QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Master Carr and Jaylen**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2018/1785, 2018/1786
DELIVERED ON:	27 August 2020
DELIVERED AT:	Brisbane
HEARING DATE(s):	26 August 2019, 28 October to 1 November 2019
FINDINGS OF:	Christine Clements, Brisbane Coroner
CATCHWORDS:	Coroners: Death after high speed car crash, vehicle stolen, juvenile driver, family concerns re facts, cultural issues.
REPRESENTATION:	
Counsel Assisting:	Ms Avelina Tarrago
Christeena Carr:	Mr Terry Lambert instructed by ATSILS
Kelly Armstrong:	Mr Matthew Jackson instructed by Caxton Legal Centre
Sergeant O'Neill:	Ms Claire McGee instructed by Gilshenan and Luton Legal Practice

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Introduction

1. I acknowledged the traditional owners on this land where the court met, the Turrbul and Yuggera people. The names of the two young people whose deaths were reported to me are referred to in these findings as “Master Carr” and “Jaylen” This is as requested by their families.

2. An inquest was held to examine the circumstances of their deaths, and specifically to establish:

    - Their identities,
    - How they died,
    - When they died,
    - Where they died and
    - What caused their deaths?

Personal information

3. At the inquest, family members provided personal details of each of the two young people, which is summarised as follows.

4. Master Carr was born on 12 March 2001. He was 17 years of age when he died on 21 April 2018. His mother, Christeena Carr, read her statement at the inquest about her son.

5. Christeena comes from Moree, Kamilaroi country. She has eight children and six grandchildren. On 22 April 2018 she received the worst news of her life from her sister’s daughter, over the phone. She had seen on Facebook that her son had died the day before.

6. Christeena described her handsome, much loved son, who grew up on Stanley Village in Moree. He loved the bush, fishing, motorbike riding and swimming in the river. He was a dare devil.

7. His mother said he loved school, where he was diagnosed with ADHD. When her son was 8, Christeena’s mother died and the family relocated to Campbelltown, Sydney. Her son made new friends quickly and made the team, playing soccer and regional swimming. He enjoyed Aboriginal art. He looked up to his two older brothers and was protective of his younger siblings. His family was the world to him. He dreamed of working, fixing motorbikes. He loved his school and his teachers loved him. The principal and teachers attended his funeral.

8. Christeena knew her son got into some trouble and spent some time in detention where he comprehended what he had done wrong. She stood by her son and supported him. She was very worried about him when he got into some trouble with police. Her son was worried that because he was an Aboriginal boy they would just take him.

9. Christeena said that at the age of 15 her son wanted to go back to Kamilaroi country and he travelled between Moree and Campbelltown.

10. Jaylen was born on 29 November 2001. He was 16 years of age when he died on 21 April 2018. His parents are Kelly Armstrong and Jeffrey Close who provided a statement which was read out by their legal counsel, Mr Jackson.

> *Jaylen was the oldest of their six children and was described as "everything to our family." He had a lot of love and respect for everyone and was well known in the community. His biggest focus was his family. He loved his parents, his siblings and extended family and as the oldest child, provided a lot of help to his parents.*
>
> *Jaylen was a really good footballer. He made a representative side twice and was best and fairest player in his team. His favourite team was the Broncos.*
>
> *His parents acknowledge that no teenager is perfect and he made mistakes, but his loss has devastated the entire family, in particular the younger children.*

11. Jaylen's grandfather, Neil Armstrong, who was in attendance at the inquest, provided a written statement directly to the court which expressed his great love and sorrow for the loss of his grandson.

12. Jaylen's aunt, Janelle Armstrong described the bond Jaylen had with his older cousins growing up in Warwick. He was described as "always happy-go-lucky and a very respectful boy, always using his manners." His cousin Elly Close said Jaylen was full of laughter and happiness. He always had a big smile on his face and was the joker of the family. Elly looked up to Jaylen as a "big brother to her." He would check on her to see she was okay and always kept contact. He is very much missed and loved.

13. Both of these young men who were aged on 17 and 16, were loved members of their families and friendship groups and their sudden traumatic deaths have caused great loss and distress.

Discovery of the deaths of Master Carr and Jaylen

14. Kenneth and Benjamin Campbell, who are father and son, are farmers and graziers. On Saturday 21 April 2018 they were travelling south along the Gore Highway towards Goondiwindi to a property then known as "Morcourt." They were travelling together to pick up a newly fitted and adjusted fertiliser spreader for a tractor. Benjamin was driving the Toyota Cruiser and his father was in the passenger seat. It was between 10:30 and 11:00am as they were crossing the Wyaga Creek when Kenneth looked across at his son whilst talking to him. By chance, he noticed a wrecked vehicle on the bank of the creek. It occurred to him that he had not noticed it on the previous day when he drove into town.

15. He mentioned it to his son as they proceeded at about 100 kilometres per hour. He said there were no obvious signs that there had been a recent accident, no smoke or dust. As they were running late for their appointment, they continued. Kenneth said in the past he had stopped at two such vehicles, fearing there had been an accident, but never discovered anyone.

16. They commenced their return journey about an hour later, this time with Kenneth travelling ahead in the Toyota as an escort, while his son Benjamin drove the tractor and spreader behind. Benjamin said they travelled at between 30 and 42 kilometres per hour, depending on the road. Kenneth had said to his son they would pull up at the creek crossing to check the vehicle, just in case, although he did not expect to find anything.

17. They stopped at about noon; neither wears a watch. They stopped, off the road at the Wyaga Creek Rest Area, with the father arriving before the son. The vehicle could not be seen from this position and Kenneth walked to the edge of the steep creek bank and looked down to the southern bank of the dry creek bed.

18. It was difficult, steep terrain, with no clear pathway as Kenneth clambered down to the wreck. He looked into the vehicle first. He wears transition glasses. He had no expectation that he would see anyone in the vehicle, he just wanted to make sure. He did not see anyone inside as he hung onto the vehicle to walk around the back. The vehicle was on a slope with the underside facing up on an angle. As he moved towards the back, holding on to steady himself, he felt the manifolds, the exhausts, which were warm from the sunshine, but not hot from the engine. That would have burnt his hands.

