Examination Order; or not to admit as an inpatient following an examination pursuant to an Emergency Assessment Order; or to discharge a patient previously assessed as suffering from mental illness warranting involuntary treatment; that decision be reviewed by a psychiatrist as soon as possible.

Recommendation 4 – Criteria for involuntary treatment

Consideration be given to removing the risk of imminent harm criterion from the “treatment criteria” contained in the Mental Health Act so that an involuntary treatment order can be made whenever a person has a mental illness that requires immediate treatment and the illness has deprived the person of the capacity to consent to the treatment or the person has unreasonably refused treatment.

Recommendation 5 – Evaluation of treatment provided to Community Mental Health Service patients with dual diagnosis

As a matter of priority and on a regular and continuing basis, the Director of Mental Health undertake an evaluation of the impact of policies designed to more effectively respond to the needs of Community Mental Health Service patients with a dual diagnosis. This evaluation should clearly demonstrate whether the alcohol and drug abuse problem of Community Mental Health Service consumers is being appropriately managed.

Recommendation 6 – Evaluation of post release programs

As a matter of priority and on a regular and continuing basis, the Director of Mental Health undertake an evaluation of the impact of policies designed to more effectively link prisoners suffering from mental illness with Community Mental Health Service after their release from prison.

Recommendation 7 – Development of prescription drug screens

The Director of Mental Health engage the toxicologists at Queensland Forensic and Scientific Services to develop blood and urine tests for the drugs commonly prescribed for the management of schizophrenia.

Recommendation 8 – Protocol for medication compliance

The Director of Mental Health develop a standardised protocol to assist case managers more systemically address the issue of medication compliance. It should reflect the extensive literature on the issues involved. The protocol should have regard to the risks posed by patients failing to take medication and in appropriate cases provide for blood or urine testing.

Recommendation 9 – Dissemination of information concerning mental health patients in crisis to Queensland Police Service officers

Pending the development of a central data base able to provide access to information from all health services state wide, the statutory restrictions on the provision of information to the Queensland Police Service by Queensland Health concerning mental health patients in crisis be reviewed with the aim of enabling local Community Mental Health Services to provide police with information relevant to police interaction with such patients.

Recommendation 10 – Greater use of pre-crisis planning

Queensland Police Service district mental health intervention coordinators collaborate with local Community Mental Health Service officers and Queensland Ambulance Service officers to make greater use of pre-crisis planning, and in particular that consumers on forensic orders and involuntary treatment orders who are not undertaking in-patient treatment be encouraged to participate in such planning.

Recommendation 11 – Review of training regarding warning to shoot

The Queensland Police Service should review the training it provides to officers regarding their obligation to warn before using firearms.

Recommendation 12 – Blood testing of officers involved in a critical incident resulting in death

The Police Service Administration Act 1990 be amended to require police officers involved in critical incidents resulting in death to provide a specimen of blood for analysis as soon as reasonably practicable after the incident.

Recommendation 13 – Development of training in tactical withdrawal

The Queensland Police Service review the operational skills training provided to officers to ensure that tactical withdrawal is more likely to be used in appropriate cases.

Recommendation 14 – Development of a critical incident review policy

The Queensland Police Service develop a procedure for reviewing critical incidents whereby the appropriateness of the actions of its officers and its policies and procedures can be expeditiously considered and remedial action taken if necessary.

Recommendation 15 – Review of operational decision making capacity

The Queensland Police Service develop a process by which, whenever an officer is involved in an incident in which someone is shot, it can assess any resulting impairment of the officer's operational decision making capacity.

Recommendation 16 – Critical incident command training for first response officers

Critical incident command training should be extended to all operational police with particular emphasis given to general duty officers in operational positions.

Recommendation 17 – Continuing evaluation of taser use

The trial of tasers should continue and the evaluation by the Crime and Misconduct Commission should have regard to international experience in the use of these implements. When the results of the trial and the Crime and Misconduct Commission evaluation are made known the Queensland Police Service should review its policy in relation to the use of tasers.

Inquests of public interest

State Coroner

Lockhart River aircraft crash

On 7 May 2005, a Transair aircraft was travelling from Bamaga to Cairns via Lockhart River when it crashed into a hillside approximately 11 kilometres north-west of the Lockhart River aerodrome. All 15 occupants died.

The initial investigation into the cause of the accident was undertaken by the Australian Transport Safety Bureau (ATSB) in accordance with the provisions of the *Transport Safety Investigation Act 2003 (Cth)*.

The state coroner found that the crash was not caused by mechanical failure or malfunction. The state coroner was of the view that the crash would not have occurred if the pilots had followed accepted aviation procedures. He found that Transair failed to adequately monitor its pilots and ensure they were complying with its policies and that its safety management system and the performance of key personnel were sub-optimal. The state coroner also commented on the apparent lack of cooperation between the two federal agencies charged with overseeing the aviation industry: the ATSB and the Civil Aviation Safety Authority (CASA).

The state coroner made the following recommendations:

Recommendation 1 – Crew resource management training

CASA expedite the introduction of mandatory crew resource management training.

Recommendation 2 – Limit on multiple or conflicting roles

CASA consider creating firm guidelines that require consideration of workload, lines of authority, potential conflicts of interest and any other factors that impact upon the ability of “key personnel” to discharge their responsibilities within an aviation organisation when its officers are approving appointments to those positions.

Recommendation 3 – Regulation of training and checking

CASA reconsider the introduction of measures to ensure the efficiency of training and checking organisations for air transport operations. This should include the way in which particular training needs of an air operator’s flight crew are to be identified (including recurrent training and CRM training) and how those needs are to be met by approved or certified training and checking organisations.

Recommendation 4 – Ministerial assessment of interagency relations

The Federal Minister for Transport, consider engaging an external consultant to assess whether high level intervention is warranted.

Kevin Edward FOGARTY

Kevin Fogarty was an apparently fit and healthy 37 year old who worked for Ergon Energy. On 17 February 2005 he fell ill and was admitted to the Winton Hospital with a diagnosis of gastroenteritis. He died two days later.

