OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Nola Jean WALKER**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Cairns
FILE NO(s):	1211/05(6)
DELIVERED ON:	23 November 2007
DELIVERED AT:	Cairns
HEARING DATE(s):	19 – 21 November 2007
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody,
REPRESENTATION:	

Counsel Assisting: Ms Julie Wilson

Table of Contents

Introduction 2
The Coroner's jurisdiction 2
The basis of the jurisdiction 2
The scope of the Coroner's inquiry and findings 2
The admissibility of evidence and the standard of proof 3
The investigation 4
The inquest 4
The evidence 5
Family Background 5
Medical history 5
Background 5
Events of 17 May 2005 6
Ms Walker is in a car crash 6
The QAS arrive 6
The QPS arrive 8
At the police station 9
The death is discovered 12
Autopsy and medical evidence 13
Findings required by s45 15
Identity of the deceased 15
Place of death 15
Date of death 15
Cause of death 16
Concerns, comments and recommendations 16
The adequacy of the ambulances officers response 16
Recommendation 1 - Exchange of information between police and ambulance officers 18
Adequacy of police response 18
Monitoring her need for medical care 18
Training issues 19
Recommendation 2 - Review of QPS training concerning intoxication 20
Failure to commence CPR 20
Referral to the DPP 20
Acknowledgment 21

The *Coroners Act 2003* (the Act) provides in s45 that when an inquest is held into a death, the coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These are my findings in relation to the death of Nola Jean Walker. They will be distributed in accordance with the requirements of the Act and placed on the website of the Office of the State Coroner.

Introduction

On the morning of 17 May 2005, Nola Walker, a retired nurse, dropped her adult son at work and was driving home when she was involved in a car crash. The ambulance officers who attended and examined Ms Walker found no significant injuries but recommended that she allow them to take her to hospital for observation and tests. She declined. Police officers who also attended became suspicious that she may have been driving while over the legal blood alcohol limit. This was confirmed by a road side breath test and accordingly Ms Walker was taken to the Cairns Police Station. She was there for about 90 minutes while the necessary paperwork was prepared and attempts were made to locate a friend to come and collect her. When an officer went to advise her that she could go, Ms Walker was found to be unconscious, without a pulse and not breathing. An ambulance was called but attempts to revive her failed.

These findings seek to explain how the death occurred and consider whether any changes to the policies and/or procedures of the Queensland Ambulance Service (QAS) and Queensland Police Service (QPS) would reduce the likelihood of similar deaths occurring in future.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

At the time of her death, Ms Walker was in the custody of the QPS, in a holding room at the Cairns police station, pending completion of documents necessary to charge her with failing to provide a specimen of breath pursuant to section 80 of the *Transport Operations (Road Use Management) Act* 1995. As such, her death was a "*death in custody*"[1] within the terms of the Act and accordingly it was reported to the State Coroner for investigation and inquest.[2]

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

[1] Refer s10

[2] Section 8(3) defines "*reportable death*" to include deaths in custody and s 7(2) requires that such deaths be reported to the State Corner or Deputy State Coroner. Section 27 requires an inquest be held in relation to all deaths in custody.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [3]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[4] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.[5]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because section 37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

It is also clear that a Coroner is obliged to comply with the rules of natural justice and to act judicially.[9] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

---

[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[4] s46
[5] s45(5) and 46(3)
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[10] (1990) 65 ALJR 167 at 168

The investigation

I will now say something about the investigation of Ms Walker's death.

Acting Inspector (then Detective Senior Sergeant) B J Eaton commenced the investigation almost immediately following the death. At the time, Acting Inspector Eaton was the Officer in Charge of the Cairns Criminal Investigation Branch. Interviews were conducted with the officers who had taken Ms Walker into custody and who had dealings with her at the police station and all other relevant witnesses including the ambulance officers. Scenes of crime officers photographed the scene of the traffic accident and the holding room at the police station. I commend the officer on the standard of his investigation.

A post mortem examination was performed by Professor David Williams at the Cairns Base Hospital Mortuary on the day of the death.

The Queensland Ambulance Service commenced an investigation into the services provided to Ms Walker on the day of her death. Colin Nash, Manager for Clinical Standards, was directed by the then QAS Medical Director to undertake the investigation. He interviewed the three QAS paramedics involved and reviewed QAS records relating to ambulance services provided to Ms Walker. A report to the Medical Director was prepared however that report was lost. Mr Nash prepared a statement detailing the investigation for the inquest from hand written notes made during the course of the investigation.

Staff members of the Office of the State Coroner have also undertaken further inquiries relating to the appropriateness of the QPS and QAS care and management of Ms Walker and potential safety hazards at the scene of the accident.

I viewed the scene of the traffic accident and the relevant areas of the Cairns Police Station.

As can be readily appreciated, any death in custody may raise suspicions in the minds of those close to the deceased and others, that he/she has met with some foul play and/or that the authorities have failed in their duty to properly care for the prisoner. It is therefore essential that even when a death appears at the outset not to be suspicious, the investigation is thorough and rigorous. I am satisfied that as a result of the contribution made by the various bodies which inquired into this case, including the evidence obtained at inquest, the circumstances of the death have been sufficiently scrutinised to enable me to make findings on all relevant issues.