19. As he got to the back of the vehicle, he suddenly discovered the body of a person on the ground about two or three feet behind the vehicle. He was taken aback as he had not expected this. The person was clearly deceased. Mr Campbell did not see any movement or hear any sound. The appearance was the person was deceased. He could not identify or recognise the person.

20. His son Benjamin was by this time also coming down and he told his son to call ‘000’.

21. Kenneth had never seen a car in as bad a condition as the wreck. The car was unrecognisable except via a Holden symbol on a tyre rim. He thought there was no way in the world that anyone could survive such an impact.

22. Father and son confirmed that phone service at the rest point at Wyaga Creek was abysmal. Benjamin hoped that he might get through on ‘000’. He did so, but only when he climbed onto the roof of the tractor cabin to get service. He reported they had found one deceased person. He was asked for the registration number of the vehicle, and therefore he climbed back down, also calling out loudly as instructed, in case anyone else had been ejected.

23. Benjamin Campbell discovered a second deceased person trapped in the vehicle. There were no signs of breathing or movement and no response to yelling. He returned back to the rest stop to report the presence of a second person. He also reported the registration number.

24. The observations made by Kenneth and Benjamin Campbell were important as they were the first people to discover the wreck and the presence of the two young people who had died. Both father and son confirmed the vehicle was warm to the touch, but this was from the sun. Both described the vehicle as "totally wrecked, with debris and stuff everywhere." Benjamin Campbell recalled a jerry can on top of the vehicle. They both stated there was no debris on the Gore Highway road surface indicating any incident.

25. The son could not recall whether the person inside the vehicle was wearing a seatbelt or not. He could remember seeing socks on the hands of at least one of the two persons, the person outside the vehicle.

26. Both father and son were aware there was a flood camera at the Wyaga Creek Crossing. They described its position on the southern side of the creek, on the eastern side of the Gore Highway.

27. Benjamin Campbell described the road conditions at the Wyaga Creek Crossing as "quite bumpy and rough and ever varying." He identified a "big, bad bump" on the northbound lane at the end of the straight section of road leading to the creek crossing. His evidence was that the bump was 100 metres to the north of where the vehicle had left the road. He said while driving the truck, he would try to avoid the bump which he said was dangerous. It has since been repaired.

28. Benjamin Campbell confirmed the road narrows across the creek way, there were no signs indicating the narrowing and both sides of the crossing have steep concrete culverts, rather than gravel shoulders.

29. He said if a driver was looking ahead on the road, proceeding in either direction across the creek, the car wreckage could not be seen.

<u>Police report of the deaths of Master Carr and Jaylen to the coroner</u>

30. The initial reports of the deaths of Master Carr and Jaylen were received by the Coroners Court of Queensland on Monday, 23 April 2018.

31. The reporting officer was Constable Di Marco. The wreckage of a single vehicle traffic crash had been discovered and reported to police at approximately 1:00pm on Saturday, 21 April 2018. The site was at the western side of the Wyaga Creek rest area, on the Gore Highway, 35 kilometres north of Goondiwindi.

32. Police attended and observed a green coloured sedan destroyed by impact with trees, scrub and the creek bank. The vehicle appeared to be on its roof and the collapsed driver's side of the vehicle. A rear bumper was found 30 metres away with a Queensland registration number.

33. Two males were confirmed deceased, and in a state of rigor mortis.

34. The first male appeared to be a juvenile, and was described as of Aboriginal and Torres Strait Islander appearance. He was lying face down outside the vehicle to the west. He was wearing a blue coloured hooded jumper, blue polo shirt and white long sleeved T-shirt. He had gloves on his hands. Subsequently, he was identified by finger print records, as Jaylen.

35. The second male also appeared to be a juvenile. He was described as Caucasian in appearance, and was wearing a black coloured long sleeved shirt with a small white coloured motif on the front left chest. He had one white coloured sock on his right hand. He was trapped inside the vehicle. Subsequently he was identified by finger print records, as Master Carr.

36. No identification was located for either person at the scene. Queensland Ambulance Service officers issued life extent certificates for the two unidentified males at 12:55pm on 21 April 2018.

37. Communication with police agencies confirmed the vehicle was stolen from an address at Peregian Springs in Queensland on Friday 20 April 2018.

38. A forensic crash investigator, Senior Constable Soper, attended the crash scene on the Gore Highway. The initial assessment indicated the vehicle was travelling south along the Gore Highway when the driver apparently lost control, initially veering west into the oncoming lane, before continuing off the road in a south west direction. The vehicle impacted with several trees, separating the front fender from the car, which continued southwest across the dry creek bed and impacted with the ditch on the other side, landing on the driver's side.

39. Queensland Fire and Rescue Service extricated the deceased person (subsequently identified as Master Carr) from the vehicle. Both deceased people were lodged with the undertaker as "unknown persons" and transported to the John Tonge Centre, in Brisbane.

40. At approximately 11:00pm on Saturday 21 April fingerprint records were matched with fingerprints taken from the two deceased males. The deceased person whose body was found outside the car was identified as Jaylen. His last address was in Toowoomba.

41. The deceased person whose body was entrapped in the driver's position of the car was identified as Master Carr. His last address was at Beenleigh.

Cause of Death of Master Carr

42. Master Carr's autopsy examination occurred on Thursday, 26 April 2018 and was undertaken by the forensic pathologist, Dr Forde. The autopsy was limited to an external examination of the deceased person together with toxicology testing, and CT imaging, which had occurred on 24 April. The limitations were authorised due to the objection of the next of kin to an internal examination.

43. A tattoo with the word "Carr" was observed on the left hand. At the time of the pathologist's examination of Master Carr, there was no jewellery on the body.

44. Dr Forde confirmed that the autopsy report incorporated the specialist radiologist report which reviewed and reported on the CT scans.

45. This report from the radiologist assisted the pathologist's external examination to identify and understand any internal injuries or disease processes.