On 9 February 2005 Mr Fogarty and a co-worker responded to two service calls on rural properties. While attending to these calls Mr Fogarty and his workmate became wet and almost certainly came into contact with mud created by a downpour. By 15 February, Mr Fogarty was extremely unwell. He was admitted to Winton Hospital on 17 February but continued to deteriorate until on 19 February it was decided to evacuate him

to Townsville for expert intensive care treatment. Mr Fogarty died before he could be transferred. He died from community acquired pneumonia as a result of a melioidosis infection which probably invaded his system following exposure to mud in the workplace.

The state coroner considered Ergon’s workplace health and safety practices and also the diagnosis and treatment of Mr Fogarty at the Winton Hospital and made the following recommendations.

Recommendation 1 – Workplace education risk of melioidosis

That Ergon Energy Ltd proactively educate their workers as to the risk of contracting melioidosis and other tropical diseases in the workplace and it review the information provided to workers in relation to these issue and give due consideration to how workers can be encouraged to actively engage with that information.

Recommendation 2 – Development of guidelines regarding medical intervention

If Queensland Health is to continue to operate hospitals that are not staffed by full time doctors it should develop guidelines that clearly identify intervention points that assist the nursing staff to know when a doctor’s assistance should be sought.

Recommendation 3 – Training and on-going advice for rural practitioners

That Queensland Health review Dr Lai’s privileges and credentials and the clinical networks that are intended to provide support to remote and rural practitioners to ascertain how doctors such as the practitioner involved in this case can be more effectively supported.

Deborah Denise BURGEM

Ms Burgen was a 49 year old woman who died on 28 February 2005 following treatment at the Mt Isa Base Hospital. The inquest heard evidence about the treatment of Ms Burgen both pre and post operatively; the competency of the treating team (which included overseas trained doctors); and the adequacy of the procedures and policies at the Mt Isa Base Hospital.

Ms Burgen was admitted following her sixth presentation to the hospital emergency department in 11 days. On each occasion Ms Burgen reported similar symptoms to five different doctors. On each visit some test or investigation was commenced but the results were not obtained, considered and acted upon. The state coroner considered there was an urgent need to implement emergency admission procedures at the hospital.

The state coroner considered the mechanism to register doctors on the basis of geographical area of need under the *Medical Practitioners Registration Act 2001*. Mt Isa was an area of need and some of the treating doctors were registered under the area of need regime. Because such registration does not depend on the doctor meeting the Australian Medical Council standards it is essential that the employer, in this case Queensland Health and the Medical Board ensure that the proposed registrant has appropriate qualifications and experience for the position. The state coroner was of the view that in relation to Dr Ashraf both organisations failed to do this. Sufficient checks of Dr Ashraf's ability to care for critically ill patients were not performed and he did not receive appropriate supervision or orientation. There was little scrutiny of his competence.

The state coroner was mindful of the fact that the level of services can not be the same in a remote area as in a tertiary hospital. However, he commented that this does not excuse a facility for holding itself out as able to deliver services that its practitioners are clearly not competent to perform. The state coroner considered the use of clinical networks, in particular, the ability of Townsville specialists to assist doctors at the Mt Isa hospital.

The state coroner referred the conduct of some of the treating doctors to the Medical Board on the basis that the Medical Board could reasonably conclude that their conduct amounted to unsatisfactory professional conduct. Dr Ross Gallery, Dr Frederick Rowland and Dr Naseem Ashraf were referred on this basis.

The state coroner made the following recommendations:

Recommendation 1 – Audit and accountability for quality processes

Mt Isa Hospital managers develop a system to ensure that the policies that were ignored in this case are periodically audited for compliance and that they implement a process that ensures that those who do not discharge their responsibilities under such policies are held accountable.

Recommendation 2 – Triage of emergency department patients

That the clinical managers of the hospital review the manner in which patients presenting to the emergency department are triaged to ensure that the failures of the pre-admission care exemplified by this case are eliminated.

Recommendation 3 – Tele-medicine

Queensland Health has for some time been investigating the establishment of video links to enable the practice of telemedicine in various remote locations. I understand the technology to enable this to happen in Mt Isa already exists. I recommend that that this be pursued as an urgent priority.

Ricky Glenn BLINCO and Michael Wayne LAST

Between 2 January 2005 and 16 January 2007, three men were killed in separate incidents at Black Duck Valley Four Wheel Drive and Motorbike Park (Black Duck Valley) at East Haldon near Gatton.

Michael Last died on 25 June 2005 while attempting a high speed, long distance motorcycle jump launched from a five metre high steel ramp. Ricky Blinco died on 16 January 2007 after he lost control of his Toyota Landcruiser while traversing a four wheel drive track.

The circumstances of these two deaths were investigated with a view to determining whether changes to the regulation of such facilities and/or changes to the way BDV is managed would reduce the likelihood of future deaths.

The state coroner made the following recommendations:

Recommendation 1 – Development applications from outdoor recreation facilities

That the Integrated Planning Act and/or Integrated Planning Regulation be amended so that local authorities dealing with development applications concerning outdoor recreation facilities are required to refer the application for assessment by the Department of Local Government, Sport and Recreation.

Recommendation 2 – Mandating sport and recreation group membership

That the Department of Local Government, Sport and Recreation stipulate continuing membership of the appropriate outdoor sports or recreation body as a condition of the application's approval. Alternatively, the department could stipulate compliance with the relevant Adventure Activity Standard as a pre-condition to approval of the application.

Recommendation 3 – Investigation by Workplace Health and Safety

That the Division of Workplace Health and safety review its determination that injury to members of the public at worksites such as Black Duck Valley is beyond its investigative jurisdiction. In the event that it is determined

that the division does have authority to intervene, I recommend that as a matter of urgency they undertake a full risk audit of Black Duck Valley and take appropriate action in relation to the findings of such an audit as provided for in the Act.