The inquest

A pre-hearing conference was held in Brisbane on 25 October 2007. Ms Wilson was appointed Counsel Assisting. Leave to appear was granted to the Officers Simpson, Flematti and MacPherson, the Commissioner of Police and the Queensland Ambulance Service. Ms Walker's son was not separately represented however he consulted with those assisting me before and throughout the inquest. The inquest then proceeded over three days commencing on 19 November 2007 in Cairns. Twenty-two witnesses gave evidence and 95 exhibits were tendered.

The evidence

I turn now to the evidence. Of course I can not summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Family Background

Nola Walker was born on 25 April 1939. She had a long and apparently successful career as a registered nurse and was described by her friend, Elizabeth McBryde, as *"very wonderful, determined, strong, caring, unstoppable woman."*[11] Ms Walker's son described her as proud and gracious.

Mr Needham-Walker, had recently moved to Cairns to stay with his mother on account of her failing health. He explained that his mother had undergone cardiac surgery and suffered a stroke previously. An incident which occurred the previous year, where Ms Walker was hospitalised without telling her family and Mr Needham-Walker was unable to contact her prompted him to move in order to care for his mother. Mr Needham-Walker's brother had arranged for Ms Walker to wear a medical alarm out of concern for his mother's health. It is clear that Ms Walker had family and friends who cared for her very much.

Medical history

Evidence concerning Ms Walker's medical history is largely anecdotal in that it mainly comes from the history taken by QAS and QPS officers at the scene of the traffic accident. Ms Walker told the second year student paramedic Nucifora (now McEachern) that she had undergone heart bypass surgery five years previously and was, at the time, taking medications Lasix, Frusamide and Aldactone. Ms Walker later told Constable Simpson that she had taken Valium the night before and that she suffered a liver problem.

As previously mentioned, Mr Needham-Walker had recently arrived in Cairns to stay with his mother on account of her failing health. He told the police that he was not aware of any medical problems that might have impacted Ms Walker's ability to drive, although she did not do so often.

Background

To celebrate an overseas holiday that Ms Walker was about to take with her friend Ms McBryde, the two travellers, Mr Needham-Walker and another friend went out for dinner on the evening of 16 May 2005. Mr Needham-Walker and Ms McBryde told the police that they observed Ms Walker consume three or four glasses of white wine over a three hour period between 7.00pm and 10.00pm. In evidence, Mr Needham-Walker qualified that observation by saying that since he and others were buying his mother glasses of wine throughout the course of the dinner, she might have consumed more that the stated three or four glasses during that period.

After they returned home from dinner, Mr Needham-Walker went straight to bed. Before retiring he observed his mother pour herself a small glass of white wine

[11] Exhibit 28

from a four litre cask. Mr Needham-Walker cannot say how much his mother had to drink before she went to bed that night.

Events of 17 May 2005

Mr Needham-Walker woke his mother at about 7.30am since arrangements had been made for her to drive him to work. This was not the usual routine. It was Mr Needham-Walker's first day in a new job and it was thought that Ms Walker might need to use of the vehicle to attend to matters associated with preparing for her holiday.

Mr Needham-Walker drove his mother's car, a small Mazda sedan, to his workplace at Hansons on the corner of Draper and Kenny Streets, Portsmith. He got out of the car and his mother moved into the driver's seat. He did not see her drive away.

Ms Walker is in a car crash

Just after 8.00am, Ms Walker was involved in a two vehicle traffic accident when she failed to give way in accordance with the traffic sign at the intersection of Kenny and Fearnley Streets, less than a kilometre from where she had dropped her son. The driver of the second vehicle was Stephen Blanchard.

Mr Blanchard immediately went to the Mazda to check on the female driver. She apologised and, although she appeared old, fragile and fairly shaken, she told Mr Blanchard that she was fine.

Anne Naylor who was employed as a safety officer with Hastings Deering was alerted to the accident having occurred outside the main gate.[12] She is trained in first aid and attended to Ms Walker who was seated in the driver's side of the Mazda which was badly damaged on the passenger side. The driver's door was open when Ms Naylor approached.

Ms Naylor observed that Ms Walker was calm and focussed. Ms Naylor was concerned to keep Ms Walker talking in accordance with her first aid training. She said that Ms Walker did not have any difficulty conversing with her. During that conversation Ms Walker expressed concern for her dog and was emphatic that she was fine and did not want an ambulance to be called, however this had already been done. Ms Naylor asked Ms Walker if there was someone she could call to attend and Ms Walker responded that her son would already be at work. Ms Naylor dressed a number of minor cuts on Ms Walker's left hand and left when the QAS arrived.

The QAS arrive

QAS officers Nucifora and Blake arrived at the scene at 8.13am having received the code 1 call at 8.05am. Soon after, a third and more senior officer, Lauretta Howarth arrived in another vehicle. Ms Howarth was providing 'back up' for Nucifora and Blake and it seems she played a supervisory role.

Ms Nucifora attended to Ms Walker who was still seated in her vehicle. She recalls that Ms Walker was lucid and able to converse with her in a meaningful way. She was orientated and answered questions appropriately. Ms Walker was

[12] Statement of Anne Naylor – Ex29

adamant that she was uninjured and did not require any assistance. Ms Nucifora was in close proximity to Ms Walker for much of the time at the scene and did not smell any alcohol on her breath. She did not notice any other signs of intoxication in Ms Walker.