46. In her evidence at inquest the pathologist, Dr Forde stated injuries sustained in motor vehicle accidents can be quite severe, including skull fractures, rib fractures, spinal and pelvic fractures as well as fractures of upper and lower limbs.

47. Master Carr had severe facial and skull fractures as well as bleeding within the head, around the surface of the brain, outside and within the cavities of the brain. There was injury where the skull meets the spine and displaced bone fragments into the brainstem. There were also limb fractures including a dislocated left shoulder and fractures of hand bones and a fracture of the right leg.

48. The pathologist was asked if there were any specific injuries associated with a person driving the car. She gave an example of an injury from a seatbelt from right shoulder to left hip and across the abdomen. No such specific injury was noted, apart from an abrasion of the right shoulder.

49. Master Carr's injuries were confirmed to be traumatic. The pathologist confirmed that at the time of the injuries, death would occur almost immediately. She did not think that Master Carr would have suffered.

50. The pathologist was asked specifically whether it was possible Master Carr had suffered a gunshot wound. Dr Forde stated, no, because the CT scan did not show any injuries to suggest a bullet wound.

51. If there had been a bullet wound there would have been a circular entry wound, and an exit wound which can have a lacerated star appearance. On the CT scan it would show a track mark where the projectile has travelled through. There was nothing like that on the CT scan.

52. Dr Forde was asked about a number of facial injuries noted in the autopsy report as abrasion and dicing injuries. Dr Forde explained the term which describes the small cutsand sharp force injuries that occur from impacting, for example, a windscreen or glass. That is probably the most likely cause of a lot of those injuries, and once the glass is broken, then the laceration injuries can occur.

53. Dr Forde was unable to determine the exact time of death by examination. There are too many variables. She was asked about the period of time which passed before autopsy occurred. It was noted that death occurred in a regional area, requiring transport and notification of next of kin and clarification of the family's attitude to autopsy, requiring communication involving the coroner, police, the family and the pathologist.

54. It was also noted that Master Carr's body was transferred to the John Tonge Centre in Brisbane arriving just prior to midnight on Saturday night 21 April. Anzac Day occurred on Wednesday 25 April, the day prior to the autopsy. The CT imaging occurred on Tuesday 24 April.

55. It was confirmed that there is no autopsy service in Goondiwindi. There is a mortuary in Toowoomba, with a sole pathologist. However, in more complex forensic cases, rather than natural causes, and where there are multiple deaths in the one incident, the deceased are brought into the John Tonge Centre in Brisbane.

56. Dr Forde stated that where a family requests a viewing the coronial counsellors are involved in communication with the family. In this particular case where the young man had severe facial injuries the counsellor advised the family it may be best for the viewing at a funeral home as the injuries could be quite distressing. It is then a matter for the funeral home once the deceased person is released into their care.

57. I note the family's application for release was lodged by the funeral company on 30 April 2018. The deceased was released to the funeral director the next day.

58. Dr Forde confirmed a funeral director is not qualified to give an opinion regarding the cause of death.

59. Dr Forde confirmed her examination of the deceased person and consideration of imagining, toxicology and the report of the circumstances in which he was found enabled her to conclude that Master Carr died due to multiple injuries as a result of a motor vehicle collision.

60. Toxicology results showed the presence of methylamphetamine, and amphetamine. No alcohol was detected.

61. Dr Forde was asked whether she could comment or assess what effect the levels of methylamphetamine would have had on the ability of Master Carr to make decisions, and drive a vehicle. She responded it was very difficult to ascribe a certain effect to a certain individual. There are certain generally accepted effects that may occur in people with regards to methylamphetamine, but how an individual reacts can be very variable.

62. Nor was there any clarity around the toxicity level of methylamphetamine. Dr Forde explained that the level of toxicity crosses between the non-toxic through to the potentially fatal range and it is impossible to say how a drug may have affected an individual.

<u>Cause of death of Jaylen</u>

63. Autopsy examination of Jaylen occurred on 24 April 2018 and was undertaken by the forensic pathologist, Dr Day. The order for autopsy was restricted to an external examination together with toxicology testing and CT scans and other imaging. This order had regard to family objection to internal examination.

64. There were distinctive oblique scars in each eyebrow. No obvious tattoos were observed.

65. The clothing was described as a blue hooded jumper, a blue polo shirt, a white long-sleeved T-shirt, khaki track suit pants, a pair of white and orange socks and a single right Black sneaker. The clothing was disposed of.

66. A green shoulder bag was present with the deceased's body. This contained tobacco, cigarettes, 7 lighters, 3 empty clear clip seal bags, an orange straw, 2 broken glass cylindrical pipes, a soft sunglass case, a brown leather pouch, and $15 in notes and additional coins contained in a purple and grey sock.

67. Numerous ants were present within the clothing and on the body.

68. CT imaging reported by the radiologist identified subarachnoid haemorrhage, intraventricular haemorrhage, and basal subarachnoid haemorrhage extending into the cervical spinal canal. There were no facial bone fractures. No cervical spine fracture was identified.

69. There were injuries within the lungs, fractures of the right clavicle, a fracture of the left scapular bone but no rib fractures.

70. In the abdomen and pelvis there was intra-abdominal haemorrhage. There were fractures of the spine at the L3 and L5 level. No lumbar vertebral fracture was identified. There was further fracture of the sacro iliac joint.

71. There were fractures of the left fingers and fracture of the left femur and left tibia.

72. Dr Day examined Jaylen and confirmed significant injuries to the head, chest, abdomen, pelvis and limbs.

73. There was no definite injury to the torso that could be consistent with a typical seatbelt-type injury. Dr Day explained a typical seat belt type injury is an oblique abrasion, bruise or laceration extending from the shoulder to the opposite hip, depending on the position in the car. There is a corresponding transverse injury across the lower abdomen.

74. Dr Day was unable to say after, examination of Jaylen what position in the car he might have been occupying.

75. He confirmed he was aware of the information in the police report, within which it was believed that Jaylen was sitting in the passenger seat and was ejected from the vehicle.