Recommendation 4 – Guidance to pathologists

That the chief forensic pathologist develop a guideline to assist pathologists undertaking coronial autopsies to identify those cases in which vitreous humour should be collected for toxicological analysis to assist in accurately determining whether the deceased person had consumed alcohol.

Ross Frederick IRWIN

On 22 April 2006, Ross Irwin, and two deckhands were trawling in fishing grounds about 35 nautical miles east of Noosa Heads when their nets snagged an unidentified object. The men started to haul the nets aboard to free the obstruction but before they could complete this task the boat rolled over and sank. Mr Irwin, an experienced mariner, was never seen again.

The state coroner referred to a previous inquest's recommendations concerning safety requirements for commercial trawlers. While acknowledging the steps taken by the Marine Safety Committee and Maritime Safety Queensland (MSQ) to implement these recommendations, the state coroner noted the resistance of the fishing industry and urged that a coercive approach to these safety issues be considered.

The state coroner also noted that there was no investigation by the government agencies charged with ensuring marine and workplace health and safety although those agencies do have an MOU relating to information sharing and providing for the agencies to work together on matters which may be both a marine incident and a workplace incident.

The state coroner made the following recommendations:

Recommendation 1 – Compliance with the NSCV

That compliance with the National Standard for Commercial Vessels be mandatory for all commercial fishing vessels to which it relates and that in particular, the elements concerning crew competencies and safety equipment be made operative immediately.

Recommendation 2 – Review of Workplace Health and Safety / MSQ MOU

That the Director of the Division of Workplace Health and Safety and the General Manager MSQ review the operation of the MOU in this case to consider whether changes are needed to encourage more collaboration in responding to incidents that appear to enliven the jurisdiction of both agencies.

Recommendation 3 – Review of failure of MSQ to investigate

That the General Manager MSQ review the policies governing the investigation of marine incidents to ensure that incidents involving serious injury and loss of life are properly investigated, and that issues arising from such investigations are responded to in the manner most likely to promote marine safety in Queensland.

Phillemon Edward MOSBY

Phillemon Mosby was a deckhand on the pilot vessel *Alert* owned by Torres Pilots which was used to transport a marine pilot to a merchant vessel on 27 October 2004. The pilot was transferred onto the merchant vessel without incident but while the pilot's luggage was being transferred via a heaving line, Mr Mosby disappeared.

Numerous experienced mariners gave evidence that it is unduly risky to move along the side of the pilot launch closest to the ship and the operator's written policies forbade it. However, this is exactly what Mr Mosby was frequently required to do when sending the pilots' luggage up onto the ship. The state coroner also considered it unlikely that Mr Mosby was wearing a floatation device when he fell over board.

Evidence was also given regarding the state of the *Alert*. It was inspected on 29 October 2004 and found to be unseaworthy. The inquest heard evidence that in May 2004 Mr Jimmy Richie had complained to MSQ that the *Alert* leaked and that the engine was a fire risk. No action was taken on this complaint. Training, safety and operations manuals were inadequate and there was a poor safety culture. The training of the crew was inadequate. Mr Mosby had been employed by the company prior to formal procedures and training requirements being developed. There was no evidence that Mr Mosby had received any training in safety, or other, procedures. The state coroner noted that many safety concerns had now been addressed by the company.

The inquest heard evidence about the role of the Australian Marine Pilots Association (AMSA) in overseeing pilotage standards in particular the Great Barrier Reef Safety Management Code (the Code) which annexes the Pilot Vessel Standard for Queensland Coastal Pilotage. The inquest also considered the investigation conducted by MSQ and Workplace Health and Safety (WH&S). Notwithstanding the existence of an MOU between MSQ and WH&S there was little cooperation between MSQ and WH&S and little investigation of the incident by either agency.

The state coroner made the following recommendations:

Recommendation 1 – Review of failure to action Richie complaint

*The General Manager MSQ establish why no action was taken in relation to Mr Richie's (a former master of the *Alert*) complaint with a view to ensuring there is no repeat of such failings.*

Recommendation 2 – Risk based targeting of monitoring activities

Having regard to the evidence put before this inquest there is in my view a sound basis to be concerned about the safety culture within Torres Pilots. I therefore recommend that this information and any future complaints be considered when MSQ monitoring activities are being targeted.

Recommendation 3 – Review of self declaration of seaworthiness

I am aware that self regulation is now the philosophical underpinning of many regulatory schemes. However, in view of the critical nature of the annual declaration that a commercial vessel is seaworthy, in a context where the regulator is unlikely to be able to regularly inspect all craft, I consider there is a basis for winding back this system with its inherent conflict of interest. I therefore recommend the General Manager MSQ review whether the Transport Operations (Marine Safety) Act should be amended to require an accredited marine surveyor to complete the certificate of seaworthiness on annual applications for renewal of registration of all commercial vessels.

Recommendation 4 – Guidelines for applying the Pilot Vessel Standard

The Principle Pilotage Officer, AMSA develop guidelines and explanatory notes to enable the pilotage industry to understand what is required for compliance with the Code.

Recommendation 5 – Review of WH&S / MSQ MOU

The Director of the Division of WH&S and the General Manager MSQ review the operation of the MOU in this case to consider whether changes are needed to encourage more collaboration in responding to incidents that appear to enliven the jurisdiction of both agencies.

Recommendation 6 – Failure to consider prosecution

The General Manager MSQ review the manner in which this marine incident was investigated to establish why no consideration seems to have been given to initiating prosecution under the Transport Operations (Marine Safety) Act.

Deputy State Coroner

Shannon Sheng Wen TANG

Shannon Tang was a 21 year old man who underwent a gastric bypass procedure to address a debilitating problem of obesity. Mr Tang resided in Singapore and travelled to Brisbane for the surgery to be performed by Dr George Fielding. According to the evidence Dr Fielding did not examine Mr Tang prior to the surgery assuming that this had been done by other staff. Mr Tang suffered from other co-morbidities and medical conditions. He died following surgery.