Officer Blake conducted various assessments of Ms Walker's health status including recording her vital signs on two occasions, at 8.15am and 8.22am. Those vital signs, including pulse rate, respiratory rate, oxygen saturation and blood pressure, were within normal limits on both occasions. An electrocardiogram (ECG) was performed throughout the period and revealed a normal sinus rhythm at a rate of 82. Those results were recorded on an ambulance report form (ARF), completed by Officer Nucifora once the officers had left the scene; they were checked by officer Blake. I was surprised to hear that officer say that he had not recorded this information but recalled it as they drove from the scene. I have no reason to doubt its accuracy on this occasion and I accept that it would not always be possible to make a contemporaneous note of this data, but as a general rule this practice should be discouraged.

The results as documented in the ARF were as follows –

Time	**8.15am**	**8.22am**
Pulse Rate and regularity	80R (regular)	82R
Respiratory rate and effort	18N (normal)	18N
Oxygen saturation	98% ⟶	
BP - Systolic - Diastolic	 140 P	 135 85
Skin - Temperature - Colour - Moisture	 N (normal) N N	 N N N
ECG Rate	82	83
ECG Rhythm	NSR ⟶	
Glasgow Coma Scale	15	15

Officer Nucifora looked under the dressing applied by Ms Naylor and observed superficial skin injuries on Ms Walker's left hand. She also noticed an abrasion over Ms Walker's right clavicle when ECG nodes were being attached. She thought that the injury was consistent with a seatbelt injury and consequently palpated Ms Walker's left side in the position where the seatbelt buckle would usually be secured. Ms Walker denied she was in any pain.

Ms Nucifora took a medical history from Ms Walker while Mr Blake was conducting the assessments. That history revealed cardiac surgery about 5

years ago and that Ms Walker was taking medications Lasix, Frusamide and Aldactone.

Officer Nucifora told Ms Walker on a number of occasions that they would like to take her to hospital to be further examined. Ms Walker was adamant in her refusal. Officer Nucifora, in consultation with officer Blake, decided that Ms Walker's refusal of further treatment was valid. Ms Howarth says that she did not discuss that decision with the other two but concurred with it. It was made in accordance with QAS procedure which is reduced to a 'ready-reckoner' card called the V.I.R.C.A. card. It requires consideration of –

- the **voluntariness** of the refusal;
- whether the refusal is **informed**;
- whether the refusal is **relevant**;
- whether the person has the requisite **capacity** to understand the nature and consequences of the refusal; and
- on the condition that the patient is to be provided with **advice** or recommendations to promote comfort and safety if the patient is to remain at home.

Given that all observations and assessments of Ms Walker by QAS officers were normal and that Ms Walker appeared to comprehend and participate in conversation about the accident and her health, the officers determined that her refusal of further treatment was valid.

The QPS arrive

Constables Flematti and Simpson arrived at the scene at 8.22am. Both officers were junior; Mr Flematti having been sworn in on 1 April 2003 and Mr Simpson on 20 April 2005 (3 weeks before the death). Constable Flematti was Constable Simpson's field training officer at the relevant time.

Constable Flematti says that soon after arriving at the scene he was told by the male ambulance officer that Ms Walker was fine. Constable Simpson also recalls being told by a QAS officer that Ms Walker was fine.[13] The ambulance officers gave somewhat inconsistent evidence about this, but all denied that they conveyed any information about Ms Walker's condition to the police officers. I don't accept that. It may be that they did not make a formal declaration about her medical condition but it seems clear that they did advise police that they were taking Ms Walker home, not to hospital and at least by implication therefore, they considered she did not require further treatment. I am of the view there was nothing improper or untoward in the ambulance officers conveying this information to the attending police officers. Indeed they may have usefully told them more, an issue I will return to later.

Constable Simpson approached Ms Walker who was still seated in her vehicle's driver's seat while the QAS officers were removing ECG nodes from her chest. He relayed to his more senior partner that the QAS officers intended taking Ms Walker home, indeed Ms Howarth had already placed Ms Walker's dog in the back of the QAS vehicle in preparation. Constable Flematti told Constable

[13] Simpson Interview with Eaton – Ex 32, p6

Simpson that they would need to speak to Ms Walker first and that they would transport her home. The dog was, accordingly, switched to the QPS vehicle.

As QAS packed up to leave, Constable Simpson spoke with Ms Walker and she told him that she was fine. He helped her out of the car and held her arm as they crossed the street to the police vehicle. Simpson said that Ms Walker could walk unassisted at that time but was very slow. He held her arm as a courtesy it seems, rather than out of necessity. During the walk across Fearnley Street Constable Simpson noticed an odour of ethanol on Ms Walker's breath. He said that smell became more profound when Ms Walker was seated in the back of the police van.

Accordingly, a road side breath test was performed and it revealed a blood alcohol concentration of 0.198%. That test, according to a computer printout[14] was conducted at 8.35am. Paramedics had left the scene by that time and the results of the test were not communicated to them.

Constable Simpson asked Ms Walker a series of questions which were recorded in his official police notebook. Those questions revealed that Ms Walker estimated that she had her last alcoholic drink at about 1.00am that morning and that she could not remember how many drinks she had had throughout the course of the night. Ms Walker told Constable Simpson that she was not on any medication but that she suffered a liver problem. She told the officer that at the time of the accident she was lost, attempting to turn left into Kenny Street and her vision was obscured by the sun. Constable Simpson said that her speech was slightly slurred.

As a result of the positive road side breath test it was necessary to take Ms Walker to the Cairns Police Station so that she could provide a specimen of breath for analysis. Constable Flematti drove the vehicle back to the station. He did not notice a smell of alcohol or that Ms Walker's speech was slurred.