76. If someone was ejected from a motor vehicle they might have secondary impact injuries, as the person impacts with the road surface or any other secondary object. Quite often, these injuries are indistinguishable from injuries sustained within the motor vehicle.

77. Typical injuries arising in car accidents include bony injuries. It depends on the type of accident, the type of vehicle, whether the person has been ejected or

not. Long bone injuries are very common as well as pelvic injuries. Bleeding on the surface of the brain, injuries to all cavities of the bodies are often seen. There is no one particular injury which defines an accident. There are many, many injuries.

78. Dr Day was asked whether the injury pattern was consistent with being ejected from the car. He said there were certain abrasions to the body, but there were none that specifically suggested ejection. Pathologists see a very wide variety of injury patterns when people are ejected. They see a very similar injury pattern in people who are not ejected. However, he was able to say the injuries were consistent with the information given about the motor vehicle accident.

79. Jaylen's most significant injuries were head and brain injuries as well as chest injury and pelvic injury. The combination was very significant and led to death.

80. Dr Day stated the bleeding in the brain in this case was due to head trauma. The disruption of the tissue itself within the lungs indicated very high impact trauma to the chest wall.

81. The time of death could not be established. He was not prepared to reach any conclusion having considered the state of rigor mortis with respect to the time of death as this was very unreliable. None of the information provided from the scene, including observations from ambulance officers could assist the pathologist in establishing a time of death.

82. He was however able to state that the degree of head injury, involving bleeding over the surface of the brain, meant that death would have resulted instantaneously or very rapidly following that injury.

83. Dr Day confirmed the appearance of ant bites was consistent with ants, many of which were seen on the body.

84. Finally, he was able to confirm that he saw nothing consistent with use of a Taser.

85. Toxicology showed methylamphetamine and amphetamine as well as the psycho active constituent of cannabis. No alcohol was detected.

86. The pathologist confirmed these were traumatic injuries consistent with a motor vehicle accident. These multiple injuries caused his death.

87. The injuries, particularly of the pelvis and long bones were consistent with injuries sustained in very high impact or high velocity trauma which is regularly seen in motor vehicle accidents.

88. Dr Day confirmed it was standard practice to dispose of clothing due to the biological hazard.

89. He also confirmed that it was very common for bodies of deceased people from regional areas to be transferred to Brisbane. It was a practice that occurs all the time. The lack of forensic pathologists in certain regions is the underlying issue.

Additional Evidence regarding toxicology results

90. Dr K Robinson from the Clinical Forensic Medicine Unit in Brisbane provided expert toxicology evidence regarding the impact of various substances on the decision-making, judgement and motor skills of the two deceased youths.

91. The proposition was put that Master Carr was the driver of the motor vehicle at the time of the accident.

92. Test results confirmed the presence of methylamphetamine as well as amphetamine, which is the breakdown product of methylamphetamine.

93. After death, drugs tend to be found in higher concentrations in the heart, lungs and solid organs such as the liver. The most useful sample for toxicology testing, to more closely reflect a level that was present in the living person, is a sample taken away from the central areas of the body, at a peripheral site. Femoral veins and arteries are the preferred sites and this is where samples were drawn in the case of both deceased persons.

94. Dr Robinson explained that methylamphetamine is a drug which is a powerful stimulant. It causes massive release of multiple neurotransmitters in the brain by acting on nerve cells and release stored neurotransmitter. There is a massive surge of psychostimulants. It is very powerful and acts upon multiple pathways throughout the brain and affects how the brain functions, but it also affects motor function. Methylamphetamine impacts on how we think, how we process, how we move and how we speak.

95. Methylamphetamine metabolises in the body mostly in the liver to amphetamine and then, over time, is excreted from the body, mostly in the urine.

96. The peak effect of methylamphetamine taken by means of smoking occurs within 10-15 minutes. If multiple doses occur, the stimulant effect will be felt within about 15 minutes and will continue to increase over the next few hours. By about the 4 hour mark the subjective feeling wears off. However, some other impacts on the body, stimulation of the heart rate and body movements will persist for longer.

97. Review of the level of toxicology results does not allow determination of how many doses the person may have had.

98. Methylamphetamine is a stimulant drug. Its use is characterised by feelings of euphoria, and increased alertness. A person may have racing thoughts. They may feel agitated. Anxiety is a commonly reported symptom. The blood pressure and heart rate increase. The pupils dilate and there is often sweating. Body movements can become rapid and a person may move around and appear restless. There can be changes to the patterns of speech including rapidity, pressured speech that comes out garbled and difficult to comprehend.

99. Toxic effects exaggerate the impacts at lower doses. There can be more extreme reactions and changes in personality. A person may be extremely agitated, irrational, confused and may become paranoid. Paranoia is commonly reported in people who are using high doses of methylamphetamine for longer periods of time. People can actually have a cluster of symptoms that very closely mimic schizophrenia. Mental illness and drug induced psychosis may last for quite some time following a binge of methylamphetamine. With chronic long-term use, the impacts can last for months and become very difficult to distinguish between actual schizophrenia and a drug induced psychosis.

100. The effects of a low-dose of amphetamine would be alertness, increased concentration, and a sense of euphoria and increased heart rate and blood pressure as well as pressured speech, that is, rapid speech.

101. Withdrawal can be experienced after a single dose of methylamphetamine and can also be experienced after a binge, as the drug levels are falling. An individual will be quite fatigued, quite tired and drained. They are quite dysphoric, down in mood. The appetite may increase but there will be a decreased pleasure in life generally which can last from hours to days.

102. Dr Robinson explained there is poor correlation between how an individual presents and what a blood level might be. Every individual responds differently to a blood level depending on the history and patterns of use of the drug as well as the individual characteristics of their own metabolism.

103. Typically, toxicity is said to occur at 0.1 milligram per kilogram with death occurring anywhere between 2.3 and higher. But there is tremendous variation.

