



**QUEENSLAND
MAGISTRATES COURT**

Office of the State Coroner

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30 November 2009

The Honourable Cameron Dick MP
Attorney-General and Minister for Industrial Relations
State Law Building
Brisbane Qld 4000

Dear Attorney

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

I advise that the report contains a summary of the investigation into each death in custody finalised during the period in accordance with section 77(2)(b) of the Act.

In accordance with section 77(2) the guidelines I have issued pursuant to section 14 of the Act can be accessed on the Queensland Courts website. I have not issued any directions under section 14 of the Act.

Yours sincerely

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

Michael Barnes
State Coroner



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State Coroner's overview



Michael Barnes
State Coroner

The increased specialisation of the coronial system has continued this year with two further full time coroners appointed in 2008. The appointment of the Brisbane Coroner to assist the Deputy State Coroner handle all matters in the greater metropolitan area, Caboolture and Redcliffe, and the appointment of the Southern Coroner to investigate all reportable deaths from Beenleigh and the Gold Coast, bring the number of magistrates now devoting all of their time to coronial matters to five. As a result, 70 per cent of the 3745 deaths reported during the year were dealt with by a full time coroner with the remaining 30 per cent reported to magistrate coroners in the other parts of the state who attend to coronial matters when court commitments permit.

During the year the full time coroners increased their reliance on in-house legal officers for inquest appearance and advice work. Not only is this more cost effective than briefing Crown Law or private counsel, it also enables matters to be case managed more intensively by lawyers with specialised skills and experience in the jurisdiction.

Increased specialisation has also been achieved with respect to the undertaking of

autopsies. With the assistance of the chief forensic pathologist and the cooperation of the government medical officers around the state, all internal autopsies shall henceforth be undertaken by fully qualified specialist pathologists. In the past, many internal autopsies were undertaken by general practitioners (GPs)/government medical officers (GMOs)—an unfair impost on those hardworking medical practitioners who were not formally trained in the necessary procedures. As a result of Queensland Health employing more full time forensic pathologists and coroners more carefully considering the extent of the post mortem examination necessary in every case, it has been increasingly feasible to avoid the inappropriate practices of the past. The expertise of GPs/GMOs in examining external injuries well equips them to undertake external autopsies which can render internal examinations nugatory in a significant number of cases. This avoids unnecessary distress for families, reduces the risk of needle stick type injuries to pathologists and mortuary technicians and saves money. When internal autopsies are necessary, the reports of specialist forensic pathologists can with confidence be relied upon.

Australia's first custom built coronial case management system (CCMS) will become operational on 1 July 2009 after two years of development by the Department of Justice and Attorney-General (JAG)'s Information Technology Services. The ease of its use and its capacity to interface with the National Coroner's Information System is a testament to

the skill and dedication of all involved in the project. Coroners from two other states have already expressed interest in adopting the system.

I also wish to acknowledge the significant improvement in the time taken by Queensland Health Forensic and Scientific Services to provide autopsy and toxicology reports. In the past, the average time lag was six to twelve months. This year, extra staff and new equipment have seen report times slashed. On average, 61.57 per cent of autopsy reports were provided within four months of the death being reported. 46.37 per cent were provided within 90 days.

After five years it was appropriate to review the operation of the *Coroners Act 2003* (the Act). While the general policy underpinnings of the legislation have undoubtedly delivered better service to bereaved families and the community generally, numerous operational anomalies that could only become apparent after the new regime was put into practice required addressing. The officers of JAG's Strategic Policy and Legislation Branch expertly managed the consultation process to ensure the views of the numerous disciplines and industry groups that intersect with the coronial system were taken into account. They also undertook wide ranging research into the legislation in other jurisdictions to assist generate remedial options. Their application and professionalism undoubtedly contributed to the development of a constructive and innovative amending Bill.

A prime objective of the Act is the prevention of avoidable death through the making of recommendations designed to improve public health and safety and the administration of justice. In 2008 Queensland coroners made 170 such recommendations directed at 183 state government departments or agencies. The agencies' responses were tabled in parliament in August 2009.

In his report of the Commission of Inquiry into Queensland Public Hospitals the Honourable Geoffrey Davies AO recognised the challenges investigating medical deaths create for coroners. Accordingly, he recommended a dedicated medical officer be appointed to the Office of the State Coroner to assist determine whether each medical death requires further investigation and a panel of different medical specialists be retained to consult during ongoing investigations as necessary. These recommendations have not been actioned and the difficulties which prompted them continue. I do however acknowledge the great assistance provided to coroners by the medical practitioners of the Clinical Forensic Medicine Unit. These doctors are available daily to review hospitals charts and to provide timely reports to coroners about investigative strategies.

A coroner's work is essentially interdisciplinary: he or she is dependent upon investigators, pathologists, counsellors and medical and other specialists to provide the information needed to make the findings and preventative recommendations. In this regard I gratefully acknowledge the tremendous support given to me and my colleagues by the members of the Queensland Police Service, and the pathologists, toxicologists, forensic scientists and counsellors of Queensland Health Forensic and Scientific Services.

In conclusion, I express my gratitude to and admiration of the staff of the Office of the State Coroner, the two regional coroner's registries and the coroner's clerks in magistrates court registries around the state. The volume, intensity and the often distressing nature of their work far exceeds that usually expected of administrative staff members. I acknowledge the fine leadership of the administrative staff by Ms Brigita White. I pay tribute to the work of my colleagues, the magistrate coroners around the state, and the full-time coroners in Brisbane, Southport and Cairns. I am particularly grateful for the support and assistance provided to me by the Deputy State Coroner, Ms Christine Clements.

Our people

Registrar's report

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

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

At the end of the reporting period, there were 30 officers employed by OSC. Of these, 22 were based in Brisbane, four in the Northern

Coroner's office in Cairns and four in the Southern Coroner's office in Southport.

Growth of the Office of the State Coroner

A full-time Southern Coroner was appointed in August 2008. This appointment followed the appointment of an additional full-time Brisbane Coroner in January 2008 and the appointment of a full-time Northern Coroner in March 2008.

The Southern Coroner is responsible for investigating deaths reported in the Logan–Beenleigh–Gold Coast region. This is an area of high growth and high demand for coronial services.

The Southern Coroner, Mr John Hutton, was appointed through a reallocation of existing resources in the region by the Chief Magistrate. The Southern Coroner is supported by a lawyer and three administrative officers. These positions were also funded by reallocating existing resources.

The appointment of the Southern Coroner and his support team has made an appreciable impact on the processing of deaths reported in the southern region.

From 1 July 2008 to 30 June 2009, 547 deaths were reported to the Southern Coroner and 567 coronial investigations were finalised. This represents a clearance rate of 104 per cent for the period.

The Southern Coroner has developed productive working relationships with local coronial partners, including police and hospitals, contributing to the efficiency of the coronial system.

Initially, the coronial support team of the Southern Coroner was located within the general registry area on the ground floor of the Southport courthouse, while the coroner's chambers are located on the third floor. In June 2009, the office was relocated to refurbished offices on the third floor. This co-location with the Southern Coroner has enabled close interaction between the team and the coroner, maximising the efficiency and timeliness of coronial processes.

Construction of new accommodation for the Northern Coroner's office will commence in the 2009–2010 reporting period.

Courts where deaths are reported

The State Coroner, in consultation with the Chief Magistrate and the local magistrates in Caboolture and Redcliffe, decided that deaths in these areas are to be reported to and investigated by the Deputy State Coroner and Brisbane Coroner. This arrangement took effect from 1 August 2008 and has relieved these busy registries of a combined total of 150 coronial matters per annum.

The Deputy State Coroner and Brisbane Coroner are now responsible for investigating

deaths in the Greater Brisbane area covering Caboolture south to Rochedale and west to Inala.

The Southern Coroner is responsible for investigating deaths in the area covering Rochedale South to the border of New South Wales, Beenleigh and Logan.

The Northern Coroner is responsible for investigating deaths in the area from Thursday Island to Proserpine, north to the Papua New Guinea border and west to the Mount Isa district.

Deaths in the remaining regions of Queensland are reported to local coroners at the following Magistrate Court registries.

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

In-house counsel assisting at inquests

Coroners are assisted by counsel assisting during an inquest. Outside Brisbane, police prosecutors often perform this role. In 2008–09, the Queensland Police Service Police Prosecution Corp assisted local coroners in 20 inquests around the state. Their contribution to the coronial process is greatly appreciated.

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

To minimise the costs of briefing counsel assisting, OSC conducted a trial of an in-house counsel assisting position at the SO₁ level. Ms Julie Wilson was appointed to the role on 12 June 2007.

During the reporting period Ms Wilson appeared as counsel assisting in the following inquests:

- Batten, Tunstead, Tunstead—assisting the State Coroner in Townsville
- Dominic Raphael Doheny—assisting the Brisbane Coroner in Brisbane
- Amanda Renee Bertram—assisting the Brisbane Coroner in Brisbane
- Steven David Beaumont—assisting the State Coroner in Brisbane
- Jillian Peta McKenzie—assisting Coroner Comans in Cairns
- Oliver Steven McVey—assisting the Deputy State Coroner in Brisbane
- John Ernest Venturato—assisting Coroner Brassington in Innisfail

This position became vacant on 3 October 2008. The OSC registrar is consulting with the

State Coroner, the Deputy State Coroner and the other full-time coroners to determine their continued support for the concept of in-house counsel. It is considered the position has not been trialled long enough to properly assess its success in reducing the legal costs associated with inquests.

Each of the full-time coroners is assisted by a legal officer. These legal officers are increasingly performing the role of counsel assisting. This is developing the skills of these officers as well as assisting to reduce inquest costs.

Legal officers acted as counsel assisting in the following inquests during the reporting period:

Mr Peter Johns, senior lawyer to the State Coroner

- Allan Duncan Lee-Chue
- Stephen James Broe
- Clay Hatch
- Amanda Lee Hirning
- Tony John Stanford
- Ronald Thomas Oram
- James Davy

Ms Eryn Voevodin, lawyer to the Deputy State Coroner

- Liam Matthew Benson
- A deceased prisoner

Ms Dionne Franklin, lawyer to the Southern Coroner

- Sridhar Shekar

Mr Peter Edson, lawyer to the Northern Coroner

- Mount Garnett motor vehicle accident
- Albert William O’Keefe
- Sharon Faye Congoo

Ms Alana Martens, lawyer to the Brisbane Coroner

- Annette Lee Spencer
- Edward Alexander McBride

Managing the provision of coronial autopsy and government undertaking services

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 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.

The contracts are worth approximately \$2.4m annually. The current contracts expire in November 2010. OSC will oversee a significant procurement tender process during the 2009–10 financial year to ensure that new contracts are in place when the current contracts expire. OSC has held an initial planning meeting with Tactical Procurement, Shared Service Agency and is in the process of costing the tender process (including funding for a tactical procurement officer) and developing the

Significant Procurement Plan and Risk Assessment documentation.

The transportation of bodies for the purpose of autopsy is necessitated by the *Coroners Act 2003* which mandates an autopsy for deaths being investigated by the coroner (s. 19(2)). There is an exception for cases where the coroner decides to stop investigating because, although the death is reportable, the cause of death is known and the coroner is able to make their findings without the benefit of an autopsy. This often occurs for hospital related deaths which have been reported directly by medical practitioners using form 1A. In these cases, because no autopsy is required, the body can be collected directly from the hospital mortuary. The State Coroner encourages medical practitioners and coroners to use form 1A process where appropriate.

For those cases where a coroner is required to order an autopsy the coroner may order an internal or external autopsy. Autopsies are performed by forensic pathologists, pathologists or government medical officers (GMOs) who are credentialed to perform autopsies. As a general rule external autopsies are able to be performed by GMOs but internal autopsies are performed by pathologists. Under the State Coroner’s guidelines, the more complex autopsies (for example multiple deaths, suspicious deaths, child deaths, deaths during child birth and deaths in custody) are required to be conducted by a forensic pathologist. Forensic pathologists are only located at Brisbane, the Gold Coast, Nambour, Rockhampton, Townsville and Cairns. Specialist pathologists who can perform other less complex internal autopsies

are additionally located in Mackay, Toowoomba and Bundaberg.