At the police station

Constable Kacey Williams was working at the front counter of the police station when officers Simpson and Flematti arrived with Ms Walker. She saw that the two officers were assisting the old lady to walk by each supporting an arm. It appeared that Ms Walker was having trouble walking; she was walking very slowly.

Ms Walker was taken by officers Simpson and Flematti to a holding room which is known as 'the bus stop' because of the two park bench type seats in side. She was seated on the one that was on the right hand wall of that room facing the opposite wall. Her dog was also brought into the room. Arrangements were then made for an officer trained and authorised to operate the breath analysis equipment to perform that test.

Strangely, officers Simpson and Flematti wheeled Ms Walker the 10 or so metres from the bus stop to the Breath Analysis Section (BAS) on an office chair with castors. They said that they did so, not because she couldn't walk by herself, but because they thought it easier to transport her that way in view of the time it had

[14] Exhibit 49

taken her to walk across the police station car park. Constable Simpson said that in the bus stop just before they moved her, Ms Walker was responsive to his questions but was starting to exhibit sleepiness in that she was nodding off a little.

At 9.11am the DRAGAR breath analysis device was activated by Sergeant MacPherson. Ms Walker was asked a series of standard questions which included questions about her health and intoxication [15] –

> M: - Are you suffering from any illnesses at all?
> W: - Not really, the liver is not what it should be
> M: - Are you suffering from any injuries? (MacPherson had observed the bandages on her left hand and blood spots on her shorts)
> W: - No, somebody wanted to bandage my wrist
> M: - Have you taken any drugs in the last, insulin or medicines in the last 24 hours?
> W: - Diuretics yesterday morning and Valium last night
> M: - What dose was the Valium?
> W: - 10mg, one dose
> M: - Have you been in a chemical environment in the last 24 hours?
> W: - No
> M: - Have you been in an industrial environment in the last 24 hours?
> W: - No
> M: - What type of liquor have you consumed?
> W: - White wine, chardonnay
> M: - What time was your first drink?
> W: - About 7 last night
> M: - What time was your last drink?
> W: - Not sure, about 1o'clock this morning
> M: - Do you have any reasons which would prevent you from supplying a specimen of your breath? A Queensland Transport certificate or a medical certificate stating you don't have to supply?
> W: - No
> M: - Can you blow up a balloon okay?
> W: - Yes

After that initial conversation, Ms Walker slumped over in the chair a number of times when she was instructed to blow into the analysing instrument. Sergeant MacPherson maintained the view that Ms Walker knew what she was being instructed to do and was simply being obstructionist in her failure to provide the breath sample. He said to Constable Simpson, "*She's playing possum.*"

Failed attempts to obtain a specimen were made between 9.20am and 9.23am and again between 9.24am and 9.26am. At that time a certificate under the *Transport Operations (Road Use Management) Act 1995* regarding failure to provide a specimen of breath was issued by Sergeant MacPherson.

Constable Emma Clarke observed Sergeant MacPherson attempting to obtain the specimen. On her account Ms Walker was going in and out of sleep during the process, with her head falling to the side from time to time. It appeared to Constable Clarke that the woman was very drunk.

Superintendent Katarina Carroll also observed Ms Walker in the BAS. She thought Ms Walker was intoxicated on account of her having difficulty sitting up straight. The Superintendent observed Ms Walker hunched over and at times

---

[15] Statement of Gregory Joseph MacPherson – Ex 7 (paragraphs 16 – 37) See also Interview – Ex33, p4

swaying from side to side in the chair. She saw Constable Simpson attempting to wake Ms Walker.

Ms Walker was then wheeled back to the bus stop. At one point her foot fell off the part of the chair where it had been resting but she was able to replace it unaided.

Constables Flematti and Simpson then attended to a number of other duties before commencing the preparation of the paper work that was required by the charge to be preferred against Ms Walker. Constable Simpson attempted to interview her to obtain more details about her drinking and the accident but he had to discontinue that process because Ms Walker kept falling asleep and was not answering his questions. Constable Simpson listed in his note book indicia of intoxication:- "*speech - slurred and slow", "balance - unsteady, falling." "breath - strong smell of liquor," "colour of face – pale"* and *"eyes - closing*."[16]

In the period between her return from the BAS until Constables Simpson and Flematti tried to wake her at about 10.40am, a number of people saw Ms Walker.

At about 10.00am Sergeant Platz states that as he walked back to his office he saw Ms Walker seated in the 'detainee room'. He describes her as sitting on a bus seat with her dog attached to her by a lead. Her head was slumped slightly forward to the left. Sergeant Platz states that at that time Ms Walker was breathing. Sergeant Platz recalls seeing the rise and fall of Ms Walker's chest.

Constable Williams observed Ms Walker a number of times. She says that during this period Ms Walker remained seated with her head slumped down and to the left. It appeared to Constable Williams that Ms Walker was sleeping and affected by alcohol.

Constable Clarke and administrative officer Donna Busch made similar observations when they walked past the holding room. Donna Busch entered the room at one stage to give the dog some water. She did not notice anything out of the ordinary. Constable Simpson says that, along with a number of other observations made from time to time that morning, he checked on Ms Walker when Ms Busch went in to give the dog water and at that stage she was alright. On a number of occasions he or Constable Flematti would wake Ms Walker to try and ascertain details of a friend or neighbour they could contact to come and collect her. On each occasion she was rousable but quickly again lost consciousness.

Usually, someone with such a high alcohol reading as that provided by Ms Walker at the road side would be placed in the watch house to sober up before being released. However, in view of her age and frailty, the officers were intent on locating someone to whom they could hand over Ms Walker.