104. Dr Robinson stated methylamphetamine does affect a driver's ability. This depends upon the pattern of use. Driving requires complex divided attention to perceive the environment, make decisions, process that and then include physical movements in your decision. In all stages of driving the effects of methylamphetamine can be quite profound. If you are hyper stimulated and agitated, your body movements are affected, and your thoughts are racing.

105. If you are distracted, unable to concentrate, confused, then all of these factors could impair driving.

106. If you are feeling euphoric and invincible, you may be more restless and take more risk. Some drivers under the influence of methylamphetamine do display driving behaviours such as speeding, weaving. They tend to leave the lane of travel and are more likely to be associated with incidents of motor vehicle accident and fatal motor vehicle crash.

107. If the person was in the withdrawal phase, they may fall asleep behind the wheel. The person may veer off the side of the road, hit a tree and there may be no signs of breaking or attempted swerving to miss an oncoming obstruction.

108. In relation to Master Carr, the level was stated to be 0.19 mg/kg. Dr Robinson stated he would be at an increased risk of having a fatal motor vehicle crash

but she could not extrapolate further on the significance of the level because of the many variables and also because of post-mortem issues at play.

109. Ideally, a sample would be collected within the day or 2 days.

110. Dr Robinson was asked to comment with respect to Jaylen, who was deemed to be a passenger in the vehicle. The methylamphetamine level recorded in his case was 0.66 mg/kg. He also had amphetamine recorded at a level of 0.14 mg/kg and THC delta -9- tetrahydrocannabinol at 0.0-4 mg/kg.

111. Dr Robinson stated he would have been affected but post-mortem redistribution would have occurred, even though a sample was taken 3-4 days following death rather than 5 days later in the case of Master Carr.

112. THC Delta-9-tetrahydrocannabinol, which was identified only in Jaylen's toxicology results, causes a feeling of euphoria, increased feelings of well-being and relaxation. However, depending on an individual, a higher dose can cause agitation in individuals. THC is stored in the body and residual levels can be found in the blood weeks later. Blood levels peak approximately 1-2 hours after ingestion but actual subjective effect tend to occur around an hour after that. Upon withdrawal, individuals can become quite irritable, agitated and have increasing appetite.

113. With respect to driving, THC use is associated at an epidemiological level with higher incidence of motor vehicle crash. The World Health Organisation states the increased risk of fatal motor vehicle crash is 1.6 times greater than somebody who has no THC in the blood.

114. The combination of THC and methylamphetamine is individual with respect to its impact.

115. The overall impact of Dr Robinson's evidence was that it was not possible to be specific about the blood level of methylamphetamine present immediately prior to the time of death. Nor could the degree of impairment be known for that reason.

116. The actual level of methylamphetamine does not correlate directly with perceived detrimental impacts upon capacity to drive.

117. Dr Robinson stated there was also evidence at the epidemiological level that people with ADHD are more likely to be risk takers with respect to driving, and there can also be a higher rate of substance use. However, no conclusion could be drawn with respect to an individual in this case.

<u>What were the circumstances prior to the deaths of Master Carr and Jaylen?</u>

118. The investigation involved a number of different police officers, including:
    (i) The first police officer at the scene, part time forensic crash unit investigator Senior Constable Soper, from Goondiwindi Road Policing Unit, who attended at the scene at 1.21pm on 21 April 2018,
    (ii) the initial reporting officer Constable Di Marco,

(iii) full time Toowoomba Forensic Crash Unit investigator Sergeant Coote, who took over from SC Soper,
(iv) Criminal Investigation Branch Detective Sergeant Walpole from Goondiwindi CIB, and
(v) Ethical Standards Command Detective Inspector Fadian.

119. It is determined that on all the evidence, at the time of their deaths Master Carr was physically entrapped within the driver position of the wreck of the green Holden Commodore and Jaylen had also been in the vehicle when it crashed. He had been ejected from the vehicle. Their identities were not immediately known due to lack of any identifying personal documentation.

120. Police were able to identify the vehicle by its Queensland registration plates. It was a 2015, 8 cylinder Holden Commodore which had been stolen from Peregian Springs on the Sunshine Coast the previous day, between 06.00am and 07.15 on the morning of Friday 20 April 2018. Two juvenile males, not Master Carr or Jaylen, were involved in stealing the vehicle. They were subsequently identified, and it is understood that they were charged in relation to that matter.

121. It is unknown how, when and where Master Carr and Jaylen first came into possession and started driving in the vehicle, but it was on that same day.

122. Subsequently a timeline of events was established by investigating police after review of traffic management systems and police information which established where the vehicle was at various times.

123. The timeline runs from 2.04pm on the afternoon of Friday 20 April until the discovery of the wreckage on Saturday 21 April 2018.

(i) At 2.04pm on Friday 20 April 2018 the Holden Commodore was recorded for the first time by a Transport and Main Roads number plate recognition camera situated on the Warrego Highway at Gatton.

(ii) At 2.16pm the Commodore was identified at a fuel drive off incident at the BP College view station on Warrego Highway. CCTV footage was recovered showing a person from the rear driver's side passenger door alight, fill up the vehicle with fuel and return to the car. No one made any attempt to pay for fuel before departing. The person appeared to be a juvenile due to their stature but could not be identified.

(iii) At about 3.30pm off duty Constable Mallet was driving to work at the Gatton Police Station. He was driving his own vehicle on the Warrego Highway at 100 kph. He observed the Commodore in his rear vision mirror, travelling at speed from behind him, in a westerly direction near the intersection of Fielding Road and the Warrego Highway near Gatton. He estimated the speed of the Commodore was about 130 kph as it approached and overtook his vehicle. He observed and memorized the registration number. He glanced at the vehicle and thought the driver was a juvenile. He did not recognize the person and cannot recall the appearance. He did not see whether there were any passengers. He did not engage with the vehicle which weaved off through the traffic heading towards Toowoomba. On arrival at work he checked the

registration number and discovered the vehicle was stolen. He entered the information about sighting the vehicle as a "street check." He contacted Police communications at Toowoomba by radio and informed them of the vehicle heading in their direction. The officer heard nothing more about the vehicle until a few months prior to the inquest.