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

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

From 25 August 2008, the governance responsibility for GMOs credentialed to undertake coronial autopsies was transferred from the Clinical Forensic Medical Unit (CFMU) to QHFSS.

On 14 April 2009, QHFSS appointed an additional forensic pathologist, Dr Dianne Little, located on the Gold Coast. Dr Little has provided valuable assistance to the Southern Coroner especially in the investigation of medical deaths.

Coroners Case Management System

The Coroners Case Management System (CCMS) is a purpose built case management

system for coronial matters which commences operation on 1 July 2009. CCMS has been developed by JAG ITS following extensive consultation with court staff involved in coronial matters.

CCMS is designed to improve the management of coronial files, to provide more accurate information about deaths reported to coroners and to interface with the National Coroners Information System (NCIS), a national database of coronial information. CCMS interfaces directly with NCIS and will therefore ensure that more up to date information about deaths in Queensland is available to inform coronial investigations, research and policy development.

CCMS will assist coroners to manage coronial files and ensure compliance with statutory requirements. Users will be able to generate forms and template letters using data entered into CCMS and will also be able to save received documents against the electronic file. This will streamline file management procedures, reduce double data entry and reduce the need to refer to the hardcopy file. CCMS interfaces seamlessly with JAG's electronic document management system ensuring that documents are stored in accordance with current legislative requirements for document management.

CCMS is designed to be a user friendly database. During March and April 2009, a two day training session was delivered by the Courts Capability Development Unit to 61 staff from 21 registries over a period of six weeks. Feedback from the training has been very positive.

Under the *Coroners Act 2003* (the Act), the State Coroner must keep a register of deaths investigated under the Act. The register must include details about the death including any findings made. The Queensland-wide Interlinked Courts (QWIC) system is the current register of deaths. From 1 July 2009 CCMS will replace QWIC as the register of deaths. All matters pending as at 1 July 2009 will be migrated to CCMS. QWIC will continue to record details of deaths finalised prior to 1 July 2009.

Communication, stakeholder relations and business improvement initiatives

On 30 July 2008, OSC held a workshop with coroners, staff and the Queensland Health coronial counsellors to discuss strategies to improve our communication with families during coronial investigations. The Northern Coroner's Office participated by video link. Issues discussed included:

- more timely identification of families who might benefit from coronial counselling support
- improved communication with the coronial counsellors about the progress of coronial investigations
- more systematic communication by OSC with families during coronial investigations
- the need to develop a more comprehensive inquest booklet

- supporting families' attendance at inquests through the reservation of seating in the courtroom, an interview room for the family and the attendance of coronial counsellors during the hearing (if required).

OSC has implemented changes to ensure families are kept better informed about the progress of coronial investigations through a process of periodic communication with investigation updates. Families are also better supported as matters progress to inquest through more proactive and early identification of families needing support from the coronial counsellors. These changes include the development of new and revised template letters. These template letters will be automatically generated through CCMS.

The OSC registrar, in consultation with the chief forensic pathologist, has implemented a process by which OSC will provide a monthly report on outstanding autopsy and toxicology reports for regular review by QHFSS. This process has already resulted in a significant reduction in the number of reports outstanding for eight months or more and has enabled QHFSS to better identify reasons for delay. The feedback provided by QHFSS through this process has enabled OSC staff to be more responsive to queries from families about the status of current investigations.

OSC staff attended an information session provided by the Health Quality and Complaints Commission (HQCC) on 29 October 2008. The session included presentations about HQCC's health quality and health service complaints assessment, investigation and conciliation functions and the outcomes of its review of

implementation of the death review standard for Queensland hospitals.

Coroners and Other Acts Amendment Bill 2008

OSC assisted the State Coroner in providing input into the development of operational amendments to the *Coroners Act 2003* during the reporting period.

On 23 April 2009, the Attorney-General introduced the *Coroners and Other Acts Amendment Bill 2008* into parliament.

The proposed amendments are primarily for the purpose of clarification, or procedural or technical in nature, and do not involve a shift in the fundamental policy underpinning the legislation.

The amendments include:

- amendments to clarify the scope and operation of the categories of reportable deaths in particular the reporting of ‘health care related deaths’ (replacing the current category of ‘deaths that were not reasonably expected to be the outcome of a health procedure’) and inserting a comprehensive definition of a ‘health care related death’
- amendments to the definition of ‘death in care’ in relation to children in care to capture all ‘out of home’ placements
- amendments to impose a duty to report deaths on those who provide residential services to people with a disability. The duty applies even if the death did not

occur at the care facility and has been or may have been reported by someone else

- amendments to the definition of ‘death in custody’ to include deaths in detention under all state and Commonwealth legislation (with limited exceptions)
- establishment of a new category of reportable death for deaths that ‘happened in the course of, or as a result of ‘police operations’ which must be reported to the State Coroner or Deputy State Coroner
- implementation of a model ‘aid to coroner’ provision agreed to by the Standing Committee of Attorneys-General to facilitate cross-jurisdictional assistance between coroners
- provision for review of decisions as to whether a death is reportable and clarification of the coroner’s powers in the preliminary investigation phase to determine whether a death is a reportable death
- amendments to clarify and improve investigation and pre-inquest conference processes and to facilitate the reopening of investigations and inquests
- amendments to facilitate access to investigation documents by genuine researchers.

All forms, templates, factsheets and web information have been revised in anticipation of the enactment of the Bill.

Coroners and their support staff—roles and responsibilities

Full-time coroners

There are five full-time coroners consisting of the State Coroner, Deputy State Coroner, Brisbane Coroner, Northern Coroner and Southern Coroner. During 2008–09, 70 per cent of reportable deaths in Queensland were reported to a full-time coroner.

State Coroner

The State Coroner, Mr Michael Barnes, is responsible for coordinating and overseeing the coronial system to ensure it is administered efficiently and that 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. The guidelines can be accessed on the Queensland Courts website.

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

Only the State Coroner or Deputy State Coroner may investigate deaths in custody. The State Coroner also conducts inquests into the more complex deaths that, if dealt with by a local coroner, would take him or her out of general

court work to the detriment of the local court diary.

During the reporting period, the State Coroner sat in Brisbane, Cairns, Townsville, Goondiwindi, Mount Isa, Maryborough, Mareeba, Thursday Island, Proserpine and Roma. During 2008–09, the State Coroner conducted 27 inquests and finalised 49 matters without proceeding to inquest.

Deputy State Coroner

The Deputy State Coroner, Ms Christine Clements, was reappointed on 11 December 2008 for a further five years. Along with the State Coroner, the Deputy State Coroner may investigate deaths in custody and acts as the State Coroner when required.

The Deputy State Coroner conducted two inquests and together with the Brisbane Coroner finalised 1272 investigations in 2008–09. This represents a clearance rate of 93 per cent. The Deputy State Coroner and Brisbane Coroner investigated 37 per cent of all reportable deaths in Queensland.

Brisbane Coroner

The Brisbane Coroner, Mr John Lock, was appointed as a full-time coroner in January 2008. Mr Lock assists the Deputy State Coroner to investigate deaths reported in the Greater Brisbane area.

The Brisbane Coroner conducted nine inquests, eight in Brisbane and one in Gladstone.

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 North Queensland region spanning from Cairns, south to Proserpine, west to Mount Isa and north to the Papua New Guinea border.

In 2008–09, 625 deaths (17 per cent of all Queensland reportable deaths) were reported in the region and 583 matters were finalised, representing a clearance rate of 93 per cent.

Southern Coroner

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

In 2008–09, 547 deaths (15 per cent of all Queensland reportable deaths) were reported in the region and 567 matters were finalised, representing a clearance rate of 104 per cent.

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 2009, deaths were being reported to local magistrates at Bundaberg, Caloundra, Charleville, Dalby, Emerald, Gayndah, Gladstone, Gympie, Hervey Bay,

Ipswich, Kingaroy, Mackay, Maroochydore, Maryborough, Murgon, Rockhampton, Toowoomba and Warwick.

In 2008–09, 1160 deaths (30 per cent of all Queensland reportable deaths) were reported in the regions and 1159 matters were finalised, representing a clearance rate of 100 per cent. Local coroners conducted 31 inquests.

Coroner's investigations

Reportable deaths

Under the *Coroners Act 2003* (the Act), reportable deaths, as defined in s. 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 one or more of the following apply:

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

Suspicious circumstances

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

the holding of an inquest must be postponed until those 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 a death that occurs in a medical setting should be reported and if so determining how it should be investigated poses considerable challenges for a coroner.

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

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

Deaths in care

Deaths of categories of vulnerable members of society (namely children in the care of Child Safety Services, the mentally ill and the disabled) are reported to a coroner, irrespective of their cause.

OSC 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 s.9(1)(a)(i), (ii) and (iii) of the Act. This information is updated regularly and posted on the OSC intranet for use by magistrates and registry staff. This information is also forwarded to the Queensland Police Service and Queensland Health facilities to assist them to identify when a death is reportable under this category of death in care.

OSC would once again like to acknowledge the assistance provided by the staff of the Community Visitor Program. The partnership which has developed between the two agencies has been invaluable in monitoring the reporting of deaths in this category. As a result there has been a substantial increase in the number of deaths reported in this category. During the reporting period, 33 deaths in care were investigated.

Deaths in custody

This term is defined in section 10 of the Act to include those who are at the time of their death actually in custody, trying to escape from custody or trying to avoid being placed into custody. 'Custody' is defined to mean detention under arrest or the authority of a court order or an act by a police officer or Corrective Services officer, court officers or other law enforcement personnel.

Detention in watch-houses, prisons et cetera is clearly covered but the section also extends the definition by reference to the legal context that makes the physical location of the deceased irrelevant. For example, a sentenced prisoner who is taken to a doctor or a hospital

for treatment is still in custody for the purposes of the Act.

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

Indigenous remains

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

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

During the reporting period, 11 matters were investigated by coroners where the remains were confirmed as Indigenous burial remains.

Purpose of coronial investigations

The purpose of a coronial investigation is to establish, the identity of the deceased, when and where they died, the medical cause of

death and the circumstances of the death. Coroners also consider whether changes to policies or procedures could contribute to improvements in public health and safety, or the administration of justice, or reduce the likelihood of other deaths occurring in similar circumstances. Inquests are held so that coroners can receive expert evidence on which to base such recommendations.

Autopsies

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

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

Although family members may not prevent an autopsy being undertaken if a coroner considers it necessary, a coroner who wishes to override a family's concerns must give the family reasons. The coroner's decision can also be judicially reviewed. No such review applications were lodged during 2008–09 and family concerns have been able to be assuaged with the assistance of coronial counsellors from QHFSS.

While precise figures are not available, a sample analysis (see the table below) indicates during the reporting period, full internal autopsies were conducted in 77.82 per

cent of cases, partial internal autopsies were conducted in 15.57 per cent of cases and external examinations were undertaken in 6.58 per cent of cases

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

Type of autopsy	1/12/03–30/06/04	2004–05	2005–06	2006–07	2007–08	2008–09
Order for external autopsy	11.7%	6.3%	7.12%	9.84%	10.1%	6.58%
Order for internal autopsy—partial	16.3%	25.2%	27.73%	22.51%	19.54%	15.57%
Order for internal autopsy—full	71.4%	68.3%	65.11%	67.62%	70.32%	77.82%
Order on cremated remains	0.5%	0.2%	0.04%	00.03%	0.03%	0.03%

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

Type of autopsy	1/12/03–30/06/04	2004–05	2005–06	2006–07	2007–08	2008–09
Order for external autopsy	107	145	198	296	314	208
Order for internal autopsy—partial	149	575	771	677	608	492
Order for internal autopsy—full	653	1559	1810	2034	2187	2459
Order on cremated remains	5	5	1	1	1	1
Total	914	2284	2780	3008	3110	3160

Measuring outcomes

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

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

The national standard for coroners' courts is that no lodgements pending completion are to be more than 24 months old.