Marilyn Webb who was at the time an administrative officer at the Cairns Police Station, also gave evidence about her observations of Ms Walker that morning. She said that she first saw Ms Walker when she went to her locker which was opposite the holding room at around 10.00 am. She said that she had concerns

[16] Exhibit 40

about Ms Walker's health and brought those concerns to the attention of another administrative officer. Ms Webb said that despite communicating her concerns nothing was done. Ms Webb did not mention that in her statement to police and her explanation for that omission is that she was fearful of the administrative officer on account of previous workplace dispute(s). Under examination and cross-examination it became clear that any concerns Ms Webb might have had in respect of Ms Walker were not communicated to any police officers on the day of the death or after. I am of the view that Ms Webb may well be confused about the timing of her concerns. I think it is more likely that when a number of officers became aware that Ms Walker was in difficulty and raised the alarm Ms Webb may well have unintentionally reconstructed her memory of some earlier events. It is obvious that she was deeply distressed by the incident. I do not consider that her evidence can be relied upon.

The death is discovered

At about 10.40am Constables Simpson and Flematti had completed the necessary paperwork relating to Ms Walker and had located details for Ms McBryde. They went into the holding room to get Ms Walker and take her to her friend's place. They repeatedly called to her '*wake up Nola'* with no response. Constable Williams went into the room after she heard these repeated calls. Constable Simpson checked for a pulse but could not find one. Marilyn Webb says she did the same. Constable Simpson states that Ms Walker felt very cold to touch. Indeed, a number of witnesses commented on this.

Sergeant Platz also heard Simpson and Flematti attempting to wake the deceased at about 10.40am. He went into the room and saw Ms Walker was seated in the same position he had observed her earlier except her head was slumped a little further forward. Sergeant Platz went to the communications room and asked Sergeant MacPherson to call an ambulance. He can't remember exactly what he told Sergeant MacPherson about Ms Walker's condition but considered he could have said she was dead as that was what he feared. That is Sergeant MacPherson's recollection of the conversation but strangely when he called the QAS at 10.42 am he told the operator that Ms Walker had "*collapsed*" but that she was still breathing. Sergeant MacPherson acknowledged his error in this regard and could not readily explain it.

Communications Operator Della Merrett made two subsequent calls to QAS, first to determine the estimated time of arrival and second, to give more specific directions about where to go once at the station. During that second conversation Ms Merrett remembers telling QAS that the woman was not breathing. She does not recall where that information came from. She also told QAS that she believed CPR was being performed. Her evidence was that she assumed that was the case but had not received advice to that effect.

Sergeant Platz returned to Ms Walker and with the assistance of Constables Flematti, Simpson and Williams, placed her in the recovery position.

The officers present formed the opinion that Ms Walker was deceased. Constable Simpson observed Ms Walker's eyes roll back when she was placed in the recovery position. CPR was not performed by any of the police officers until after the QAS officers arrived.

QAS received the police call at 10.42am. Officers Blake and Nucifora were at the station at 10.52am and commenced resuscitation. Officer Howarth states she was called to back up officers Blake and Nucifora at 10.48am. She arrived at the station at 10.54am. When she arrived Constable Tanswell was doing external chest compressions while Officer Blake was managing Ms Walker's airway and officer Nucifora was preparing equipment.

Prior to that Ms Nucifora had been performing chest compressions. Officer Nucifora recalls a cracking sensation under her hands when performing the first, second and third compressions.

Ms Howarth noted that Ms Walker's hands and arms were cold and her pupils were fixed and dilated. The cardiac monitor showed pulseless electrical activity. Ms Howarth recalls having conversations with various officers which caused her some confusion about how long Ms Walker had been in her current condition. The impression that she formed was that Ms Walker had not been seen for 15 minutes prior to police discovering she was not breathing.

Resuscitation attempts continued for about 15 minutes. The decision to discontinue was based on significant 'down-time' between Ms Walker being discovered unconscious and CPR commencing.

The investigation detailed earlier then commenced. Ms Walker's son identified her body to police.

Autopsy and medical evidence

Professor David Williams performed the autopsy examination. The internal examination showed evidence of severe trauma and significant natural disease. The major trauma injuries were penetrating injuries of the left lung caused by displaced fractured ribs and a lacerated spleen.

At the time of her death Ms Walker was suffering established micronodular cirrhosis of the liver, emphysema and chronic obstructive airways disease.

According to Professor Williams, Ms Walker died predominantly from the acquired injuries. Toxicological analysis found a blood alcohol level of 0.194% and the presence of diazepam and its metabolite. This indicates that Ms Walker was severely intoxicated and moderately anaesthetised by the combination of alcohol and hypnotic drugs. This might explain why the deceased made no complaint of pain following the accident.

Professor Williams noted that "*there are several fractured ribs particularly at the left side of the chest. Ribs 6, 7, 8 and 9 are fractured posterially and ribs 5 and 7 are also fractured laterally.*" He also noted that "*the bone appears somewhat brittle.*"[17]

Professor Williams found that the "*left lung shows penetration by at least 3 anteriorly displaced fractured ribs and there is evidence of haemorrhage associated with these puncture wounds to the back of the left lung (basal aspect of the lung)*". There was evidence of bleeding to the left side of the thoracic

[17] Exhibit 56

cavity and the lungs were punctured by fractured ribs displacing towards the front of Ms Walker's body.