It was difficult to determine the cause of death. Following medical evidence the deputy state coroner concluded that the combination of both a respiratory condition and the subhepatic ulcer contributed to the overall condition of sepsis which led to multi organ failure and death.

Recommendations

- *That relevant specialist colleges and/or hospitals consider and review a requirement for face to face consultation between patient and surgeon and the appropriate minimum period prior to the proposed surgery for such consultation.*
- *That relevant hospitals and/or specialist colleges consider and review the level of specific information about risk of mortality in consent forms to be signed by a patient prior to treatment.*
- *If a surgeon is relying on an assessment being made by intensive care staff preoperatively of a patient's suitability for surgery, that the surgeon provide specific written communication of such request accompanied by the patient's relevant medical history to the intensive care staff.*

Nardia Annett CVITIC

Nardia Cvitic underwent a radical hysterectomy as part of her treatment for cervical cancer. The surgery was performed by Dr Bruce Ward on 11 February 2002. On 14 February 2002 Ms Cvitic collapsed after complaining of severe lower right abdominal pain. No blood tests had been performed in the interim under the advice of Dr Ward.

Ms Cvitic underwent numerous post-operative procedures to determine the cause of the collapse. Dr Ward with assistance performed an emergency laparotomy. The site of the bleeding was not able to be identified and Dr Ward considered other explanations for the cause of the collapse, primarily a pulmonary embolus. Dr Ward treated Ms Cvitic for pulmonary embolus and 10000 units of heparin were administered.

Other doctors attended and ruled out pulmonary embolus and cardiac tamponade and formed the view that the problem was post-operative bleeding. Dr Ward maintained the contention of pulmonary embolus and was reluctant to consider blood loss as the cause of the problem. The cardiac surgeon instructed the anaesthetist to give the patient more blood to try to make up blood volume. Dr Carmody (a general surgeon) had also been contacted to assist in theatre. Dr Carmody concluded that there was an unresolved bleeding problem and identified bleeding from a vein which had been punctured during the initial surgery. Despite all efforts, Ms Cvitic's condition continued to decline and she died on 22 February 2002. The cause of death was multi-organ failure due to multiple transfusions required for post operative bleeding due to bleeding disorder.

The death occurred before 1 December 2003 and the commencement of the *Coroners Act 2003*. The coronial investigation and inquest was conducted under the *Coroners Act 1958*. Under that Act, coroners had the power to commit a person to stand trial. The deputy state coroner was satisfied that a properly instructed jury could make a finding of guilt based on criminal negligence against Dr Bruce Ward for causing the death of Nardia Cvitic. Dr Ward was charged that between 11 February 2002 and 22 February 2002 at Brisbane in the State of Queensland he unlawfully killed Nardia Cvitic.

Arisa HUBER

Arisa Huber was born late in the afternoon on 16 August 2005 in the Mater Mother's Hospital. She died in hospital on 18 August 2005 after suffering a severe hypoxic episode while in bed with her mother.

The inquest heard evidence that Arisa's mother was exhausted following a long labour and a disturbed night in the postnatal ward. The evidence was clear that the baby had been placed with her mother in bed for breastfeeding but no specific warning was given by the nurse to the mother before the baby was placed with her. Mother and baby were in the mother's bed between 5.00am and 6.45am without any supervision.

The nurse was busy during the shift. Her evidence was that she was aware of the risks of SIDS but she was not specifically aware of the policy in place at the time about breastfeeding in bed. The policy required monitoring at 15 to 30 minute intervals and had not been complied with.

At 6.45am on 17 August, the baby was discovered to be not breathing and without a pulse. The baby was vigorously resuscitated and then required ventilation and intubation. The baby died on 18 August 2005.

Comments

The deputy state coroner added her support to the proposed review of the ratio of patients to staff where babies are counted as separate patients rather than being grouped with the mother as one patient.

The deputy state coroner noted that there was a need for audit and review processes to check that training in relation to policies, such as the breastfeeding in bed policy, is effectively delivered and translated into appropriate action on the wards.

The deputy state coroner noted that the practice of care pathways being documented with various prompts and guides has taken over from the previous practice of detailed chart notes. However, some extra cues may assist staff and family members. For example, 'cot cards' placed externally on cots reminding parents and staff of risk factors and best practice to promote the safest environment for the child. It would also be helpful to have an easy to use section in the care chart document where a staff member can record the time and physical location of the baby on each occasion of observation with the mother. This could also assist in promoting safety and reminding staff of the issue.

The deputy state coroner made lengthy comments regarding the need to balance the benefits of breastfeeding and safety concerns as outlined below. While acknowledging cultural and personal practices, there is a risk where mother or baby are asleep in the same bed but much is to be gained by breastfeeding in bed provided safety can be assured. Safety requires making an informed choice. Some factors must always be considered too risky for an infant to be in bed with an adult. These include where the parent is alcohol, drug or medication affected or exceedingly tired. Obesity in the parent can also create a risk. A parent who is a smoker has also been demonstrated to increase risk of death in the baby. The safest option appears to be the position adopted by the Mater Hospital which does not recommend co-sleeping but which supports breastfeeding, including in bed, where it is safe to do so.

It is important to promote and support the benefits of breastfeeding and skin to skin contact. At the same time, the safety of a child and reduction of the risks of accidental suffocation must be paramount. Hyper linking the policy documents for staff so that they associate and consider both the risks and benefits of the baby being in bed with the mother would be helpful.

Education of parents and all medical and nursing staff is of critical importance. The process must commence in the community before the child is born and be reinforced and physically demonstrated in hospital. Resources must be provided and maintained in the community sector to support and reinforce the education provided in hospital.

These resources must be available both antenatally and postnatally. They must be broadly accessible and inclusive of different cultures and languages.