Number of deaths reported

In recent years, coroners have observed a steady annual increase in the number of deaths reported. In 2008–09, 3745 deaths were reported to coroners across Queensland—an increase of 6.57 per cent from the total number of deaths reported in 2007–08 (3514).

Finalisation of coronial cases

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

The Queensland coronial system achieved a clearance rate of 97.7 per cent. The appointment of additional full time coroners and dedicated coronial support teams has been a significant contributor to this success.

As at 30 June 2009, 10.1 per cent of pending matters are more than 24 months old.

This figure exceeds the national benchmarking target of 0 per cent largely due to the increasing number of lodgements and the more rigorous investigation required under the *Coroners Act 2003*. The finalisation of a coronial investigation depends on the finalisation of autopsy and toxicology reports and the outcome of police or other expert investigations. In addition the coronial investigation is postponed pending the outcome of any criminal proceedings. As at the end of the reporting period, of the 226 matters that are older than 24 months, 71.2 per cent (161 matters) are waiting for police or other expert investigations or the outcome of criminal proceedings. Excluding outstanding reports (police and others) and criminal prosecutions, 65 matters (2.9 per cent) of pending matters are older than 24 months.

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

Coronial investigators

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

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

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

organ/tissue retention and supporting families during inquest hearings.

The Coronial Support Unit, Queensland Health Clinical and Forensic Medicine Unit (CFMU), the Coronial Counselling Service and QHFSS are integral parts of the coronial process. Each of these agencies 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 dedication, commitment and professionalism of these agencies are greatly appreciated by OSC, as well as the families of the deceased.

Coroners' access to independent clinical expertise

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

independent clinical expert opinion. During the reporting period, a memorandum of understanding between OSC and CFMU was finalised whereby CFMU agreed to provide expert medical advice to coroners and the staff to assist with the investigation of deaths.

Other sources of independent clinical advice accessed by coroners include private clinicians commissioned to prepare expert reports for the coroner.

Monitoring responses to coronial recommendations

In 2006, the Queensland Ombudsman released his report on the Coronial Recommendations Project concluding that the ability of the Queensland coronial system to prevent death and injury would be substantially improved if public sector agencies were required to report on their responses to relevant coronial recommendations. The former Attorney-General, the Honourable Kerry Shine MP strongly supported the public reporting of government responses to coronial recommendations and introduced an administrative process for monitoring these responses.

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

The report will be accessible on the Queensland Courts website.

Genuine researchers

The coronial system is an important source of information for researchers who in turn provide an invaluable resource for coronial systems in their preventative role. Section 53 of the Act facilitates access to coronial documents by researchers. The following genuine researchers were approved under s. 53 of the Act during the reporting period:

Professor Dorothy Buck and Professor Ian Thomas (CESARE)

The Centre for Environmental Safety and Risk Engineering (CESARE) within the Health, Engineering and Science Faculty of Victoria University undertake research in the area of fire safety and risk engineering. Professor Ian Thomas is the director and Professor Dorothy Buck is a staff member of CESARE.

CESARE has developed a detailed database of the circumstances of adult fire fatalities in Victoria over the period 1998–2005 with the objective of identifying and understanding the risk factors and key aspects of human behaviour in life threatening fire situations.

CESARE proposes to expand the Victorian database to establish a national database of fire fatalities using data extracted from NCIS, supplemented by further information from relevant coronial files in each jurisdiction. The proposed national database aims to enhance fire death and property damage prevention through the development of a more sophisticated understanding of the risks posed by a variety of structural, demographic and behavioural factors.

Dr Margaret Legosz

Dr Legosz is the Director of the Crime and Misconduct Commission (CMC)'s Research and Prevention Division. This division conducts research in support of CMC's strategic goals, in the area of policing methods and services and also to explore and report on public policy issues arising from referrals or under statutory review requirements. Dr Legosz's research will inform a statutory review of the effectiveness of the off-road motorbike noise laws under the *Police Powers and Responsibilities Act 2000*. The review process will include an analysis of police and courts data on off-road trail bike complaints, accidents and related offences and will also consider other issues associated with off-road trail bike riding including safety and trail bike deaths.

Dr Legosz proposes to report on the number of trail bike associated deaths and to use this information to identify any hot spot areas where safety is an issue.

Dr Richard Franklin

Dr Franklin has been the Royal Life Saving Society of Australia (RLSSA) National Manager for Research and Health Promotion since 2002. Dr Franklin's research expertise is in the public health field of accident and injury prevention. Dr Franklin's research will inform RLSSA's annual report on drowning deaths, which monitors and analyses the patterns of drowning in Australia and informs the prevention activities of Australian water safety organisations.

Mr Lance Glare

Mr Glare is the manager of Building Codes Queensland Division (BCQD) Building

Legislation and Standards Branch. BCQD oversees the administration of the *Building Act 1975* and associated subordinate legislation including the Building Code of Australia and the Queensland Development Code.

Mr Glare's research will inform the BCQD's Balustrade Project, which is aimed at determining whether there are any links between falls from balconies and decks in existing (older) buildings in Queensland and the different balustrade requirements that have applied over time. The project involves an assessment of the extent of the problem having regard to data collected from agencies including NCIS, Queensland Injury Surveillance Unit, Queensland Health and the Department of Community Safety (in conjunction with existing work conducted by Monash University), a review of existing balustrade requirements and a cost assessment of balustrade and window upgrades.

The research will inform the project's development of options including educational programs for building owners or regulation to upgrade existing balustrades and window protection, with or without a grant or rebate system.

Michelle Johnston

Ms Johnston is currently completing a master's degree in pharmaceutical science at the School of Pharmacy, University of Queensland. Ms Johnston is undertaking a research project which aims to construct a physiological-based pharmacokinetic (PBPK) model for determining changes in drug concentration after death. The proposed research project into a PBPK model has the potential to assist forensic experts to better interpret toxicology results.

The registrar and the Deputy State Coroner's legal officer represent OSC on the QHFSS Human Ethics Committee. The committee operates in accordance with the National Statement on Ethical Conduct in Human Research. The committee reviews and oversees research and other non-diagnostic activities involving autopsies and autopsy material and 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.

These new researchers brought the number authorised to access coronial documents to 35. The full list of these researchers can be found at appendix 4.

Research projects

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

Details of the current projects are set out below.

Investigating family concerns about internal autopsies

Prior to December 2003, there was an almost total reliance on full internal autopsies for coronial findings as to cause and circumstance of death. Under the *Coroners Act 1958*, very scant information was provided in the initial report of the death from police and there was no mechanism 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 coroners might have difficulty reconciling these obligations to families with their duty to ensure all relevant evidence is gathered. To help address this he joined with a criminologist from the School of Justice Studies at QUT and the Chief Forensic Pathologist to investigate ways coroners have been handling these issues. The project is funded by the ARC to the extent of \$225 000 over three years and aims to develop guidelines to assist coroners make autopsy orders that respect family concerns without jeopardising the coronial investigation.

The project 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 non natural causes. In an effort to contribute to the prevention of these deaths the State Coroner has joined with researchers from the Australian Institute for Suicide Research and Prevention (AISRAP), Queensland Health, the New South Wales Department of Health, the Black Dog Institute, Lifeline and others, to investigate the frequency and effectiveness of suicide risk assessments undertaken by medical practitioners with patients objectively identified as being psychologically distressed.

The study is funded by the ARC to the extent of \$391 000 over four years and some of the industry partners are also making cash contributions.

This study aims to:

- determine the degree of psychological morbidity recognised by health 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, as well as recommendations for better health service delivery.

Data collection finished in 2008. In total 277 suicide and 183 sudden death next-of-kin interviews have been completed, and 213 suicide and 93 sudden death healthcare professional interviews have been completed. The research has established that mental health problems were the reason for the last

health care professional contact in 51 per cent of suicides. The outcomes of the study indicate a need to enhance existing health care professional guidelines and training to better equip them to deal with patients at risk of suicide

Further data analysis and interpretation will follow in 2009.

Firearm control and suicide

In conjunction with researchers from the AISRAP, the State Coroner accessed information from the Queensland Police Service firearms licensing system and compared changes in the rate of firearm license with the rate of firearms suicide. The goal was to investigate whether a reduction in firearm licenses was mirrored by a reduction in suicide. The results were ambiguous. Firearm suicides decreased in younger males but not in older males. This led to a conclusion that the implementation of firearm restrictions may not have been responsible for observed reduction in firearm suicide. Rather it was open to interpretation that a change in social and cultural attitudes contributed to a shift in method preference.

The results of the research were published in an article in the *Social Psychiatry and Psychiatric Epidemiology* in October 2008.

Inquests

This section contains a summary of coronial investigations into all deaths in custody and other inquests of note conducted during the reporting period. Full reasons for decisions are found on the Queensland Courts website.

Deaths in custody

Inquests into police pursuits

During the reporting period the State Coroner held inquests into five deaths which occurred following a police pursuit foreshadowing a further two inquests into similar deaths to be held during 2009–10. The five inquests held during the reporting period are summarised below. The State Coroner has indicated that he will consider recommendations about relevant police policies at the conclusion of the seven inquests.

Samantha Anne Maslen

On 5 June 2005, Samantha Maslen was a passenger in a car that drove away from a petrol station in Yelarbon in South Western Queensland without anyone paying for petrol. The vehicle was seen heading towards Goondiwindi, some 56 kilometres away.

The theft of the petrol was reported to the Warwick Police Station where the officer who

received the call discovered the vehicle had been reported stolen. That information was conveyed to a police officer at Goondiwindi and two vehicles set out to intercept the stolen car.

Both police cars headed towards Yelarbon. One only went five kilometres before stopping to set up an interception point; the other continued on until it came across the car and commenced a chase. After travelling seven to ten kilometres, the stolen car came upon the other police vehicle. The officer in that car was standing on the road directing the car to stop. He was also ready to deploy a tyre deflation device. When he realised that the driver of the stolen car was not going to stop, he moved off the road and pulled the deflation device into the path of the car. In an attempt to avoid the deflation device the driver of the car swerved to the right losing control of the car. The vehicle rolled over a number of times. Ms Maslen was seriously injured and was pronounced dead on arrival at the Goondiwindi Hospital a short time later.

The State Coroner concluded that the officers involved in the pursuit believed they were acting appropriately and attempted to adhere to the relevant policies. However, he believed the matter should have been handled

differently and this may have led to a better outcome. The State Coroner was of the view that the situation arose because the officers did not have sufficient regard to all of the safety risks and inflated the significance of the law enforcement objectives of the pursuit. The policies in place at the time gave insufficient guidance about how to balance these competing objectives.

The State Coroner stated that the issue of training of pursuit controllers warranted further evidence and consideration. Similarly the policies surrounding the use of tyre deflation devices, particularly in relation to the safety of officers deploying them, and potentially other members of the public also warranted further consideration.

Joseph Douglas Duncan

In the early hours of 9 January 2006, Joseph Duncan aged 18, was a passenger in a vehicle that crashed as it sped from a pursuing police vehicle on Beaudesert Road, Moorooka. He died at the scene.

The evidence of the police communications room operator on the timing of the commencement and length of the pursuit allowed the State Coroner to conclude the crash occurred at approximately 2.04 am following the pursuit which lasted 2 minutes 30 seconds.

The State Coroner's view was that when balancing the risk against the necessity to pursue, the requirement that safety be given primacy must mean uncertainties are not resolved by presuming no harm will be done. In this case pursuing the car at high speed

towards the city was fraught with risk and the known circumstances did not justify such dangerous action.

Although the State Coroner questioned the wisdom of pursuing the vehicle he did not believe the officer breached Queensland Police Service pursuit policy. The State Coroner concluded that the pursuit controller had insufficient information and insufficient time to take effective control of the chase. He stated there was no basis on which to conclude any individual officer failed to comply with the policy.