(iv) At about 9.38pm police officer Sergeant O'Neil sighted the Commodore at the 7/11 business at the roundabout intersection of James and Mackenzie Street in Rangeville, Toowoomba. Sergeant O'Neil is the officer in charge of the Toowoomba dog squad. At commencement of his shift at 9.00pm a briefing included information of a stolen Commodore. It was a distinctive shade of green. He was patrolling and saw the Commodore in the 7/11 business stopped at a fuel bowser. An occupant from the vehicle was outside the car. The police officer did a u turn and saw the vehicle leaving the service station traveling southbound on MacKenzie Street at a great speed. He contacted police communications informing them of the vehicle and asking what resources were available. No resources were available, so Sergeant O'Neil returned to the petrol station. The vehicle was out of sight. He accessed and viewed the CCTV recording of the vehicle at the time and observed at least two occupants in the front of the car. He returned to normal duties. He made no attempt to follow the vehicle. He described the driver as Caucasian appearance, six foot, wearing black shorts, no shoes, and black hoodie with white writing across the front. The CCTV footage showed the Commodore drive into the station, stop, while one person exited. Sergeant O'Neil believed that when he drove past, he was sighted and the vehicle left the premises. No attempt to fill up with fuel was made. He did not observe a black vehicle of a similar model approach the green Commodore. The footage could not be downloaded at the time but was downloaded subsequently.

(v) At 10.15pm an attempted fuel drive off occurred involving the Holden Commodore at the Coles Express Service Station on Ruthven and Alderley Street Toowoomba. The console operator was suspicious and cancelled the fuel delivery. The Commodore left the scene travelling west on Alderley Street. CCTV footage was recovered and showed the driver was consistent with the appearance of Master Carr.

(vi) At an unknown time between 5.00pm on 20 April and 10.30 on the morning of Saturday 21 April a purple Honda CR- V wagon was stolen by unknown person(s) from Hall Road, Yandilla in the Millmerran police division.

(vii) At 10.46 pm a number plate recognition camera on the Gore Highway at Southbrook recorded the Holden Commodore number plate.

(viii) At 12.35am on Saturday 21 April the Holden Commodore was sighted at BP Service station at Captains Mountain. CCTV recordings were later recovered and police concluded that the appearance of the driver of the Commodore was established as consistent with Master Carr. He obtained fuel and left the station without paying for it. This incident was not reported at the time. The stolen Honda CR-V vehicle was at the station at the same time.

Subsequently on about 4 June 2018 Detective Sergeant Walpole became aware from Ethical Standards Command Detective Inspector Fadian of information discovered by family members of one of the deceased that there was a possibly a second vehicle at the BP Captains Mountain fuel stop. They feared there was a second vehicle involved with the Commodore that night, potentially involving police. DS Walpole attended the fuel stop and spoke with console operator Helen Dwyer and a second person. He requested and was shown the CCTV recording of 12.35 hours on 21 April which he viewed. At inquest he said he saw the green Commodore pulling in, then another vehicle he described as "sort of crept up beside the vehicle, and waited." The second vehicle left first, before the green Commodore. He said then they "Take off at speed." He clarified you can't see that the vehicles have arrived together, but you can see when they take off together." He said the person refueling the car did not seem startled by the other car.

From his own knowledge of vehicles he identified the second vehicle as a Honda CR-V. He obtained draft statements from the console operators and returned to Goondiwindi to make enquiries about the registration and ownership of the second vehicle, the Honda CR-V. He discovered it was a Honda CR-V which had been stolen in the relevant time period from a local business. A member of the public who knew the vehicle had noticed it at 10.30 on the Saturday morning 21 April and informed the owner directly. The owner retrieved the vehicle. It was about 3 kilometres south of Captains Mountain fuel stop. It was reported stolen at some later date for insurance requirements. By the time all of this became known to DS Walpole it was too late for fingerprint examination.

The evidence from the console operator at the BP Captains Mountain service station confirmed she worked from 6pm Friday 20 April until 12.30am Saturday morning 21 April. She recalled when she was in her vehicle leaving she saw two vehicles arriving. One pulled up at the bowser and one pulled up at the ice box. The bowser area is lit up, but not the ice box area. She recalled the vehicles coming in together. She could no longer recall details of descriptions of the vehicles. She recalled on her way home she was overtaken by a vehicle she described as "black" which overtook her, "flying past" her, and it overtook a truck that was just pulling out. She could not identify the vehicle. I am unable to draw any conclusions from this particular evidence. However, I do consider the evidence of the CCTV recording at Captains Mountain does show the green Commodore obtaining fuel without paying. The driver appeared to Sergeant Walpole to be Master Carr, as previously identified by Master Carr's friend YZ at the Ruthven fuel station at 10:15pm the previous evening, wearing the same clothing. On review of the CCTV footage Sergeant Walpole could not see into the second vehicle, the purple Honda CRV, sufficiently to see the driver.

It is possible on the evidence that Master Carr and Jaylen had taken the Honda CRV from the poultry farm between Southbrook and Captains Mountain where both vehicles were then seen together and the Commodore was refueled. It is possible that Jaylen was driving the Honda for an undetermined period before that vehicle was abandoned and Jaylen returned to the Commodore and their journey resumed.

(ix) At 12.59 am on Saturday 21 April, Bradley Parker was driving a truck along the Gore Highway towards Goondiwindi. He was just south of Kindon School when the truck was overtaken by the Commodore at a very high speed. The truck had dash cam operating which recorded the green Holden Commodore overtaking

the truck. The truck driver gave evidence that no other vehicle was following. No other vehicle overtook the truck.

(x) At about noon on the Saturday 21 April the wreck of the Commodore was discovered by Kenneth and Benjamin Campbell. They found the bodies of two young males, one entrapped in the vehicle and the other immediately behind the vehicle which was on the bank of the dry Wyaga Creek close to the Wyaga Creek crossing rest stop.