Margaret Florence Anne BODELL

Margaret Bodell was admitted to the Redcliffe Hospital on 13 June 2006 due to breathlessness caused by severe lung disease. Mrs Bodell's lung condition was stabilised but it did not improve and the treating doctors formed the view that her condition was so serious that she would not benefit from intensive care or ventilation in the event of arrest. It was noted on Mrs Bodell's chart that 'not for resuscitation orders' should be discussed with the family and the inquest heard evidence from doctors involved in the treatment that they had discussed the seriousness of Mrs Bodell's condition with the family.

By 23 June 2006 it was suspected that Mrs Bodell was also suffering from a duodenal ulcer. She was treated appropriately with the medication Nexium. The treating doctors decided not to proceed with an endoscopy to examine and treat the ulcer because of the underlying respiratory disease. That decision was reviewed by independent experts and confirmed to be appropriate in the circumstances. Mrs Bodell died on 25 June 2006.

The death certificate for Mrs Bodell noted the cause of death as infective exacerbation of chronic obstructive airways disease. The death certificate was issued by a junior member of the treating team. Mrs Bodell's death was not reported to the coroner and she was buried. Mr Bodell provided sufficient information to raise doubts about the accuracy of the death certificate and a coronial order for exhumation was made together with an order for autopsy. The pathologist who performed the autopsy identified the cause of death as gastrointestinal haemorrhage from a duodenal ulcer. The underlying chronic obstructive airway disease (emphysema) and coronary atherosclerosis significantly contributed to her death.

The inquest considered the treatment provided to Mrs Bodell and the policies surrounding 'not for resuscitation orders'.

Comments

The deputy state coroner considered the treatment of patients with chronic obstructive airways disease where carbon dioxide retention due to inefficient exhalation has developed. The trigger for respiration can change from the level of carbon dioxide in the blood to the level of oxygen in the blood. When this has been identified it is important to monitor the level of oxygen supplementation to avoid too high a level of oxygen. Otherwise, respiratory arrest could be inadvertently triggered. The deputy state coroner found that this had not in fact occurred during Mrs Bodell's treatment.

The risk is that apparent respiratory distress can influence nursing staff to automatically respond by increasing the level of oxygen flow. Because of this risk if carbon dioxide retention has been identified, it is important that this information is clearly handed over at the end of each change of shift of medical and nursing staff. It is also important that prominent documentation is displayed at the oxygen outlet itself informing all staff of the need to maintain the current level of oxygen flow for the patient as ordered by the doctor.

The deputy state coroner noted that Redcliffe Hospital had initiated training on this issue and displayed information about the condition at the oxygen outlet point and recommended that it be considered across both Queensland Health and private health service facilities.

The deputy state coroner considered the issue of "not for resuscitation" recognising that while medical staff aim to successfully treat patients sometimes this is not possible and patients die while in hospital. While it is a difficult task for staff to raise this topic with a patient and their family, it is necessary for this to be done to properly inform a patient and family of treatment decisions. In Mrs Bodell's case, her condition had not improved much overall during her admission. Based on a sound review of her medical condition, a decision was made by the treating team that it was medically inappropriate (in the event of a cardiac or respiratory arrest) to transfer her to

the intensive care unit or to ventilate or intubate her. This plan was noted in the medical records.

The evidence indicated there was some variation amongst nursing staff as to what "not for resuscitation" meant. There was also a delay in discussing the issue with the patient and her family. The doctor who ventured to perform this difficult task does not appear to have been a primary member of the treating team. Mrs Bodell and Mr Bodell had difficulty in accepting the reality of the information and the doctor left the issue to be discussed again when appropriate. Events overtook a suitable opportunity and Mrs Bodell died before the treatment decisions could be discussed again. The family was to some extent unprepared for her death. Misunderstandings about whether or not Mrs Bodell had received proper and sufficient treatment arose in this context.

The deputy state coroner noted that since Mrs Bodell's death, Redcliffe Hospital had commenced developing protocols about 'not for resuscitation orders'. The coroner agreed with a report prepared by Professor Malcolm Fisher that an appropriate 'do not resuscitate' order must include the following:

1. the time and date of the discussion
2. the persons who participated in the discussion
3. the reasons that active treatment is not considered being the best option for the patient
4. what was agreed
5. what is to be withheld, what is to be discontinued or not commenced
6. when the decision is to be reviewed.

The deputy state coroner strongly recommended a full review of this issue with a view to developing uniform standards of practice and documentation across public and private hospitals.

The deputy state coroner next considered the completion of the death certificate noting the current practice in many hospitals that death certificates are completed by a junior member of the treating team. This can lead to inadvertent oversights and errors. The advent of the Health Quality and Complaints Commission and the establishment of a standard in reporting deaths should see an improvement in this area. While noting that Redcliffe Hospital has implemented changes to ensure a review of cause of death certificate by senior clinicians the deputy state coroner encouraged all hospitals to take on review of this documentation by senior clinicians.

The deputy state coroner noted that some hospital staff had very little awareness of their duty to report deaths to the coroner. She recommended that Queensland Health and medical and nursing courses consider ways of ensuring compliance with legislative requirements including possible standardisation of any forms to be completed when a patient dies in hospital and an online system prompting referral to the coroner in certain circumstances.

The deputy state coroner noted that inadequate staffing levels adds to the possibility of discontinuity in care and problems with communicating with families and also recommended a review of overnight and weekend hospital staffing levels.

Brisbane Coroner

Janet Louise YOUNG

Janet Louise Young died from multiple injuries as a result of a traffic accident in Collinsvale Street, Rocklea on 10 May 2006. She was 35 years old at the time.

The traffic accident involved a semi-trailer rolling over as it turned through a 90 degree bend in the road. The shipping container being transported on the trailer was loaded with bricks. The trailer rolled first causing the prime mover to follow. The container impacted heavily with the delivery van driven by Mrs Young.