The State Coroner noted that in this case there was some confusion about when the pursuit controller assumed responsibility for the pursuit and this issue warranted further consideration.

Kristina Ann Tynan

On 22 May 2006, Kristina Tynan was a passenger in a vehicle that crashed into a lagoon after leaving the road on Ann Street, Maryborough. Moments prior to the crash, the vehicle had been pursued by police after failing to stop as directed. The driver of the vehicle, Edward Keyworth and the other passenger escaped from the vehicle as it lay in the lagoon. Ms Tynan died at the scene.

On 21 March 2007, Mr Keyworth pleaded guilty to a charge of manslaughter and was sentenced to seven years imprisonment.

The State Coroner did not accept the submission that the pursuit did not contribute to Mr Keyworth speeding. As indicated by the pursuing officers, when they observed him initially he was driving appropriately and only

sped off when they activated the siren. However, the State Coroner was satisfied the actions of the officers involved in the incident were reasonable and in accordance with the policy then in place.

Niceta Maria Madeo

On 20 June 2006, three teenagers were joyriding in an old Commodore two of them had stolen from the front yard of its owner in Proserpine. As they were heading north along the Bruce Highway, the car was seen by patrolling police officers. The officers pursued the vehicle and the driver of the Commodore sped up in an attempt to get away. The pursuit came to an end when the driver of the Commodore lost control in the central business district of Proserpine. He unsuccessfully attempted to take a sharp left hand corner and crashed into a stationary car at an intersection driven by Mrs Niceta Madeo. She suffered fatal injuries and died soon after.

The State Coroner found the QPS pursuit policy was not adhered to by the senior officer in the pursuing vehicle or by the pursuit controller. He readily acknowledged that in neither case was this the result of a wilful disregard of those policies: rather, serious errors of judgement were involved. He also acknowledged no malicious or improper purpose was involved in these errors. The State Coroner accepted submissions that it could not be proven that the death would have been avoided had the officers complied with the policies. However, there was no doubt that by failing to do so they increased the likelihood of a harmful conclusion to the pursuit.

Paul James Moore

On 22 September 2006, Paul Moore drove away from the Injune Hotel having spent the preceding few hours drinking in the public bar. Minutes later he was detected by a local police officer speeding along the Carnarvon Highway. Ignoring the officer's direction to stop, he turned abruptly onto an unpaved road and soon sped out of sight. Two kilometres further on Mr Moore's vehicle crashed into a tree, causing the vehicle to split in two and killing him almost instantly.

As soon as possible after initiating a pursuit, the officers involved were obliged to broadcast this fact to the local radio room. They did not do this although there was nothing stopping them from doing so. Accordingly, while the breach was minor, they failed to comply with the policy. The State Coroner found that the officers were driving safely and there was no likelihood they would have been directed to act any differently had they radioed the Roma Station. The pursuit was of short duration and the failure certainly did not in any way contribute to the fatal crash.

Steven David Beaumont

On 25 February 2005, while suffering from severe depression and under the influence of intoxicants, Steven David Beaumont inflicted severe knife wounds upon himself. He would not allow ambulance officers to treat him and so police, who also attended, handcuffed Mr Beaumont so that he could be attended to. He was then loaded into the ambulance but died on the way to hospital.

Mr Beaumont had a long history of schizophrenia and depression but at the time of his death he was not the subject of an involuntary treatment order. In the months before his death he made reasonable efforts to manage his mental illness with some success. However, towards the end of 2004 and in January 2005 Mr Beaumont ceased taking his medication and suffered severe depression as a result. The depot injection he had the day before his death would not have been sufficient to restore his mental equilibrium. His mental state undoubtedly deteriorated further as a result of his consuming large amounts of cannabis on the day of his death. The State Coroner considered the treatment given to Mr Beaumont by his treating clinicians Dr Parke and Dr Ratnam and concluded that there was nothing they could have done to prevent the death. There was insufficient evidence to warrant Dr Ratnam seeking to have Mr Beaumont made subject of an involuntary treatment order. Further the State Coroner considered it highly unlikely that such an order would have been made.

The medical evidence indicated Mr Beaumont's death could only have been prevented if he received expert medical attention within a few minutes of the severing of his trachea. The delay in receiving such treatment was solely due to his resisting the ambulance officers and police. The State Coroner did not consider that the paramedics or police officers could reasonably have been expected to have handled the situation differently.

The State Coroner was therefore unable to make any recommendations that would reduce

the likelihood of similar deaths occurring in future.

Deceased Prisoner

The prisoner was born on 20 September 1920. He was aged 85 years at the time of his death. On 1 May 1997, when he was 76, the prisoner was sentenced to nine years imprisonment in respect of sexual offences against children. On 16 August 2005, he was made subject to an indefinite detention order under s. 13 (5)(a) of the *Dangerous Prisoners (Sexual Offenders) Act 2003*.

The prisoner served his sentence at the Arthur Gorrie Correctional Centre. His corrective services record indicates that he had no breaches or self harm history, but he was listed as having multiple health problems. He had been diagnosed as HIV positive since 1993. He was known to the nursing staff of PAH secure unit having been admitted on 26 occasions since the commencement of his incarceration on 30 May 1996.

He was admitted to the PAH Secure unit on 5 June 2006 from Arthur Gorrie Correctional Centre.

At 10.20 pm on 22 June 2006, a nurse checked on the prisoner in his room and he was still breathing. However at 10.35 pm when she returned to his room on a routine check the prisoner's breathing had stopped. Doctors were called to attend. The attending doctor advised there were no suspicious circumstances surrounding the death as according to his medical file he had been admitted to palliative care on 19 June 2006. The death was not unexpected.

The State Coroner found that Corrective Services staff followed all applicable 'death in custody' protocols and that none of the correctional officers or inmates at the PAH secure unit caused or contributed to the death and that, under the circumstances, nothing could have been done to save the prisoner, who passed away expectedly from natural causes. The State Coroner also found that the prisoner received all appropriate medical treatment while he was in custody.

Craig Robert Shepherd

On 16 June 2006, Craig Shepherd was riding his motorcycle north on the Pacific Highway at Tugan. Susan Delaney, Mr Shepherd's girlfriend, was riding as a pillion passenger. The bike was one of three travelling in a group.

A police motorcyclist attempted to intercept the three bikes. Mr Shepherd did not stop but rode off at high speed.

Shortly afterwards he was seen by two other police officers who followed him on the Pacific Highway towards Nerang. Mr Shepherd turned off the highway, headed into Nerang and continued west with the police vehicle continuing to pursue at speeds of up to 150km/h. He had run two red lights and overtaken a vehicle over double lines by the time he turned off Nerang-Murwillumbah Road onto the unlit and winding Beechmont Road. The police vehicle continued to pursue him.

Approximately 700 metres along Beechmont Road, Mr Shepherd approached a 90 degree left hand bend at high speed. The motorcycle skidded, failed to take the turn and catapulted the two passengers towards an almost sheer

rock wall near the side of the road. Mr Shepherd died almost immediately. Ms Delaney suffered severe and permanent injuries.

The officers in the pursuing vehicle broadcast a message via their radio advising of the crash and seeking assistance. This was the first time police communications knew anything of the pursuit.

The State Coroner reached the conclusion that some of the officers involved in this incident did not comply with the pursuit policies in force at the time. He believed they should be held accountable for this and was critical of their conduct in this regard noting however that it is important to acknowledge they were not motivated by any improper purposes.

Allan Duncan Lee-Chue

Allan Duncan Lee-Chue was 45 years of age when he died on the Burke Development road between Dimbulah and Mareeba on 26 June 2007. He had been arrested by police earlier in the morning and was being transported in a police utility vehicle to Mareeba. During conversation with one of the officers he stopped talking mid sentence and began to convulse. The officers removed him from the vehicle, by which time he had stopped breathing, had lost consciousness and had no pulse. Despite treatment from Queensland Ambulance Service officers, who arrived some minutes later, he never regained consciousness and was declared deceased at the scene.

A comprehensive police investigation was conducted into the circumstances of this

death. The investigation, coupled with the autopsy results, revealed that Mr Lee-Chue passed away suddenly after having suffered a heart attack caused by significant coronary atherosclerosis.

There was no evidence of his suffering any violence or of there being any involvement of any other person in his death. The State Coroner accepted both police officers acted appropriately at all times in their dealings with Mr Lee-Chue and that prompt medical treatment had been provided by the Queensland Ambulance Service.

Clay Hatch

Three police officers (two constables and a police recruit) attended the Tinana Shopping Centre in Maryborough on 2 May 2007 in response to emergency calls indicating there was a man armed with a knife involving another person at the Food Works store. As police arrived in the car park they were updated with further information that there was a group of about five men and one had a knife. As they arrived they were not sure whether there was a group of offenders, whether there was a fight or precisely what the situation was. It became clear that there was a man armed with a knife holding another man hostage. A group of six men with their arms linked in front of the first two were acting as a human shield.

The man armed with the knife was Clay Hatch. The police officers alighted from their vehicle and one of the officers tried to calm Mr Hatch. Mr Hatch threatened to kill the hostage and demanded the officers throw down their guns although there was no evidence that any officer

had drawn their weapon at this time. Mr Hatch stabbed the hostage a number of times and the surrounding group dispersed in various directions.

When the surrounding cordon broke, and the hostage became free, Mr Hatch ran towards the male police officer with his arm outstretched, clutching the knife around shoulder height. He was shouting he would kill him.

The officer retreated a couple of steps before drawing his gun and firing a single shot. The distance between the officer and Mr Hatch when Mr Hatch started running was less than ten metres and the distance between them when he fired was less than five metres. Mr Hatch landed on the ground even closer to the officer after he was shot. He died almost immediately.

Mr Hatch had an extensive history of mental illness and illicit drug use. At the time of the incident he was subject to a forensic order and was being managed by the Gold Coast Mental Health Service. On 30 June 2007 he absconded from the Gold Coast and accessed amphetamines and diazepam in unknown circumstances. Mr Hatch became psychotic and disconnected from reality in the lead up to the tragic incident. The Deputy State Coroner considered the mental health treatment provided to Mr Hatch was appropriate.

The Deputy State Coroner considered that there had been a failure by police communications in that although police communications were aware that the situation was a hostage situation, they failed to communicate this to the attending officers. The Deputy State Coroner also considered the

involvement of the police recruit and cautioned police to be mindful of instructions not to expose inexperienced and unarmed recruits to potentially dangerous situations.

The Deputy State Coroner concluded that in the circumstances of this case the officer had no option except to shoot to prevent grievous injury or his own death. The police officer reacted professionally in the circumstances.

Inquests of public interest

State Coroner

Derek Batten, Peter Tunstead and James Tunstead

On Sunday 15 April 2007, the Kaz 11, an ocean-going sailing catamaran, steamed out of the Abel Point Marina at Airlie Beach. On board were its owner, Derek Batten, his neighbour and close friend, Peter Tunstead and Peter's brother, James Tunstead. Their ultimate destination was Mandurah in Western Australia but they expected to next make port in Townsville after a two or three day passage.

They have not been seen since. Three days after leaving the Abel Point Marina, the boat was found drifting and unoccupied approximately 88 miles north-east of Townsville.

The State Coroner found that there was no evidence of foul play or that any third party was involved. Money and valuable electronic equipment were found on board when the boat was recovered, ruling out robbery as a motive.

It was inconceivable they would all have left the boat voluntarily, mid ocean and had they

been on an island they would have been found by the extensive search which followed the discovery of the boat. They were not young men, but they were far from feeble. The three of them could not have been overcome without very considerable violence that would almost certainly have left evidence of it having occurred.

The State Coroner also found that there was no evidence to suggest that the men had staged their disappearance.

The State Coroner believed the scientific examination of the vessel by police was sufficiently thorough.

The State Coroner concluded that the men were dead and that this had occurred when all three of the men found themselves in the ocean, without life jackets soon after the boat passed George Point. Once in the water it would have been impossible for the men to get back onto the boat which was being blown by a 15 knot wind. From that point, the end would have been swift. None of them was a good swimmer, the seas were choppy; the men would quickly have become exhausted and sunk beneath the waves. The State Coroner found that the most likely cause of death was drowning.