Evidence of Bradley Parker, Truck Driver

124. Bradley Parker was an important witness in the events preceding the Commodore leaving the Gore Highway and crashing into the southern bank of the Wyaga Creek. Mr Parker is a truck drive with 40 years' experience, including driving fuel tanks and road trains. In April 2018 his usual daily trips involved driving from Toowoomba to Brisbane to load fuel, and then out to Goondiwindi to unload, and back to Toowoomba where he changes over with another driver. On 20 April he commenced from Toowoomba at 4.00pm returning back to Toowoomba at 6.00am on 21 April.

125. He described a very, very quiet night for driving, not uncommon after 10.00pm. He was travelling out towards Goondiwindi and had just passed the Kindon School. There was no sign of any light behind him, no-one was around. A little further past the school he started to see the haze of headlights shining off the trees. He thought it strange because he had not passed any vehicles on the side of the road and had not seen the vehicle coming down the straight leading towards the Kindon School. Nor had he seen any vehicles coming out from properties on either side. He wondered where the vehicle had come from. Very shortly after that he realised it was coming down the highway at a heck of a speed, catching up behind him. He travelled about another kilometer and by this stage he could see the actual headlights and that the vehicle was coming at a very fast speed. He moved over to the left, not too far, but knowing that the vehicle was going that fast that it could not afford to make a mistake. He did not want to throw up any rocks that might cause it to lose control.

126. He said the vehicle "shot past, very, very fast – travelled on the right-hand side of the road for quite a distance. There was a very slight bend to the right that you can't actually see around as you approach it. The vehicle travelled around that bend on the wrong side of the road. It then travelled down a straight and disappeared out of sight around a left-hand bend.

127. He was asked whether there was another car following immediately after he was overtaken by the vehicle. He said, certainly not. Nor were there any emergency vehicles that overtook him.

128. He said when the vehicle overtook him he was probably about 1 kilometre away from the left hand bend. When he got to that bend there was the light of an oncoming vehicle which he thought was a truck. He was expecting a comment on the UHF radio but there was no contact. He thought it was a small truck and it may not have had a UHF fitted. Mr Parker could still see the car at the far end of that straight, its lights illuminating a blue sign which indicates there is a parking bay 5 kilometres

down the road. The vehicle disappeared around a right-hand bend and Mr Parker did not see it again.

129. He travelled on and passed through the Wyaga Creek rest stop area, but he did not stop there. He specifically looked out for any sign of a favourite coffee cup gift he had accidentally left previously. He did not see the crashed vehicle. He thought it likely he had his lights on high beam because it was such a quiet night.

130. He acknowledged having fears for the vehicle that overtook him because of the speed. He said anything could have sent it wildly out of control, particularly as there are often kangaroos. He kept a lookout for wheel tracks on / off the road but did not see any.

131. Mr Parker's vehicle was fitted with "dash cam". The footage goes through to Hills Tankers and the footage is stored in the iCloud for a period. There is no access to the footage by a driver. The footage can be accessed and follow up occurs if there are any concerns observed in the driving of the tankers. The footage is focused on the road ahead, and within the cabin and has registers and records the time, the speed of the truck, the revs and the GPS coordinates.

132. The maximum speed for his truck was 90 kilometres per hour.

133. The dash cam recording from his truck at 1 minute to 1:00am on the morning of 21 April 2018 showed the speed of his truck at 90 kilometres per hour, 1400 revs (top gear) and the GPS coordinates. He was concentrating on his driving as the vehicle passed him but he recalled the colour which he described as pale green.

134. Mr Parker contacted Police link on the Sunday evening after seeing a news report which referenced Wyaga Creek and showed the wreck of a pale green vehicle. Mr Parker was saddened on hearing of the death of the two young boys. He had lost a daughter that age and he expressed his sorrow to their families.

135. Mr Parker was aware of the existence and position of the flood camera at Wyaga Creek crossing, which he described as on the left-hand side going out towards Goondiwindi, just after the flood way.

136. Mr Parker held a strong opinion of the condition of the Gore Highway which he described as "shocking", stating "the whole road is uneven, it's rough." He did not consider the road was dangerous as long as you drove correctly. Kangaroos at night can make it dangerous, and if people aren't used to driving at night they can become fatigued because there is nothing of significance between Captain's Mountain and Goondiwindi. He said there were no actual potholes in the road.

137. He did not see a police vehicle passing him in either direction on this section of road. He said it was very rare to see a police vehicle out that far from town. He would have remembered if he saw one because it is information of particular interest to truck drivers.

138. His evidence was very helpful and is accepted. His evidence enabled the narrowing of the period of time at which the Commodore must have left the road at Wyaga Creek Crossing to between 1.15am and 1.30am on 21 April 2018.

Evidence of YZ, a friend of Master Carr and Jaylen

139. YZ had been contacted by family members of the deceased who wanted to know what he knew about events of 20 April 2018 involving Master Carr and Jaylen. His statutory declaration was volunteered to the coronial investigation and inquest. YZ was directed pursuant to the power under the *Coroners Act 2003* to give his evidence at the inquest, thus enabling the evidence to be received but excluding any use of his evidence to prosecute him for any offending identified by self-incriminatory evidence. This was explained to him, including that he could still be prosecuted and punished if he lied to the court, which would be a serious offence of perjury.

140. It was important to hear his account because he was in the Holden Commodore with Master Carr and Jaylen for a period from at least about 8.00pm to 9.00pm on Friday 20 April 2018. His evidence was a bit jumbled, sometimes contradictory and not always clear but he appeared to be doing his best. He was quite open about the events of that evening, including his use of drugs which probably affects his recall, including the time and detail of places. His statutory declaration was made on 31 July 2018. The following is what I understand of his recollections.

141. He was helped by family members when that document was prepared. He remembered the night that his friends Master Carr and Jaylen had the accident. They came around to his home in Newtown in Toowoomba, at around 8.00pm. Jaylen was driving the green car. He said Master Carr was wearing black Nike shorts and black Nike jumper, and a little bucket hat. He was wearing his big gold chain.

142. Master Carr and Jaylen told YZ they had “snaked” one of the boys for the car, meaning they took it from one of the other boys. He did not know details of how those boys obtained the car, but he knew the particular boys.