Mechanical inspections revealed no defects. At the time of the incident, the truck was being driven by Mr Lawson who was transporting a load of bricks from Boral Brickworks at Darra to the SCL yard at Rocklea. An empty container would be loaded onto the trailer at SCL and then Mr Lawson would travel to Boral to collect a load of bricks. At Boral, the bricks were loaded into the container by Boral workers. Mr Lawson was not involved in the loading process and was not spoken to by his employer, SCL or Boral about the nature of the load or any safety precautions.

Boral maintained that the method of load restraint complied with the National Load Restraint Guide (LRG) but were unable to point to any documentation that confirmed that the method had been assessed as compliant. Contrary to Boral's view, Queensland Transport's Compliance Manager advised that the method for loading the bricks did not comply with the National LRG.

The speed limit in Collinsvale Street was 50 km per hour. That limit was not signed but applied as the default speed limit in a built-up area. There was no sign indicating a lower advisory speed at the 90 degree corner. At the time the prime mover was coming out of the bend it was travelling at about 49 km per hour.

The coroner found that in hindsight the roll over of the truck was avoidable. The crash would not have occurred with a slightly lower speed or lower centre of mass. A truck tilting sign or speed advisory sign may have warned the driver to reduce his speed. More instruction to the driver about the potentially high centre of mass may have induced a more precautionary speed. Evidence was also given about other trailer combinations which would have reduced the centre of mass.

The Brisbane coroner made the following recommendations:

Recommendation 1

That Queensland Transport incorporate information about driver responsibility for loads generally; and the risks of rollover at low speed for high centre of mass loads in any information and training it provides in relation to the new 'Chain of Responsibility' concepts to be introduced through legislation this year.

Recommendation 2

That Queensland Transport investigate the Electronic Stability Program systems and if it is regarded as suitable and viable take up with the industry and the National Transport Commission its more widespread use.

Recommendation 3

That the Brisbane City Council:

- *erect a truck tilting sign in Collinsvale Street within the next two months*
- *undertake a safety audit of Collinsvale Street to determine what else might be done to improve safety*
- *undertake a safety assessment of those locations within its jurisdiction that are set out in the Webcrash data.*

Recommendation 4

That the Department of Main Roads issue a directive to relevant staff to review the Webcrash database to identify locations where there has been a 'cluster' of accidents and then assess those locations (when they are within the Department of Main Roads jurisdiction) for possible safety improvements.

Coroner Tonkin

Frank Maurice WHITTINGTON

Frank Maurice Whittington suffered from chronic pain, having sustained back and neck injuries in a motor vehicle accident in 1991. On 11 September 2002, a Medtronic SynchroMed EL Implantable pump was implanted under the abdominal skin to deliver a measured dose of morphine sulphate through a catheter located under the skin. The patient must return regularly to the clinic to have the pump re-filled and re-programmed.

In February 2004 Mr Whittington suffered a fall following which he complained of increased pain. The pump was checked and the catheter was found to have disconnected. Mr Whittington underwent surgical replacement of the catheter on 24 February by Dr Rossato.

Following surgery, Dr Rossato and Registered Nurse Couper refilled and reprogrammed the pump. The dose to be injected into the pump was calculated by reference to a 'cheat sheet' (Postoperative Priming Bolus Calculation Worksheet) supplied by Medtronic, the pump manufacturer. The 'cheat sheet' contained no warning that it applied to new pumps only, or that allowance should be made for the presence of fluid in pumps already in use. Relying on the 'cheat sheet' an amount exceeding the dose necessary was given to Mr Whittington.

The coroner determined that the cause of death was a heart attack as a result of chronic heart failure. The coroner was not satisfied that the overdose of morphine contributed to the death and found that the doctor had reasonably relied on the manufacturer's instructions in determining the dosage.

The coroner made the following recommendation:

Recommendation 1

Section 5 of the Medtronic Manual entitled "Pump Implant: Critical Tasks and Procedures" should have added to it a warning that the procedure described for Calculation of the Postoperative Bolus Dose should be modified in the case of a previously primed pump to take account of the fact that the internal tubing volume of .26ml should not be added. A second Postoperative Priming bolus Calculation Worksheet should be developed that takes account of that, and it should be added to the References and Resources section of Section 5 of the Manual.

Coroner Springer

Patricia Dell NEWMAN

Mrs Newman was admitted to Rockhampton Base Hospital on 11 March 2006 and died in hospital on 29 March 2006. She was 73 years of age.

The day before Mrs Newman's admission she had been unwell and was vomiting. On the day of admission she was found by one of her daughters on the floor inside her home and was very unwell. Both Mrs Newman's daughters gave evidence that they visited her on a regular basis and that she appeared in good health. The family raised concerns about Mrs Newman's care in the Rockhampton Base Hospital and the information that they were given about their mother's diagnosis and prognosis.

The inquest heard medical evidence that Mrs Newman was suffering from acute renal failure and was very malnourished. The clinical evidence was that Mrs Newman's condition was of a long-standing chronic nature rather than something that had developed over the week prior to admission.

The coroner found that, although Mrs Newman presented to normal visual observation as someone who was not gravely ill, that presentation hid significant clinical findings showing the contrary. At the time of admission Mrs Newman was profoundly unwell, suffering from the effects of multi-organ failure over a period of weeks to months and, that condition was not properly understood or appreciated by her family.

The coroner found no evidence to suggest that Mrs Newman received anything but appropriate treatment and satisfactory care at the hospital. The coroner acknowledged that grave illness and probable imminent death of a beloved parent is very distressing and that patients and family members are often given information about a patient's prognosis and treatment options at a time when they are tired and stressed. The ability of health professionals to convey important information in an informative and empathetic way will vary between individuals. Consequently, the information being given by a health professional in some situations may not be properly understood. If that is the situation or the information is not conveyed clearly, it may create an added layer of stress and possible hostility between the people involved.

The coroner made the following recommendation:

Recommendation 1

While appreciating the workload of medical professionals Queensland Health should consider developing a brochure to be provided to family members at the time they are being given important information about the prognosis and treatment of a gravely ill family member. The brochure could set out how family members might obtain additional or clearer information about treatment of their ill or injured family member with relevant contact numbers provided.