The State Coroner recommended:

- that the Queensland Police Service and the Volunteer Marine Rescue review the procedures governing their interface to ensure information gathered by VMR volunteers is disseminated to police in a timely and consistent fashion
- that Emergency Management Queensland review the protocols governing 'all ships'

broadcasts to ensure they come to the attention of those who may have relevant information

- that Queensland Transport consider amending the registration marking requirements of all sea-going ships to ensure that such vessels can be readily identified from Coastwatch, surveillance and search aircraft.

12 year old boy at Kowanyama

On 19 January 2004, in accordance with an arrangement brokered by the then Department of Families' officers in the preceding week, the 12 year old boy moved from the house where he had been living with his adoptive mother to another residence in Kowanyama because of concerns about inappropriate behaviour by the adoptive mother's husband.

The following day, the 12 year old boy returned to his adoptive mother's house on a number of occasions. On the last occasion, at around sunset he was obviously upset and sulking and said he did not want to return to his new placement. Later, at some stage during the evening, he went missing and extensive searches failed to locate him.

The next morning the 12 year old boy was found hanging in a wardrobe in the bedroom he had previously occupied in his adoptive mother's house. It was apparent that he had been dead for some time.

The State Coroner recommended:

- that as a matter of urgency the Department of Communities (Child Safety Services) develop policies specific to the

delivery of child protection services in Indigenous communities. Training packages to assist staff to apply these policies and to understand best practice in this context should also be developed

- that the resources allocated to the Cape York and Torres Strait Island Child Safety Service Centre be reviewed to ensure it is sufficiently funded to fill all established positions and provide the training necessary to enable child safety officers to safely and effectively discharge their functions within the mandated timeframes
- the lead agency of the Cairns Suspected Child Abuse and Neglect (SCAN) team pilot and evaluate the constituting of a multi disciplinary, multi agency meeting with the same focus and role of the SCAN team in a Cape Indigenous community.

Annette Maxfield

For at least twenty years prior to her death, Annette Maxfield had suffered abdominal pain and intestinal problems that numerous operations and therapies had been unable to resolve. Despite numerous tests and examinations, the cause of these symptoms was never identified.

On 24 November 2004, Mrs Maxfield underwent surgery at the Mount Isa Base Hospital for the radical surgical excision called an abdominoperineal excision of the rectum (APER). She died later that day as a result of severe haemorrhaging that could not be controlled.

The inquest:

- considered whether the APER surgery should have been performed
- considered whether it should have been performed at the Mount Isa Base Hospital
- critiqued the standard of the surgery
- considered whether adequate attempts were made to control the bleeding
- considered whether any changes to the policies or procedures of the Mount Isa Hospital are needed to reduce the likelihood of deaths occurring in future
- considered whether the conduct of any of the medical practitioners involved in the case should be referred for the consideration of the medical board.

The State Coroner considered the evidence showed that Mrs Maxfield died as a result of an inappropriate operation being undertaken by an insufficiently experienced surgeon, in an inappropriate fashion, while being assisted by an inadequately experienced anaesthetist who made basic errors from the outset.

The State Coroner was of the view that the medical board could conclude that both Dr Ross Gallery and Dr Louis Peachey engaged in 'unsatisfactory professional conduct' and referred the information gathered during the inquest to the board for its consideration.

Willowbank aircraft accident

On 2 January 2006, a light aircraft transporting skydivers took off from a private airstrip near Willowbank in South-East Queensland. There were seven people on board—the pilot and three pairs of tandem jumpers. Shortly after

take off the plane crashed, killing five of those on board.

On the morning of 2 January 2006, the pilot, Mr Winter arrived at the airstrip just before 8.00 am. The weather was fine and clear with good visibility and minimal wind.

Two flights were completed without incident, and the aircraft was back on the ground adjacent to the jump centre shortly after 10:30 am. A number of people noticed the engine revolutions randomly increasing and decreasing. Some described it as surging. A number of people saw black exhaust smoke issuing from the engine and occasional puffs of blue smoke.

At about 10.45 am the fatal flight commenced. Witnesses said that as the plane proceeded down the runway nothing seemed out of the ordinary or concerning.

However, the plane continued to fly away from the airstrip without gaining height. The right wing clipped a tree causing the plane to cartwheel and crash.

The Australian Transport Safety Bureau experts concluded from their examination of the wreckage and the eyewitness accounts that the engine was still operating at the time of the crash, albeit not in a normal manner so as to generate sufficient power to enable the aircraft to climb. It is clear the pilot was attempting to get the plane to climb and the crash did not occur because of any deliberate action or inaction on his part. There was no suggestion that any airframe failure contributed to the crash, or that wind shear or other external forces were brought to bear on the aircraft.

The State Coroner found that the plane crashed because it suffered a partial engine failure soon after take off and the pilot did not execute an emergency landing before the aircraft struck a tree and plummeted out of control. The State Coroner was unable to find with sufficient certainty the cause of the loss of power shortly after take off.

The State Coroner recommended:

- the issue by the Civil Aviation Safety Authority of an advisory bulletin alerting operators of Cessna 206 aircraft of the possible dangers of modifying those aircraft in accordance with STC 2123NM
- the Civil Aviation Safety Authority reconsider its interpretation of s27 of the Civil Aviation Act and Civil Aviation Regulation 206
- the Australian Parachute Federation should review the issue of the use of single point cabin floor restraints
- the Civil Aviation Safety Authority consider requiring pilots who have not received current training in responding to an engine failure after takeoff to undertake such training before their licences are next renewed.

Malu Sara

In a media release announcing the launching of six new Department of Multicultural and Indigenous Affairs (DIMIA) immigration response vessels (IRVs) in late August 2005, the then Minister for Immigration and Multicultural Affairs, Senator Vanstone, acknowledged the valuable work undertaken

by Indigenous Movement Monitoring Officers (MMOs) and predicted, *'These boats will greatly enhance the operations of DIMIA's Torres Strait officers who play a vital role maintaining border control.'*

Six weeks later, on Friday 14 October 2005, one of those vessels, the *Malu Sara*, disappeared while travelling from Saibai Island to Badu Island. On board were two DIMIA officers and three passengers, including a five year old girl. None of them survived.

The boat had become lost in fog and had sought assistance from the Thursday Island DIMIA office. In the early hours of 15 October 2005, the skipper again made contact with the office and advised that the vessel was taking on water and was sinking.

On 23 October 2005, the body of one of the passengers was located by Indonesian fishermen near Deelder Reef, approximately 50 nautical miles north-west of the *Malu Sara's* last known position.

The inquest:

- confirmed the identity of the missing persons and that they had died
- sought to establish the time, place and medical cause of the deaths
- considered how the boat was lost and whether the manner in which it was acquired by DIMIA, built and brought into service contributed to the disaster
- considered whether DIMIA's officers and the Queensland Police Service officers to whom the unfolding problems were

reported, adequately responded to the information they received

- critiqued the search for the missing people
- made recommendations as to how the problems highlighted by the events could be addressed.

The State Coroner summarised the events as follows:

The people lost when the *Malu Sara* sank didn't die because some unforeseeable, freak accident swept them away before anything could be done to save them. Rather, they died because several people dismally failed to do their duty over many months.

DIMIA failed to consider the added risk of buying custom built boats, and despite being alerted to its regional manager's lack of training and experience in procurement processes, it failed to adequately respond.

The boat's builder failed to meet the most basic standards of workmanship, and concealed his defective work with false certificates of compliance.

The hidden danger he created would have been detected and defused had the regional manager checked the boat complied with the terms of the contract for its supply, and ensured it had the necessary safety and navigation equipment.

Instead, he rushed the defective vessels into service without ensuring those who were to cross miles of open ocean in them had been trained in their use.

When he received graphic evidence the *Malu Sara* leaked, the regional manager failed to address the problem, despite knowing that in two days time the vessel would set out on a long and difficult passage.

When the vessel became lost in the fog, the duty officer failed to raise the alarm before nightfall.

When the incident was reported to police and the national search and rescue authority, the danger to the people on the *Malu Sara* was continually trivialised, and reports of their worsening predicament were disbelieved, ignored and even mocked.

The regional manager and other staff had flown home in helicopters, and were dining with family and friends while two Commonwealth public servants were struggling to get DIMIA's vessel back to its base. The regional manager failed to take charge of the incident, leaving a junior officer to manage as best he could.

Those on the *Malu Sara* were searching in the dark for specks of land in a roiling sea. They were struggling to pump out water that kept surging into the cockpit of the boat. The tide, the waves and the wind swept them away from safety. As the skipper, Wilfred Baira, continued to seek assistance over a telephone that only sometimes worked, his calm manner, likely a masquerade to minimise the fear of his passengers, was used as an excuse for inaction.

Mr Baira would have done all he could to get himself and his passengers back to land. As more water leaked into the bilge and sloshed around the cockpit, the vessel would have

become increasingly difficult to control. Undoubtedly, the older and experienced serviceman, Mr Harry, would have provided resolute support. It is likely Ms Saub and Ms Enosa helped, although the latter also had to calm and console a frightened and exhausted child.

When no help came and the engines failed and water leaked into the supposedly watertight bilge faster than it could be pumped out, it is likely the boat capsized and soon sank.

The State Coroner referred both Mr Gary Chaston and Sergeant Warren Flegg for disciplinary action.

The State Coroner made recommendations in relation to:

- search and rescue mission coordinator training and performance
- Department of Immigration and Citizenship's procurement policies and Torres Strait emergency response plan
- Maritime Safety Queensland's boat builder and designer accreditation
- Australian Maritime Safety Authority's paper based boat surveys
- vessels, equipment and training for movement monitoring officers
- training for Australian search and rescue organisation officers
- search assets in the Torres Strait.

Stephen James Broe

Dr Stephen Broe was a highly accomplished medical doctor with a passion for SCUBA diving. On 28 April 2005, shortly after midday, he emerged from the ocean a few kilometres north of Moreton Island after completing a dive and climbed onto a charter boat. He almost immediately complained of burning pain in his chest and severe shortness of breath. Despite assistance from people on the boat, Dr Broe lapsed into unconsciousness and died a few minutes later.

The following issues were considered at the inquest:

- whether Dr Broe was appropriately certified fit to undertake the diving course that led to his death
- whether the two dives undertaken on the day of Dr Broe's death were undertaken in accordance with appropriate industry standards, including in particular whether:
 - the sequence of dive depths
 - the time intervals between them
 - the decompression stops planned and executedwere within acceptable limits
- whether changes to the manner in which Dr Broe's equipment was brought back onto the dive boat at the conclusion of the dive could improve public health and safety
- how the gas mix in his NITROX cylinder came to be other than what was intended.

The State Coroner made the following recommendations:

- the MOU between the QPS and Workplace Health and Safety Queensland (WHSQ) be reviewed to ensure it facilitates the specialist units in both agencies being expeditiously notified of all diving deaths. The review should also involve the Office of the State Coroner so that procedures can be developed to ensure the early notification of the coroner
- the director, Forensic and Scientific Services, cause a protocol for the CT scanning of deceased divers in Queensland Health regional hospitals to be developed
- WHSQ consider amending the Recreational Technical Diving Code of Practice to provide guidance to dive operators on preferable methods by which technical divers may reboard the dive platform and highlighting physical exertion following a dive as a risk factor for the onset of decompression illness
- Joint Standards Australia/New Zealand Committees overseeing the relevant standards for both recreational and occupational diving review the dive medical forms contained in the relevant standards in light of the evidence in this inquest. In particular, consideration should be given to explicitly stating the role and responsibility of the medical examiner.

Deputy State Coroner

Oliver Steven McVey

Oliver McVey died unexpectedly at the Mater Mothers' Hospital on 15 April 2006. He was the second of twin sons born prematurely by caesarean section at 31 weeks gestation on 7 February 2006.