There is conflicting medical evidence regarding the cause of the rib fractures and displacement. The question is which injuries were caused by the motor vehicle accident (if any) and which were caused by compressions administered by officer Nucifora during CPR (if any).

Professor Williams' opinion was that all rib and lung injuries were caused by the force of the traffic accident. He did not believe that the extent of the injuries were likely to have been caused by compressions administered during CPR at the watchhouse however under cross-examination he deferred to the opinion of clinicians.

Professor Williams gave evidence that 2 – 3ml of blood was found at each of the puncture sites. This is not conclusive in respect of the question as to whether the lung injuries occurred ante or post-mortem.

Dr Cleary, Executive Director Medical Services for the Southside Health District and emergency medicine specialist, was also of the opinion that the injuries were more likely to have been caused in the traffic accident. While he agreed that rib injuries often occur during CPR, he thought the far greater forces of the traffic accident were a more likely cause in this case. In his view, direct force would need to be applied to Ms Walker's body to produce those injuries. The photographs of her car show that the squab of the front passenger seat was deformed a considerable distance to the right and forward into a position that would make it likely that Ms Walker was smashed against it as her car was driven sideways by the impact of the much larger 4WD.

Like Professor Williams, Dr Cleary thought it more likely that the force of CPR would cause anterior, rather than posterior or lateral, rib fractures. He said that the cracking noises heard by QAS officers during CPR might have been the already fractured ribs moving. Dr Cleary's evidence was that the pain attributable to the combination of injuries might have been masked by Ms Walker's intoxication but conceded that it was difficult to reconcile the extent of injury with evidence of Ms Walker's movement at the scene and her ability, at that time, to provide a specimen of her breath.

Dr Rashford's evidence was that while the posterior and lateral rib fractures might have occurred as a result of the accident, in his opinion the markedly displaced rib fractures and consequent punctures of the left lung were likely to have been caused during CPR. The basis for this opinion was that Ms Walker would have felt significant pain had the injuries been caused during the accident and the level of intoxication would not have been sufficient to mask that pain. He said that a patient administered morphine and suffering those injuries would feel significant pain. He did not accept that Ms Walker would have exhibited no sign of pain or discomfort had she been suffering the displaced rib fractures when attended to by the QAS officers soon after the accident. He also noted an apparent absence of respiratory compromise after the accident although I am less convinced that the officers who observed Ms Walker in the police station were particularly alert to this. Further I note that she required three attempts to provide a specimen for the road side breath test.

It is puzzling that Ms Walker either did not experience or concealed the pain one would expect had her ribs been fractured, but pain varies greatly between individuals. It is notable that after she arrived at the police station Ms Walker hardly moved. Superintendent Carroll's evidence that she was swaying like someone who was drunk and falling asleep is more persuasive than that of Sergeant MacPherson who was convinced that Ms Walker was swivelling her head around attempting to avoid providing a specimen of breath.

While the evidence is difficult to reconcile, I am of the view that, having regard to the opinion of the various experts who gave evidence, it is more likely that the ribs were fractured as a result of the traffic accident. I am unable to determine whether those broken bones immediately lacerated the lung against which they pressed or whether that happened when they were displaced by the chest compressions performed during CPR.

On post-mortem examination the splenic capsule showed tearing which caused bleeding. 1.2L of blood was found in the abdominal cavity on account of this injury. That is significant blood loss sufficient to cause death.

Dr Cleary gave evidence regarding four classes of shock a person will move through during the course of increasing blood loss. He suggested that soon after the accident Ms Walker would be suffering class I shock and the lack of clinical signs of her injury reflect that. While it is surprising that she did not report feeling pain on palpation of her left side by officer Nucifora, the evidence of the masking effect of intoxication and the early stage of the injury might provide some explanation.

Immediately prior to her death, Ms Walker was suffering class IV shock which manifested itself principally through lethargy.

Dr Cleary was unable to pinpoint with certainty the point at which Ms Walker's splenic injury became so serious she would not have survived even with medical attention. However, the blood loss was progressive and Ms Walker had a chance of survival with medical attention for a period of time while in police custody had those detaining her known that she was not just affected by alcohol.

Findings required by s45

I am required to find, as far as is possible, who the deceased was, when and where she died, what caused the death and how she came by her death. I have described above my findings in relation to this last aspect of the matter, the manner of death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other particulars of the death.

Identity of the deceased	The deceased person was Nola Jean Walker
Place of death	She died in a holding room at the Cairns Police Station
Date of death	She died on 17 May 2005

Cause of death	She died from blood loss due to the tearing of the spleen and fractured ribs occasioned by a motor vehicle crash.

Concerns, comments and recommendations

Section 46 provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

The circumstances of Ms Walker's death, in my view, raise the following issues for consideration from this perspective:-

- Did QAS provide appropriate treatment and undertake all necessary observations when assessing Ms Walker at the scene of the traffic accident?

- Was it reasonable in the circumstances that QAS did not recognise that Ms Walker was suffering serious injuries following the traffic accident?

- Was it reasonable for QAS to accede to Ms Walker's desire not to be taken to hospital?

- Was it reasonable for police not to seek medical treatment for Ms Walker while she was in custody at the police station?

- Was it reasonable for police not to attempt resuscitation during the period between when it was discovered Ms Walker was not breathing and when QAS attended?

- Are the OPMs and police training adequate in respect of identifying the need for medical treatment in similar circumstances?

The adequacy of the ambulances officers response

The finding that Ms Walker suffered significant traumatic injuries in the car crash that lead to her death about two hours later, naturally leads to a query as to whether the care given to her by the QAS officers in the intervening period was adequate.