Coroner Brassington

Allan Thomas WIGG

Allan Wigg was employed as a banana bagger by Michael and Moeris Grima. On 3 December 2004 Mr Wigg died after being pinned underneath a banana bagging machine. A banana bagging machine is an elevating work platform allowing workers to travel between banana trees and elevate themselves to banana bunches without leaving the machine. The machine is controlled by an operator who stands in a basket on a platform at the end of a boom.

The bagging machine had been purchased from Mr Grant of Grant's Mobile Workshop in 1999. The machine had a number of modifications which had not been performed or authorised by Mr Grant.

The parking brake was removed, a new materials basket welded to the operator's basket, hydraulic hoses placed externally on the machine rather than internally within the boom, new boom support post welded to the turntable and additional gussets and plates welded to the boom and new pins and welds holding the pins. Mr Grima gave evidence that he always used appropriately qualified tradesmen for machine maintenance. Mr Grima had given Mr Wigg instruction about how to operate the machine. At the time there was no certification required to operate the machine.

The Coroner found that the evidence supported the conclusion that as Mr. Wigg was driving the machine along the track, the rear levelling support pin fell out because of the failure of the welds intended to secure it, causing the work platform to collapse, ejecting the operator. The banana bagging machine continued to move forward inflicting grievous injuries on Mr. Wigg until its path was stopped by a tree.

The coroner noted that the investigating police officer having satisfied himself that there were no suspicious circumstances essentially handed the investigation over to the Office of Workplace Health and Safety Queensland (OWHS) and took no further part in the investigation. The coroner raised concerns that the OWHS investigation focussed on whether there had been any breaches of

Workplace Health and Safety regulations and did not investigate matters that would be of concern to coroners. There was a need for better liaison between investigatory bodies in these situations.

The coroner also noted that once OWHS decided that there would be no prosecution the OWHS officers returned the bagging machine to the owner without consulting with the coroner. This made examination of the machine by another expert more difficult and continuity of the evidence was lost.

The coroner made the following recommendations:

Recommendation 1

That the OWHS facilitate the development and usage of a harness for operators of banana bagging machines in Queensland.

Recommendation 2

That there is an urgent need for inspection of current machinery or an alert issued to ensure all banana bagging machines are checked by a competent person and modifications, particularly to the joints securing of the working platform, checked.

Recommendation 3

Given evidence of significant modification to the machine without reference to the original designer, a clear warning or requirement that the manufacturer be notified of changes to design should be included in the manual supplied.

Recommendation 4

That the OWHS consider the development of a system to include systemic, regular inspection of high risk farm machinery to ensure compliance with Australian Standards.

Recommendation 5

That the relevant department consider an alert noting both the security and integrity of levelling rods for elevating work platforms is most critical to the safety of the operator and they should be designed and maintained in a professional manner.

Recommendation 6

That the OWHS ensure that investigators have access to, and coroners are routinely supplied with, information as to the statistical frequency of similar incidents to those being investigated.

Recommendation 7

That OWHS investigators adopt a similar process to other agencies (including the Queensland Police Service) to apply to the coroner for an indication that an exhibit is no longer required before returning the exhibit. Section 59 and 60 of the Coroners Act 2003 apply to physical evidence seized by the police officer for the investigation and require the coroner to return the evidence to the lawful owner as soon as no longer required for the investigation.

Coroner Black

Kenneth MAGGABLE

Kenneth Maggable died on 9 August 2005 at the age of 70 years. In the preceding 24 hours he had twice presented at the Cairns Base Hospital on the recommendation of his doctor. Following his second presentation on 9 August 2005 Mr Maggable was discharged to go home with his wife at 4.50am. He died at home at 6.25am. The fact that Mr Maggable passed away so shortly after discharge from the hospital raised concerns about the quality of care provided by the Cairns Base Hospital.

The autopsy established the cause of death as acute coronary occlusion due to or as a consequence of extensive coronary atherosclerosis. Chronic obstructive pulmonary disease and prostate cancer also contributed to the death.

The inquest considered whether the decision to discharge was based on an adequate clinical examination of the patient and in accordance with hospital procedures. This was made difficult given that the medical record was unclear. However, the coroner accepted that continued oxygen therapy in hospital would not have postponed death in such an unwell patient. The decision to discharge was made by Dr Tan, an intern. Hospital procedures required such decisions to be approved by a senior medical officer. While Dr Tan had no independent recollection of his decision to discharge he advised that his normal practice was to consult with a senior medical officer. Unfortunately the medical record did not reflect this. The evidence was that Mr Maggable also wished to be discharged. The inquest heard evidence that the Emergency Department was understaffed at the time but that staffing had been increased since Mr Maggable's death.

The coroner made the following recommendations:

Recommendation 1

That, as a matter of urgency, the Regional Health Authority, in conjunction with Queensland Health, review or (if appropriate) develop and implement procedures for the auditing of interns in their clinical record keeping practices and procedures. The time of such consultation ought to be a matter of some substance to be included in the clinical record.

Recommendation 2

That Queensland Health undertake a feasibility study into the implementation of an integrated, electronic, computerised, patient information system, incorporating clinical notes, treatment plans and discharge summaries, allowing for access to patient data across the Cairns Health Service District, at least.

Coroner Glasgow

Christina Mae WATSON

Christina married David Watson on 11 October 2003 at home in the United States. They honeymooned in Australia and on 21 October 2003 they went on a dive trip organised by Mike Ball Dive Expeditions Pty Limited (the dive company).

Although Mr Watson was an experienced diver Mrs Watson was not. Once on board the dive vessel *Spoilsport* dive company staff obtained details about the diver's experience and briefings were provided on the operation of the *Spoilsport* and safety requirements. Mr and Mrs Watson commenced a dive. Mrs Watson died during the course of the dive. The initial police report noted that at a depth of 45 feet the deceased signalled to her husband that she wanted to surface, they both began swimming against the current towards the dive vessel; the deceased became fatigued so her husband began towing her. The deceased panicked and grabbed her husband's dive regulator, he looked into her eyes and saw her eyes were wide open but there was no response. The deceased then sank to the sea floor.