Sometime after his birth, Oliver was diagnosed with a patent ductus arteriosus. Surgical ligation occurred successfully on 13 April 2006 and he was returned to the intensive care nursery. He was ventilated with a 3.0 mm endotracheal tube connected to a Draeger Babylog 8000 ventilator. The ventilator had sufficient capacity for Oliver's weight (2.66 kilograms) when used in the conventional synchronised positive pressure ventilation mode. The ventilator was not recommended to be used in the high frequency oscillation mode for babies over 2 kilograms.

There were problems with carbon dioxide retention on the first post surgical night. A partial lung collapse was suspected. The attending doctors increased the pressure and then changed the mode to high frequency oscillation ventilation mode. Oliver's condition improved in the early hours of 14 April. Given the known limitations of the ventilator in this mode for babies of this size, consideration of a changeover of ventilator to the higher capacity 'Stephanie' ventilator was to be undertaken the following day.

On 14 April, the consultant neonatologist reviewed Oliver. She directed monitoring of his condition and physiotherapy to assist with clearance of mucus secretions. The same

ventilator used in the high frequency mode was continued as it appeared his condition was stable, although carbon dioxide levels were rising by the end of the day.

At about 11.00 pm on the second post surgical night Oliver's ventilation required an increase in pressure to address rising carbon dioxide levels. Again, subsequent expert review considered the adjustment to be 'modest'. Nursing staff monitored Oliver's condition and although there was a persistent leak from the endotracheal tube there were no apparent signs of a serious decline in his condition. He was suctioned at 3.30 am due to moderate levels of creamy secretion and at 3.31 am blood gas results were received. These results revealed Oliver's ventilation was critically awry with a carbon dioxide level of 145 as well as increasing respiratory acidosis. Doctors reviewed Oliver and he was hand ventilated through the existing tube with an anaesthetic bag and this achieved an increase in chest wall movement. Oliver was returned to the conventional SIPPV mode of ventilation on the Draeger Babylog ventilator.

It is unknown what had triggered this critical decline in Oliver's ventilation. There was no evidence of complete blockage of the endotracheal tube, or of a kink in the tube. A partial blockage was a possibility or some unknown underlying lung pathology. What was apparent was a significant leak around the endotracheal tube. The consultant considered this may be adding to the difficulties in ventilating Oliver and she decided to upgrade the endotracheal tube to a size of 3.5mm. Independent expert review considered this decision was a reasonable clinical judgment

call. In retrospect, Oliver could have remained on conventional ventilation under close observation as conventional ventilation had increased chest wall movement.

The registrar then attempted to re-intubate Oliver with the larger size tube. Initial intubation prior to surgery was uneventful but the re-intubation proved problematic to the registrar, the consultant and the anaesthetic registrar who all made attempts to introduce the larger tube. The consultant was finally successful but she acknowledged there was a period estimated at 15 minutes of the overall 25–35 minute period during which Oliver was not sufficiently oxygenated. He arrested and all efforts to resuscitate him were unsuccessful. The treating team were uncertain of Oliver's cause of death.

Autopsy examination excluded any anatomical reason or disease or infective process to account for Oliver's death. The examination of the surgical site confirmed the procedure was effective in closing the patent ductus arteriosus. There was histological evidence of the lowest grade of pulmonary hypertension. Expert comment considered this was merely resolving muscularisation in a premature baby and the pathologist resiled from her previous view that the condition contributed to Oliver's death.

The consultant, who also had expert experience in research involving lung development in infants and the physiology of pulmonary vascular smooth muscle, postulated this reaction as an explanation why the team experienced such unexpected difficulty in resuscitating Oliver. However the

coroner considered there was insufficient evidence to reach a conclusion on this proposition.

The reason for Oliver's critical levels of carbon dioxide and respiratory acidosis remain unknown. A partial blockage of the endotracheal tube appears the most plausible explanation.

The findings of the coroner were that Oliver died due to lack of sufficient oxygenation in the course of a complicated endotracheal tube re-insertion. The context of the need for re-intubation was to remove an air leak by re-inserting a larger endotracheal tube (3.5mm) to assist in ventilation. The need for ventilation was due to recent successful surgery to close a patent ductus arteriosus. Oliver's prematurity was a contributing factor in his death.

The coroner made several comments in relation to general record keeping and continuity of care, and recommended that the factual circumstances of the case and Mrs McVey's articulate and careful observations regarding Oliver's care be considered by the Director of Nursing. Recommendations were also made in relation that further training be given to staff regarding the workings and limitations of the ventilators used, more research be considered in assessing the benefits of using echocardiographs for early diagnosis and the assistance of having the device known as a laryngeal mask airway to assist in the circumstances of difficult re-intubations.

Michael Warren

Mr Warren died on 14 August 2004 from sepsis and lung collapse which was precipitated by

burns to 35 per cent of his body sustained while smoking a cigarette in the courtyard of the Beaudesert Hospital on 28 June 2004.

In early 2004 Mr Warren had been diagnosed with Motor Neurone Disease (MND). The progression of the disease was rapid. He was no longer able to speak, his walking deteriorated and his fine motor skills were diminishing. In June 2004 he was admitted to Logan Hospital for an aged care assessment. It was determined that he required a high level of care and he was then transferred to Beaudesert Hospital on 23 June to wait for a permanent nursing home placement.

On 28 June, Mr Warren attended the nursing station and had a dressing gown put on him. He then indicated, by showing an unlit cigarette, to the nursing staff that he was going out for a cigarette in the outside courtyard which was connected to the television room. About 10 minutes later, the same nurse was walking along the corridor when her attention was drawn to the courtyard where she saw Mr Warren standing with his clothing alight. Mr Warren was unable to talk. Another nurse came to her assistance and attempts were made to put out the fire using strategies such as a bed sheet and fire hose. These were not successful. The Director of Nursing attended and used the fire extinguisher to douse the flames.

Mr Warren received emergency care at Beaudesert Hospital before being transferred to Royal Brisbane Hospital where he died on 14 August. The pathologist noted the complications of infection and noted that the MND worsened his capacity to recover from his injuries.

Mr Warren had been a lifelong smoker, and as his health deteriorated smoking remained one of his few pleasures. The inquest heard evidence from a neurologist who specialised in MND. She acknowledged that one of the principles of care is patient autonomy. The doctor also identified the need for specialist palliative care people suffering chronic neurological disease, which required highly specialised nursing care rather than highly specialised medical care. Mr Warren was still sufficiently mobile to go outside into the open courtyard smoking area. He had modified his smoking technique so that he continuously kept the cigarette in his mouth as he smoked it and did not remove it to tap off the ash, leaning forward to eject the stub directly from his mouth into an ashtray. Evidence at the inquest and from the medical records indicated that the issue of Mr Warren's smoking in terms of his personal safety was not specifically considered. The risk for Mr Warren was always one of fire. The inquest highlighted the risk of smoking where a patient's physical or mental capabilities were diminished and the importance of actively assessing and managing that risk.

The inquest made a number of recommendations including the need for regular practical fire training for all hospital staff and also referred the expert comments to Queensland Health with respect to the specialised nursing care needs of MND patients. Importantly, while recognising that smoking is not consistent with good health and commending Queensland Health in its policies aimed at banning smoking, the coroner considered that patients, staff and

visitors will smoke within the health facility environs. A safety assessment of the physical risks of smoking must be considered as the first step. Further a patient's capacity may change through the course of their admission and needs to be continuously assessed.

It should be noted that Queensland Health introduced policy on 1 July 2006 (subsequent to Mr Warren's death), which discourages smoking as much as possible but permits each hospital district to allow smoking in designated smoking areas only. At the time of the inquest Beaudesert Hospital had banned smoking in its facility and grounds.

Brisbane Coroner

Benjamin Glasgow

An inquest was held between 10 and 13 February 2009 (with findings handed down on 20 March 2009) into the death of Benjamin Glasgow who died at the Mater Mothers' Private Hospital on 19 October 2006 very shortly after he was born. His delivery was by way of an emergency caesarean section due to a brow presentation. During the caesarean section it was identified that Benjamin's head had become stuck in his mother's pelvis and a procedure to disimpact his head was performed by the obstetrician and a midwife. At autopsy multiple skull fractures were found and severe brain injury was identified. According to the treating doctors, pathologists and independent specialist obstetricians, these injuries were very unusual, if not, unprecedented.

The coroner found that although criticism could be laid against some of the following: the lack

of documentation of patient information, the lack of a verbal handover and inadequacy of handover documentation and communication issues during the labour process; ultimately these would not have changed the tragic outcome.

The experts agreed that the decision to proceed to a caesarean section was made at the appropriate time and was conducted in a timely manner. The procedure was conducted with the recommended technique. The decision to request assistance by a midwife (to assist in pushing Benjamin's head from the vagina) was correct and timely.

The Coroner found that the balance of evidence would support that the fractures and brain injury occurred whilst the obstetrician and midwife were endeavouring to disimpact Benjamin's head from the pelvis. He also found that the evidence would not support a conclusion that the brain injury occurred in the course of labour due to compression of the skull in the pelvis. The coroner also found that there was no evidence that suggested that undue force was required but clearly it was enough force to cause the injuries however it could not be said what part of the process caused the injuries.

No recommendations or referrals to any disciplinary boards were made however the coroner noted that he would send a copy of his decision to the Royal Australasian College of Obstetricians and Gynaecologists on the basis that it could be used to advance some areas of technique and/or promote discussion within a clinical education context with regards to caesarean sections performed at full dilatation

and the technique adopted by the obstetrician and midwife to disimpact Benjamin's head.

Shealah Ann Woolgar

An inquest was held between 24 and 25 February 2009 (with findings handed down on 20 March 2009) into the death of Shealah Ann Woolgar who died at Greenslopes Private Hospital on 22 August 2007 following tricuspid and mitral valve repair. Mrs Woolgar's surgery proceeded as expected and testing of the competency of the tricuspid and mitral valves revealed that the valves were competent. During decannulation, significant blood was seen accumulating in Mrs Woolgar's pericardium. Cardiopulmonary bypass was re-established and Dr Tam (the cardiothoracic surgeon performing the operation) found a small perforation at the base of the antero-lateral portion of the left ventricle. Despite numerous attempts at repair, Dr Tam was unable to stop the bleeding and Mrs Woolgar subsequently passed away in the Intensive Care Unit. The autopsy examination found a perforation in the left ventricle, at an area which showed evidence of attempts at surgical repair.

The coroner concluded that the perforation of the left ventricle was caused by the use by Dr Tam of a bevelled rubber tubing (known as Blake's tubing) attached to a syringe which was used to test the competency of the mitral valve. The coroner found that this tubing should not be bevelled.

No recommendations or referrals to any disciplinary boards were made however the coroner noted that he would send a copy of his decision to the Royal Australasian College of

Surgeons on the basis that it could be used to advance some areas of technique or promote discussion within a clinical education context.

Elise Susannah Neville

On 05 January 2005, Dr and Mrs Neville took Elise, aged 10 and their two other children on holiday to Kings Beach, Caloundra. The Neville family stayed in a two bedroom unit, with the three children staying in the one room. The bed arrangement included a bunk bed and a trundle bed. Elise was on the top bunk. The bunk bed had no guard rails around it and would not have complied with then current, but non-mandatory Australian standard for bunk beds.

On the night of 6 January 2002, Elise retired to bed at approximately 9:30 pm. At approximately 1:50 am, Dr and Mrs Neville awoke to a loud crashing noise and crying. They entered the children's bedroom and found Elise on the floor below the bunk bed. It was apparent that Elise had fallen from the top bunk which was from a height of some 1.435 metres. Elise was conscious, crying and complained that the left side of her head was hurting.

By 3 am, it was apparent to Dr Neville that Elise had become increasingly agitated. Elise was restless, talking a little but mostly moaning. At about 3:10 am, Elise vomited.