As I have detailed earlier, when QAS officers Blake and Nucifora attended the scene they spoke with Ms Walker, took readings of her vital signs and looked for indications of injury.

Ms Walker was adamant that she was not injured. She seemed lucid and spoke clearly and coherently, impressing the officers with her ability to remember and accurately pronounce the names of pharmaceutical drugs she had taken the day before. Her vital signs were within normal ranges and stable when taken on two occasions about seven minutes apart. The officers undertook some physical examination of her shoulder and rib area but did not auscultate her chest or ask her to enter their vehicle so that they could more effectively examine her abdomen.

It is highly surprising that the examination of Ms Walker gave no indication that she was suffering serious injuries. However, having regard to the evidence of Dr Rashford and Dr Cleary I am of the view that their examination of her was, in the circumstances, adequate.

The QAS officers recognised the diagnostic limitations of their examination of Ms Walker and recommended that she allow them to take her to hospital for observation and, if deemed necessary, further investigation.

Ms Walker was adamant that she did not want to go hospital. Her son acknowledged in evidence that it is likely that Ms Walker would have been quite insistent about this. She buttressed her claim that she did not need to by referring to her employment as a nurse for 40 years. As we now know, Ms Walker was mistaken in her belief that she did not need any further medical attention but even though the ambulance officers did not agree with her, in the circumstances I consider they had no authority to compel Ms Walker to accompany them to hospital.

Refusal of patients to accept treatment is an issue ambulance officers must deal with frequently. The relevant law and policy is contained in the *Ambulance Service Act* 1991 and the QAS Clinical Practice Manual. The policy regarding refusal of treatment has been condensed onto the 'VIRCA card' previously mentioned. Section 38(1)(a) of the Ambulance Service Act provides that an authorised officer, in providing ambulance services, may take any reasonable measures to protect persons from any danger or potential danger associated with an emergency situation. Section 38(2)(h) further provides that in order to protect a person in such situation an authorised officer may administer such basic life support and advanced life support procedures as are consistent with the training and qualifications of the authorised officer.

In this case I consider the officers reasonably concluded that Ms Walker had the capacity to understand the nature of her condition and their advice to her; she was therefore entitled to make an informed decision to refuse further treatment. They had no basis to conclude that she had any life threatening injury of which she was unaware.

As the ambulance officers were preparing to depart the scene of the motor vehicle accident, the police officers were commencing their inquiries into the accident which led Constable Simpson to suspect that Ms Walker may have been intoxicated. It seems that suspicion was not confirmed until after the QAS officers had left and they candidly admitted in evidence that even if they had been told she was very drunk, it is unlikely that they would have acted differently by, for example, examining Ms Walker more thoroughly or revising their decision that she had capacity to refuse treatment. However, one can readily imagine cases where this information would impact the actions of QAS officers and indeed the QAS officers involved in this case told Mr Nash during the course of his investigations that such knowledge may have led to more thorough investigations and a more critical assessment of Ms Walker's capacity.

Similarly, the ambulance officers did not advise the police officers that undetected injuries might become more apparent in the coming hours and that they might

manifest themselves in ways the officers or others could observe if alert to them. It was suggested that the QAS officers did not know that Ms Walker was going to be detained by police and that in any event it would be inappropriate and/or impractical to make a medical type handover to non medical people. It was also suggested that research has demonstrated that written warnings about potential adverse developments do not assist people respond to them.

I am not persuaded that the issue is so complicated. The simple facts are that on occasions police officers will have information that will assist ambulance officers to do their job and vice versa. Moreover, I suspect that on many occasions an informal exchange of intelligence occurs making the jobs of ambulance officers and police officers easier, while increasing patient/defendant safety. For example, were the ambulance officers to have said to police, "*She's been involved in a pretty serious crash; just keep an eye on her; if she becomes vague or drowsy or if she gets cold and pale or shallow of breath give us a call,"* I expect the officers may have paid more attention to these issues and not so readily assumed that Ms Walker was just drunk. All I am suggesting is that the possibility of increasing these useful exchanges be explored.

Recommendation 1 - Exchange of information between police and ambulance officers

I recommend that the QPS and the QAS consider ways of ensuring that information relevant to the health and safety of patients/prisoners is passed between the services.

Adequacy of police response

Monitoring her need for medical care

It is clear that Ms Walker's condition deteriorated rapidly once she reached the police station. I do not accept the submission that her decline was a slow and gentle dozing off.

QAS officers saw minimal signs of intoxication at the scene of accident. At most, on Simpson's account, Ms Walker's speech was slightly slurred and she walked slowly but she was alert and coherent. Just prior to her being taken to the BAS to provide a specimen of breath she started to "*nod off."* At the BAS her condition markedly changed. She was falling asleep such that her head was dropping and she was swaying from time to time in the chair. Constable Simpson feared she may fall from it. Back in the holding room, Constable Simpson gave up trying to interview Ms Walker because she kept losing consciousness. From then on she was seen often and by many seated at the left corner of the bench seat with her head slumped forward and slightly to the left, albeit she was still able to be roused.

All assumed that she was simply succumbing to the effects of alcohol. We now know they were gravely mistaken. However, the officers who arrested her had been led to believe by the ambulance officers who examined her that Ms Walker did not have any significant injuries and they also had evidence of a very high level of intoxication. They had not been alerted to the possibility of concealed injuries. In all of the circumstances, it is easy to understand how they fell into error.