The inquest heard that the dive company had been prosecuted for breaches of the *Workplace Health and Safety Act 1995* for failure to comply with its own procedures as set out in its manual. The coroner accepted evidence of the dive company's representatives that training procedures were immediately reviewed following the death and steps taken to ensure that the company's procedures are maintained and followed at all times.

The inquest heard that investigators formed the view that some of Mr Watson's explanations lacked credibility. The coroner noted many inconsistencies in Mr Watson's oral and written statements and also a possible motive for murdering Mrs Watson arising from Mr Watson's request that Mrs Watson increase her life insurance and make Mr Watson the beneficiary.

Because the death occurred before 1 December 2003 when the *Coroners Act 2003* commenced, the investigation and inquest were conducted under the *Coroners Act 1958*. Under that Act, coroners had the power to commit a person to stand trial. The coroner was satisfied there was evidence of sufficient reliability, when viewed in the context of all of the evidence, on which a properly instructed jury could make a finding of guilt against David Gabriel Watson on a charge of murder. A warrant was issued for Mr Watson's arrest.

Appendix 1

Operating expenses 2007/08

Employee related expenses	\$1,470,548.00
Supplies and services	\$644,257.00
Burials and cremations	\$742,723.00
Conveyances	\$1,119,596.00
Autopsies	\$775,644.00
Private counsel fees	\$288,305.00
Crown law fees	\$245,129.00
Travel expenses	\$85,321.00
Conferences	\$1,677.00
	\$5,373,200.00
Burials assistance contributions recovered	\$289,936.00

Appendix 2

Number of coronial cases lodged and finalised in the 2007-08 financial year and the number of cases pending as at 30 June 2008

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
Atherton	11	-	15	15	-	-	-	-
Beenleigh	198	1	203	204	116	23	11	150
Bowen	16	-	18	18	-	1	-	1
Brisbane	1,149	12	1,238	1,250	435	80	40	555
Bundaberg	77	-	81	81	53	13	6	72
Caboolture	96	-	97	97	37	2	3	42
Cairns	304	2	212	214	281	70	16	367
Caloundra	50	1	55	56	21	1	1	23
Charleville	10	-	13	13	4	1	3	8
Cloncurry	-	1	-	1	-	-	-	-
Cunnamulla	4	1	2	3	3	2	-	5
Dalby	24	2	22	24	19	3	1	23
Emerald	42	-	25	25	33	5	1	39
Gayndah	5	-	6	6	4	-	-	4
Gladstone	46	-	49	49	21	3	-	24
Gympie	31	3	40	43	15	-	1	16
Hervey Bay	25	-	29	29	9	1	3	13
Innisfail	16	2	28	30	3	3	2	8
Ipswich	119	4	111	115	61	16	5	82
Kingaroy	22	-	13	13	17	-	1	18
Mackay	85	-	80	80	34	6	3	43
Mareeba	10	1	6	7	-	-	1	1
Maroochydore	137	3	120	123	58	7	4	69
Maryborough	35	1	24	25	21	-	1	22
Mitchell	-	-	-	-	-	-	2	2
Mossman	6	-	6	6	-	-	-	-
Mount Isa	9	-	23	23	-	-	5	5
Murgon	4	-	6	6	-	3	2	5

Appendix 2 continued

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
Nanango	-	-	1	1	-	-	-	-
Oakey	-	1	-	1	-	-	-	-
Proserpine	11	-	24	24	2	1	-	3
Redcliffe	46	-	40	40	17	2	2	21
Rockhampton	126	3	119	122	48	15	7	70
Roma	3	-	7	7	-	1	-	1
Southport	388	2	507	509	166	34	25	225
State Coroner	64	31	57	88	31	30	57	118
Toogoolawah	1	1	2	3	1	-	1	2
Toowoomba	135	-	95	95	77	14	1	92
Townsville	163	4	170	174	2	4	2	8
Warwick	46	-	36	36	18	3	-	21
Total	3,514	76	3,580	3,656	1,607	344	207	2,158

Source: Queensland Wide Interlinked Courts (QWIC) system and 2007-08 manual survey for the Report on Government Services (RoGS)

Appendix 3

Presentations 2007 – 2008

State Coroner

Medico Legal Society of Queensland annual conference, *“The coroners role in referring the conduct of medical practitioners to the Medical Board”*, August 2007

Queensland Health Medical Superintendent’s Forum, *“Operational issues that ease the interaction with the coroner”*, September 2007-09-17

RB&WH, *“Working with the coroner to improve patient safety”*, September 2007

TPCH, *“Coronial investigation of adverse events”*, September 2007

QEII Hospital Ground Rounds, *“The role of the state coroner in investigating adverse events resulting in death”*, September 2007

Asia Pacific Coroners Society annual conference, *“Developments in QPS pursuit driving policy”*, November 2007

Beach Safety and the Law National Summit, *“The role of the coroner in beach safety”*, November 2007

University of Queensland Medical School, *“Why are coroners’ autopsies unique?”*, January 2008

Department of Emergency Services command and control seminar *“The role of the state coroner in a mass disaster”* February 2008

QUT LWN151 Health Law. *“The state’s supervision of death”*, May 2008

Deputy State Coroner

The deputy state coroner made several presentations to major teaching hospitals in the Brisbane area through this reporting period.

Brisbane Coroner

Cairns Base Hospital, 10 March 2008

Yarrabah Health Service, 13 March 2008

Townsville Base Hospital, 18 March 2008

Northern Coroner

Queensland Police Service, Cairns District

Queensland Police Service, Innisfail District

Queensland Police Service, Mareeba District (Senior Officers)

Queensland Police Service, Townsville Police

Queensland Police Service, Townsville Academy

Townsville General Hospital

Townsville Nurses



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