Dr and Mrs Neville took Elise to the Caloundra Hospital to see whether she required treatment. They arrived at the Caloundra Hospital at approximately 3:25 am. Dr Doneman was the only doctor on duty and was rostered on a 24 hour shift which had

commenced at 8 am the previous day. Dr Doneman was 19 hours into the 24 hour shift.

Neither a CT scan nor any other radiological investigations were undertaken. Elise was not held for observation. Dr Doneman did not consider that Elise's condition warranted observation in a hospital setting and therefore did not recommend to Dr and Mrs Neville that Elise be taken to the Nambour Hospital or any other hospital. There was some discussion about keeping Elise there for observation and it seems that Dr Doneman had come to a reluctant agreement to do just that. However, Dr Doneman was of the opinion that it was not the policy of Caloundra Hospital to admit children for observation. After checking and confirming with nursing staff that this was the case he told her parents that Elise could not be admitted for that purpose.

Elise was discharged back into the care of her parents at some time between 4:10 and 4:30 am. When Elise arrived back at the holiday unit, she was placed in her parents' bed and Mrs Neville slept on the mattress on the floor. Elise kept complaining about her sore head but eventually settled at about 6 am. Dr Neville dozed off and woke up at about 7 am to find that Elise had a rash over the left side of her body and her back. Elise's jaw had a rigid appearance and the pupils were fixed and dilated.

An ambulance was called and arrived at 7:20 am.

The ambulance arrived at the Caloundra Hospital at 7:40 am. It was decided that Elise should be air lifted to the Royal Children's

Hospital in Brisbane. The medical retrieval team was requested at 8 am.

The medical retrieval team arrived at 8:50 am. Elise was prepared for evacuation and was air lifted by heli-ambulance with a medical retrieval team at approximately 9:40 am.

Elise arrived at the Royal Children's Hospital just after 10:00 am. She received a CT scan of her head. The results of this scan showed an extensive left sided extradural haematoma and a skull fracture. She was immediately taken to the operating theatre to have the haematoma evacuated.

Elise's neurological condition continued to deteriorate following the surgery. Tests conducted on 9 January 2002 confirmed that brain death had occurred and her parents were advised of this at about midday. A decision was made at approximately 5:30 pm to cease life support. Elise passed away without regaining consciousness.

The coroner made 13 recommendations including that:

- a comprehensive report prepared by the Ombudsman following the death be released and made public
- Queensland Health:
 - conduct a review of the capacity of rural or remote hospital facilities or regions to perform emergency neurosurgical and vascular surgical procedures
 - fund a medical crew of retrieval teams for aircraft

- implement the telemedicine project across the state
- fund a half to one FTE senior medical officer for the Emergency Department at Caloundra Hospital
- install a CT scanner at Caloundra Hospital by August 2009
- the Medical Board of Queensland develop a standard regarding the regulation of excessive working hours for doctors in the public and private hospitals sectors
- standards and warning labels on bunk beds be overviewed.

Coroner Fingleton

Maurice Henry Bauer

Maurice Henry Bauer died on 1 March, 2006 from a work injury. His employer, Mr Forsyth, was an electrician contracted to wire a house under construction.

Mr Forsyth made the decision to work live, despite there being no requirement for the work to be performed live. The *Electrical Safety Regulations* outline certain specific circumstances where live work could be required. Mr Forsyth did not prepare a risk assessment for the performance of the live work. Other requirements of the regulations were also neglected.

Mr Bauer was under the house feeding wiring for the kitchen located above through to another worker Mr Paul Blackmore when he was electrocuted. This occurred at about the same time as Mr Forsyth was pulling the mains

cable from the switchboard box. By the time the ambulance arrived Mr Bauer was dead.

The failure to properly isolate the power supply from the house, combined with the sub-standard taping of the wires caused an arcing which set off an electrical current to move through the house which caused the death of Mr Bauer.

The coroner recommended that safety alerts should be issued as soon as possible after a death or a serious incident has occurred at a workplace. In relation to a risk arising from a workplace hazard, regardless of any detailed investigations being carried out, to best warn or remind those working in the industry as to those hazards.

There is no requirement presently in the Wiring Rules that manufacturer's packages for electrical tapes should indicate the number of the appropriate Australian Standard being present on packages for electrical tapes. The coroner recommended that steps should be taken to institute or reinstitute such a requirement in the Wiring Rules.

The coroner referred the matter to the Office of the Director of Public Prosecutions for consideration.

Coroner Luxton

Barry John Charles Cusack

Mr Cusack worked at the Mount Norma Mine South-West of Cloncurry. The mine operator was Australian Mining Investments Ltd which later became CuDeco Ltd. On 24 November 2004 Mr Cusack arrived at work and met with Mr David Wood, Mine Manager and Company

Surveyor. Mr Wood instructed Mr Cusack to drill some holes in the northern mine face of bench 345. Bench 345 was located on the western side of the mine and ran roughly in a north-south direction. The eastern side was the open face of the bench.

Mr Cusack used a Gardner Denver model ATD, 3700A 'Air Trac' drill carrier to carry out this task. Mr Wood left the bench to attend to some tasks of his own returning at approximately 10.30 am. Upon approaching the work bench he observed a quantity of dust and noted that the air compressor was still running. When he reached the work bench he observed the 'Air Trac' drill some 15 metres below the bench with Mr Cusack lying alongside the machinery.

Mr Wood immediately went to Mr Cusack and after failing to detect any vital signs went to the mine plant to advise Mr Peter Hutchison of the accident and to call for an ambulance. Both men returned to the accident site where Mr Hutchison checked for vital signs. Upon finding none, Mr Hutchison returned to the plant whilst Mr Wood stayed at the accident site until ambulance officers and a doctor arrived. Police officers and mines inspectors from the then Department of Natural Resources and Mines arrived some time after the attending doctor had pronounced Mr Cusack deceased.

The cause of death was the injuries he received when the Air Trac, of which he was operator, went off the 345 workbench, sliding down to a rill 11 metres below and then coming to rest 20 metres below the 345 workbench.

The coroner considered there were two issues which warranted consideration. First, was the issue of whether a safety bund should have

been installed on the workbench. Secondly, the issue of Mr Cusack's training—specifically how the training was conducted, how Mr Cusack was assessed as being competent and what safety and health management systems were in place prior to the accident on 24 November 2004.

The coroner believed the installation of a bund on a workbench such as 345 would have been a prudent course of action. However, it was not possible to determine whether the installation of a bund at axle height would have prevented Mr Cusack's death.

After the fatality occurred, mine management had taken positive steps to ensure that risk assessment training was undertaken and that the mine plan was re-visited. High bunding, well above the minimum, was put in place at the mine after the accident.

There is a legislative requirement for mines to have a safety and health management system which is signed off by the senior site executive but this is only a requirement for mines which employ more than 10 people. Mt Norma mine employed nine.

The coroner recommended that the Mines Inspectorate consider legislative change for small mines and quarries (those which employ 10 persons or less) to develop and implement a safety and health management system to suit the nature and complexity of the operation.

Coroner Ryan

Hannah Isabella Alyson Plint

Hannah Plint drowned in the family pool on 4 October 2007. The above ground pool which

was attached to the rear deck of the house was fenced with a steel swimming pool fence with a gate and approved swimming pool style locking mechanism. Hannah had moved a chair to the gate, opened the gate and accessed the pool while her mother was busy inside the house attending to another child. Hannah's mother gave evidence that Hannah would have been out of her sight and hearing for approximately five minutes. Upon finding Hannah lying face down in the pool her mother retrieved her and immediately commenced CPR. The ambulance attended and transferred Hannah to the Laidley Hospital where she was pronounced dead.

The inquest heard evidence about the type of pool fence and gate, council inspections of the fence and gate and whether they complied with relevant standards. The inquest also heard evidence about the ambulance response and medical treatment received at the Laidley Hospital.

The coroner found that the gate and fence themselves complied with Australian Standards although no application for construction of the pool gate and fence was made to the local council and therefore no compliance certificate existed. However, the pool was positioned too close to the fence which made the gate and fence non-compliant. The coroner found that the erection of the timber deck linking the house to the pool contributed to the death. The coroner found that the care provided by staff of the Laidley Hospital was acceptable and that the ambulance response was timely and the assessment and treatment provided by paramedics appropriate.

The coroner made the following recommendations:

- that the Australian Standard pertaining to swimming pools and especially swimming pool gates and fences be reviewed, upgraded and inspected, to include a child resistant lock incorporating a vertical and horizontal locking mechanism
- that all local authorities adopt a system to identify all properties in their local authority areas which have both inground and above ground swimming pools installed
- that all local authorities be required by legislation to institute a regular system of inspection of swimming pools and surrounding structures to ensure compliance by pool owners
- that the Real Estate Institute of Queensland and the Queensland Law Society review the standard contract of sale to provide a mandatory condition that a certificate of compliance and clearance be received from the local authority before settlement of a property at which a swimming pool has been constructed.

Coroner Comans

Jillian Peta McKenzie

On 12 September 2006, Jillian McKenzie had been feeling unwell and had pains in her chest. She left work early and returned home. She later presented to Babinda Hospital where she was treated by Registered Nurse Ann Barba and Enrolled Nurse Tanya Barba. She was

examined by Dr Richard Lane, a resident medical officer from Cairns Base Hospital, who was relieving medical officer at Babinda. Babinda is a level one hospital having only basic facilities. Jillian was given three Brufen tablets and discharged from the hospital to go home. She died in the early hours of the following morning from heart failure.

One of the issues looked at was whether there had been contact with Cairns Base Hospital prior to attending Babinda Hospital. Jillian's husband gave evidence that he had called Cairns Base Hospital and been told there was a seven hour wait and that's why they had gone to Babinda. The coroner accepted there was some reluctance on the part of Jillian and her husband to attend Cairns Base Hospital.

The coroner accepted that Dr Lane did advise Jillian about blood tests being available to eliminate heart trouble and that could only happen that night in Cairns. However, the coroner was not convinced that Jillian was advised by Dr Lane that she should attend Cairns Hospital that night as a matter of urgency.

Dr Lane was 99 per cent sure that the source of the pain was muscular and that Jillian was at low risk of any heart problems. Dr Lane was unaware of the protocol of a patient remaining in the intermediate risk category until the ECG and blood tests were done.

The inquest accepted evidence from medical experts that it was an error of judgement to send Jillian home. Professor Brown referred to National Heart Foundation guidelines and the guidelines in force at Babinda Hospital which required Jillian to remain classified at

intermediate risk of acute coronary syndrome until the ECG and blood tests had been done and then repeated several hours later.

Sending Jillian home was contrary to the guidelines for managing patients with chest pain and, as an intermediate risk patient, she should have been admitted to Cairns Base Hospital for testing and monitoring. The coroner considered that Jillian would have had a better chance of survival had she been in hospital rather than at home.

The coroner found that the care, treatment and advice received from nursing staff at Babinda Hospital was adequate and appropriate. The coroner found that Dr Lane's examination was thorough and professional and the diagnosis that the pain was muscular was a reasonable one.

The coroner noted that Queensland Health had improved procedures for managing patients with chest pain at Babinda Hospital in response to the death. The coroner also considered the staffing of level one hospitals by junior doctors. Dr Lane was a first year post registration doctor sent to Babinda where he was the sole doctor in charge. Dr Lane's evidence was that he had no supervision.

The coroner made recommendations in relation to the level of experience of relieving doctors at level one hospitals and access by junior doctors to senior practitioners at all times

Coroner McGinness

Patricia van Putten

Patricia van Putten had been treated for anxiety and depression in the 10 year period

prior to her death but her mental health had deteriorated significantly from July 2005. In July 2005 she presented to Tablelands Mental Health Service and to her general practitioner, Dr Towne. She was treated on many occasions by Dr Towne and referred to the Tablelands Mental Health Service and to a private psychiatrist, Dr Woolridge who diagnosed her with severe depression, bipolar disorder and personality difficulties.

From December 2005 until her death in February 2006 she made numerous suicide attempts. On 2 February following a very serious suicide attempt Patricia was admitted to the Cairns Hospital intensive care unit requiring surgery.