Training issues

A number of QPS training materials and OPM provisions were examined during the inquest. Those documents show that the QPS has endeavoured to educate its officers about medical aspects of intoxication including the risk that the symptoms of other life threatening medical conditions can mimic or be masked by intoxication.

The Watchouse Custody Awareness booklet states that "*if a prisoner does not appear to be sobering up this could be a result of a head injury or other serious medical condition".*[18]

The Cairns District has also developed some excellent training materials and its officers have had the benefit of lectures from an experienced GMO. It must be said however that the two junior officers involved in the detention of Ms Walker seem to have retained very little of that training.

The OPMs have changed significantly since the time of Ms Walker's death and they now appear to deal with the health and safety of intoxicated or apparently intoxicated prisoners in comprehensive detail. The provisions however deal specifically with those detained in watchhouses which was not the case here.

I accept that this case involved a set of circumstances that are unusual and that those circumstances made the identification of Ms Walker's parlous condition difficult. The difficulty of such cases however should not bar attempts to improve police knowledge that might help identify such cases in the future.

Dr Cleary expressed the view that it would be valuable to review the training materials to draw together all the key themes relating to the medical aspects of custody awareness training. Themes that could be reinforced include:

- Not assuming that a person who appears to be intoxicated is intoxicated;
- Being alert for indications of conditions that mimic or mask intoxication;
- Recognising that if an intoxicated person is becoming more vague and less lucid over time they should be reviewed; and
- Recognising that concealed haemorrhage is one cause of deterioration in a person who *is, or* appears to be, intoxicated.

I agree with Dr Cleary.

Dr Cleary also suggested that more thorough observations might have alerted police to the seriousness of Ms Walker's condition earlier. The evidence was that while the observations of Ms Walker were frequent they were from a distance which did not allow an assessment of her temperature, breathing or pallor. Changes to the OPM 16.13.1 (Assessment of Prisoners) address this concern however a number of the requirements are directed towards prisoners processed through a watchhouse. I consider that the provisions are equally necessary for those held in police holding rooms

[18] Exhibit 61, p68

Recommendation 2 - Review of QPS training concerning intoxication

I recommend that as part of its commitment to continuous improvement, the QPS review training materials and the OPMs in order to draw together and reinforce the medical issues identified by Dr Cleary associated with intoxicated and apparently intoxicated persons wherever they may be encountered.

Failure to commence CPR

None of the officers commenced CPR. We now know that resuscitation attempts by the officers would have been fruitless but they did not and could not know that at the time. So far as they were aware she had been sleeping normally minutes earlier and was only drunk. The OPM in 16.24.2(iii) obliges an officer to attempt resuscitation when finding an apparently dead prisoner, "*if appropriate*." There does not seem to be any reason why a resuscitation attempt in these circumstances would have been inappropriate. The officers involved should be reminded of their obligations in this regard.

Referral to the DPP

The Coroners Act by s48 requires a coroner who, as a result of information obtained while investigating a death, "*reasonably suspects a person has committed an offence"* to give the information to the appropriate prosecuting authority.

I take "*committed an offence*" to mean that there is admissible evidence that could prove the necessary elements to the criminal standard.

As detailed earlier, the medical evidence indicates that had Ms Walker been taken to hospital at some stage before she collapsed, she may well have been saved. This raises the question of whether the police officers who had her in custody for the two hours before she was found dead, could be held criminally liable for the death.

The Criminal Code in s285 provides, so far as is relevant to this case, that it "*is the duty of every person having charge of another who is unable by reason of…detention…to withdraw from such charge, and who is unable to provide herself with the necessaries of life…to provide for that other person the necessaries of life; and the person is held to have caused any consequences which result…by reason of any omission to perform that duty."*

In this case, the officers who arrested Ms Walker had her in their custody and as a result she was unable to access medical attention had she been so inclined. In those circumstances the officers had a duty to provide medical attention and they are deemed by the section to have caused the consequences of a failure to do so. A jury could conclude the consequences were the death of Ms Walker.

However, the provisions of chapter 5 of the Code modify the criminal responsibility for acts that might otherwise be crimes by creating defences and excuses. Section 24 provides, so far as is relevant to this case, that *"a person who …omits to do an act under an honest and reasonable but mistaken belief in the existence of a state of things is not criminally responsible for…the omission to any greater extent than if the real state of things had been such as the person believed to exist."*

In this case the officers honestly but mistakenly believed that Ms Walker was only suffering the effects of intoxication. As I have indicated that belief was not unreasonable having regard to the information they had received from the ambulance officers that she did not require medical attention. In those circumstances their criminal responsibility is limited to what would have been the outcome if they had been right in their assumption that Ms Walker was only drunk. It is easy to conclude that she would in all probability have suffered no harm. Accordingly the officers could not be convicted of any offence and no referral to the DPP arises for consideration.

Acknowledgment

In critiquing the performance of the ambulance and police officers who dealt with Ms Walker on the day of her death, I have necessarily focussed on aspects of their performance that could have been better or missed opportunities to avoid the death. This should not be construed as personal criticism of the officers involved. I saw no evidence of malice or callous disregard for Ms Walker. On the contrary, there were a number of examples of caring and compassionate treatment of her as one would expect of public servants dealing with a frail and elderly member of the public. I trust that each of the officers involved has learnt some valuable lessons from this sad case that will make future deaths in similar circumstances less likely.

I close this inquest.

Michael Barnes
State Coroner
Cairns
23 November 2007