Although Patricia's sister and friend raised concerns with the hospital that Patricia would continue to attempt suicide if released, she was discharged on 12 February 2006 subject to a discharge plan. The plan involved intensive community follow up including daily visits by mental health nurses, consultations with psychiatrists and support from her fiancé.

At 2 pm on 17 February Patricia phoned Ms Walker, a mental health nurse and advised that she had some Roundup. Ms Walker went to the house and collected the Roundup. On 18 February despite his agreement to stay with Patricia the fiancé left Patricia by herself from 9 am. Ms Walker arrived at Patricia's home at 10.15 am but found a note on the gate saying that Patricia and the fiancé had gone for a drive. Ms Walker accepted this to be the case and left planning to return later that day. Soon after Patricia's neighbour found Patricia in her flat. Patricia had swallowed Roundup. She was

taken to Mareeba Hospital where she was declared life extinct at 11.25 am.

The inquest was assisted by independent expert psychiatrist, Dr Kingswell. The inquest heard evidence from the treating clinicians about Patricia's diagnosis and treatment. Some of the clinical documentation in the medical files was inadequate making it difficult for the independent expert to follow how the treating clinicians had formed their diagnosis and treatment plans. However, the coroner accepted Patricia's condition was extremely complex and difficult to diagnose and concluded the evidence supported the diagnosis and treatment approach taken by the treating team. The coroner accepted that appropriate medication was prescribed and there was no evidence that it contributed to the death.

The coroner considered whether the discharge on 12 February and the decision not to force a return to hospital on 17 February by way of an involuntary treatment order were appropriate. After considering evidence given by the treatment team the coroner concluded that the decision to treat by way of a consensual therapeutic alliance was an appropriate decision when balancing the difficult factors involved in this case.

In relation to the actions of Patricia's fiancé, the coroner accepted the nurses' evidence that a different treatment plan would have been formulated if they thought Mr Lowe-Brock would not be present at all times.

Coroner McGinness referred to the previous inquest into the deaths of Baggott, Lusk and Barlow conducted by Coroner Previtara.

Coroner Previtara delivered findings on 15 December 2006 following a thorough review of mental health services and made over 50 recommendations about mental health service reform. At the time of the present inquest Queensland Health had reviewed Coroner Previtara's findings and developed a response titled 'Coroner's Action Plan'. Coroner McGinness noted that since February 2006 the 'Coroner's Action Plan' had resulted in many positive changes but there was still much to be achieved.

The coroner endorsed the recommendations previously made by Coroner Previtara noting that many recommendations remained outstanding.

Robert Harris

Robert was 60 years old at the time of his death. He was first diagnosed with depression in 2001. He was prescribed an anti-depressant which he stopped taking and then resumed taking in 2004. Robert first attempted suicide on 15 May 2006 by taking an overdose of various substances. He was admitted to Cairns Base Hospital. He was seen by Dr Underhill on 16 May 2006 who noted that the suicide attempt was serious and requested psychiatric input into the treatment plan.

Robert attended the mental health service on the 17, 18, 25 May and 1 June 2006. During June, Robert attended at the Community Mental Health Clinic. He also attended the Cairns Base Hospital. On 27 June 2006 Robert again attempted suicide. The following morning on 28 June 2006, Robert presented to Community Mental Health. Later that day police found Robert hanging from the tree

where he had attempted suicide the previous day.

Coroner McGinness made 29 recommendations including:

- recommendations in relation to training of mental health and primary health staff
- enhancement of the internal audit system, redesign of the Cairns Base Hospital Emergency Department
- staffing levels
- policies and procedures
- a statewide electronic network of patient information
- increased funding to a range of community-based services to assist both adults and children with mental health problems.

Coroner Brassington

John Ernest Venturato

At about 2 am on 6 September 2005, a convoy of vehicles left the Victoria Mill at Ingham. The purpose of the convoy was to escort a wide load to Innisfail. The wide load was a house that was 8.9m wide, 4.5m high and 27m long. The route of the wide load was largely along the Bruce Highway through Cardwell, Tully and then to Innisfail.

Just before 5.30 am on 6 September 2005, John Venturato said goodbye to his wife to travel to Tully. There he planned to meet up with his friends and go on an overnight reef fishing expedition. To get to Tully he had to drive his

four wheel drive from his home in El Arish and south along the Bruce Highway. On the Bruce Highway, at Feluga, he drove into the side of a house being moved north along the Bruce Highway. He was killed instantly.

The coroner was unable to draw conclusions to the requisite standard as to what caused Mr Venturato to collide with the wide load but found the transport of the wide load north of Tully on 6 September 2005 could have been done better but that it was not necessarily the reason for the collision. The coroner made five recommendations addressing the risks identified to prevent repetition.

Coroner Hennessy

Colin Arthur Greaves

Mr Greaves was working for Transpacific Industrial Solutions (TIS) at the Queensland Alumina Limited Refinery (QAL) plant at Gladstone on the night of his death on 17 July 2005. His workmate on the shift was Mr Charlie Hepburn. Mr Greaves had been employed at the company since February 2003 as a casual employee. Mr Hepburn had worked for the company and its predecessors for about 10 years, in Gove, WA and Gladstone. He is an experienced hydroblaster. Mr Hepburn was the primary witness in the Inquest regarding the events of that evening.

The task the men were undertaking on the night in question was hydroblasting scale from the inside of a Settler tank. Settling is a process in the refining of bauxite which involves the use of caustic acid.



During the shift, Mr Hepburn sent Mr Greaves to another crew to advise them they would be required once a job allocation was attended to. Mr Hepburn became concerned for Mr Greaves when he could not sight him. He walked in that direction and saw Mr Greaves' helmet on the top of the tank adjacent to Hatch A. He quickly retrieved the light used for looking into the tank and shone it in the tank, and through the hatch. He saw Mr Greaves lying inside the bottom of the tank

The immediate cause of the fatality of Mr Greaves was a fall from height caused by a failure to secure the hatch on the settler tank and the absence of any barricades, harnesses or restraints to protect Mr Greaves against falling from height through the void of the open

hatch. The incident occurred at night with minimal lighting which was compounded by shadowy areas on the tank top.

The coroner made 17 recommendations in relation to

- the level of lighting on tanks
- fatigue management systems
- policies regarding clearing of mud and scale
- risk assessment procedures
- hydroblasting training courses
- the responsibility of the Workplace Health and Safety Division to conduct coronial investigations.

Appendices

Appendix 1: Operating expenses 2008–09

Employee related expenses	\$2 049 567
Autopsies	\$875 605
Burials and cremations	\$944 613
Conveyances	\$1 466 437
Fees for private counsel	\$455 233
Crown Law fees	\$208 312
Travel fees	\$96 466
Conferences	\$3 893
Supplies and services other	\$294 200
NCIS grant	\$90 368
Funds recovered – burials assistance contributions	(\$295 569)
Total	\$6 189 125

Appendix 2: Number of coronial cases lodged and finalised in the 2008–09 financial year and the number cases pending as at 30 June 2009

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
Beenleigh	15	-	63	63	-	1	1	2
Brisbane	1 369	9	1 263	1 272	568	85	72	725
Bundaberg	63	1	56	57	54	16	7	77
Caboolture	9	-	14	14	-	-	-	-
Cairns	625	4	579	583	329	58	34	421
Caloundra	48	-	55	55	11	2	2	15
Charleville	25	-	22	22	11	1	1	13
Cunnamulla	-	-	4	4	-	-	-	-
Dalby	53	4	17	21	47	7	1	55
Emerald	31	-	40	40	22	3	2	27
Gayndah	8	-	6	6	6	-	-	6
Gladstone	50	-	47	47	22	4	1	27
Gympie	41	-	30	30	23	3	1	27
Hervey Bay	45	-	40	40	16	-	-	16
Innisfail	-	2	-	2	-	-	2	2
Ipswich	134	2	129	131	70	8	-	78
Kingaroy	26	-	28	28	14	-	1	15
Mackay	112	-	65	65	75	13	3	91
Mareeba	-	1	-	1	-	-	-	-

Maroochydore	150	4	144	148	58	7	4	69
Maryborough	41	-	45	45	15	3	-	18
Mount Isa	-	1	3	4	-	-	-	-
Murgon	9	-	11	11	-	-	3	3
Proserpine	-	-	2	2	-	-	1	1
Redcliffe	5	-	12	12	-	1	2	3
Rockhampton	120	9	117	126	44	5	15	64
Roma	-	-	1	1	-	-	-	-
Southport	547	-	567	567	227	54	30	311
State Coroner	44	27	49	76	23	13	34	70
Toogoolawah	1	-	1	1	-	-	-	-
Toowoomba	149	2	144	146	75	9	7	91
Townsville	-	3	1	4	-	-	2	2
Warwick	25	-	33	33	13	-	-	13
Total	3 745	69	3 588	3 657	1 723	293	226	2 242

Source: Queensland-wide Interlinked Courts (QWIC) system and 2008–09 manual survey for the Report on Government Services (RoGS).

Appendix 3: Presentations 2008–09

State Coroner

- Royal Australasian College of Medical Administrators master class, *'Minimising post mortem pain'* - July 2008.
- Queensland Health Suicide Prevention Conference, Cairns, *'Challenges to accurate suicide data'* - July 2008.
- Qld Health Suicide Prevention Conference, Cairns, *'Suicide risk assessment'* - July 2008.
- World Suicide Day Public Forum, *'Ophelia's inquest and maimed rights'* - September 2008.
- QUT Faculty of Law, *'Inquests – theory and practice'* - September 2008.
- Gold Coast Airport Emergency Management Committee, *'The coroner's role in an aviation disaster'* - September 2008.
- Logan Hospital grand rounds, *'Working with the coroner to improve patient safety'* - October 2008.
- Griffith University Medical School, *'The Queensland coronial system from a doctor's perspective'* - October 2008.
- Royal Australian College of Medical Administrators Qld chapter, *'Minimising post mortem pain'* - October 2008.
- Maryborough Hospital grand rounds, *'Working with the coroner to improve patient safety'* - November 2008.
- Domestic violence homicide forum, *'The coroner's role in responding to domestic violence homicides'* - December 2008.
- Griffith University medical students - 21 January 2009.
- University of Queensland medical students - 22 January 2009.
- Autopsy Symposium Bond University, *'The Queensland coronial system'* - February 2009.
- Autopsy Symposium University of Queensland, *'The Queensland coronial system'* - February 2009.
- Logan Hospital - 13 February 2009.
- Medico—Legal Society of Queensland, Moot Coroners Court - May 2009.
- Metropolitan South Region Queensland Police Service Detectives Conference, *'Working with the Coroner'* - June 2009.

- Metropolitan South Region Queensland Police Service Detectives Conference - 30 June 2009.

Deputy State Coroner

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

Brisbane Coroner

- Toowong Private Hospital
- Wesley Private Hospital
- QE II Hospital
- Queensland Nurses Conference
- Caboolture Hospital
- Royal Brisbane and Women's Hospital
- Queensland Public Interest Clearing House

Appendix 4: Register of approved genuine researchers

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

Dr Nathan Milne	Queensland Health Scientific Services
Dr Beng Beng Ong	Queensland Health Scientific Services
Professor Ian Thomas Director of CESARE	Centre for Environmental Safety and Risk Engineering
Dr Margot Legosz	Crime and Misconduct Commission
National Manager for Research and Health Promotion (Dr Richard Charles Franklin)	Royal Life Saving
Lance Glare (Manager BCQD Building Legislation & Standards Branch)	Building Codes Queensland Division (BCQD)
Michelle Johnston	School of Pharmacy, University of Queensland
Dr Damian Clarke	Paediatric Neurology Department Mater and Royal Children's Hospital
Professor Grzebieta, Hussein Jama and Rena Friswell	NSW Injury Risk Management Research Centre—UNSW
Director—John Lippmann OAM	Divers Alert Network Asia Pacific
Michelle Hayes	Department of Communities



QUEENSLAND
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