143. They went to James Street flats and picked up his cousin WX, who then started driving the car. They made it just around the corner before the car ran out of fuel. So then they were all out of the car looking for petrol in people’s yards. They found two fuel drums (jerry cans) after about 20 to 30 minutes, a red one and a black one. These were taken from a big ute. There was some inconsistency about who was driving next, either WX continued or Jaylen took over. They then started looking for petrol stations to fill the vehicle.

144. YZ wanted a lift home and they went to a 7-Eleven fuel station but it was closed and so they went to another fuel stop. He thought it was a Puma fuel stop. As Jaylen drove in, YZ said a “black car got thingy behind us, like trying to block us.” He said the black car came flying in and so we just took off, reversing to get away, without getting any fuel.

145. He eventually said he could not see into the black car because they took off before the other people had a chance to get out. He thought they said something to them, like, “We’re going to get you.” One of them got out of the black car and was coming towards them and the car was trying to aim at the driver’s side door of the green car. Jaylen was still driving at that time and he took off, reversing away. YZ said none of them knew the people in the other car, but he thought it was the owner of

the green car. He made this assumption. He said they did not see the black car again.

146. He said that's when he was dropped off back to his home and he jumped out, as well as his cousin. He thought it was about 9.00pm by this time. He did not see Master Carr or Jaylen again.

147. Descriptions of the details of the fuel stops and the name of streets appeared to be vague. YZ said while he was with Master Carr and Jaylen they did not see any police cars. He did not see any guns, or anyone with guns.

148. YZ said all four of them were taking drugs together that night. They were all smoking Ice together, through a pipe. He said they had heaps of rock which they smoked. He said he did this often. While they were driving around, they went to a few dealer's houses to get drugs.

149. He said because of the drugs he could not sleep when he got home so he rang Jaylen and Master Carr. He said he rang Master Carr on Snapchat. This was quite soon after he had been dropped off. Master Carr said it was "red hot", meaning people were looking for the car and they had to get out of Toowoomba. Master Carr said he wanted to go to Beenleigh to get his clothes and wanted to go to Moree to his girlfriend.

150. YZ spoke with Jaylen on Facebook Messenger who said he did not want to go to Moree. Jaylen then logged off and YZ rang Master Carr back.

151. After that YZ said he was sending messages asking what they were doing. The answer was, "Nothing, just driving." There was no further mention of the black car.

152. YZ assumed during these calls that Jaylen was driving, around 9.30ish. He did not speak to them after this. He said he was off his head with the drugs and he did not remember speaking to the boys after this.

153. YZ was shown the CCTV footage recorded at the Coles Express fuel station at Ruthven Street at South Toowoomba at 10.15pm that night. He could not remember going to that petrol station. He recognized the green car and identified Master Carr who was seen getting out of the car. He could not see the person in the front passenger seat but he presumed it was Jaylen. Accepting YZ's evidence, this occurred after he had been dropped at home.

154. YZ assumed that it was Jaylen who was driving after he and his cousin were dropped off. He said it was hard to get Jaylen out of the driving seat once he was in it. YZ said when he was in the car it was going a lot faster than the speed limit. He said they were going twice the speed limit.

155. YZ's evidence appeared to be prone to some exaggeration and he was uncertain of exactly where they were driving and in what sequence events occurred. Subsequent checks with Puma fuel stations indicated that there was no fuel drive off that occurred on that evening involving the green Commodore.

156. However, there seems to be no reason to doubt YZ's evidence that there was some sort of incident with a black car, which appeared to be attempting to intercept the

green car at a fuel station. YZ's account must be seen in the context of his acknowledgement that he and the other boys were all smoking Ice and he was clearly affected by the time he was dropped off at home, when he was unable to sleep. His interpretation that the black car was after them might well have been true, particularly in the context of the Holden Commodore driving around Toowoomba seeking fuel tanks to steal and attempting to access fuel from fuel stations without paying. The boys and the green vehicle may well have been seen during this period. On YZ's account there were some verbal threats made from people in the black car, and the possibility of physical violence against them. YZ said the boys in the green car responded by escaping in the vehicle and they had contemplated using the vehicle itself to respond to any attack.

157. After YZ had been dropped off at his home, there was no clear evidence from his communication with Master Carr and Jaylen that established who was driving the green Holden Commodore.

158. It was fortunate that two of the boys got home safely that night. Sadly, their friends continued on a journey which ended in their deaths.

Police Investigation of Crash

159. The investigation of the crash was commenced by Senior Constable Soper, a qualified part time crash investigator who was the first police officer on the scene at about 1:20pm on 21 April 2018.

160. He examined the evidence at the scene by walking north on the Gore Highway for a distance of about 300 metres. He saw track marks in the grass and followed this path to the vehicle. He checked further north to see if there were any markings on the road before the vehicle left the road surface. There was no debris and no markings. He did not identify any potholes or divots in the road surface. The road surface was in good condition and was straight for quite some time and level.

161. He found markings, a drain area where there were scrape marks consistent with the undercarriage scraping as the vehicle left the road surface. He marked this position with paint and flags for mapping purposes. Scenes of crime personnel subsequently arrived and took photographs at his direction.

162. He followed the path of the vehicle through quite difficult terrain to the wreck of the vehicle and the two young deceased males.

163. He decided, depending on the circumstances that were apparent at the time, what was appropriate and necessary physical evidence. He did not believe any of the debris was pertinent to the investigation. He was wearing a body camera which was activated, recording the scene and examination. The complete record remains downloaded and cannot be edited.

164. He was in contact with the officer in charge at Goondiwindi, Senior Sergeant McIntosh and Detective Sergeant Walpole, CIB. He was informed the vehicle was stolen. In the circumstances of there being two deceased juveniles and a

stolen vehicle, he proceeded to compile his examination, which was to be transferred to a full-time crash investigator and overviewed by the Child Protection Investigation Unit.

165. He did not specifically recall seeing a jerry can, nor did he identify a particular "big bump in the road." He agreed the road can be bumpy, but did not observe anything that would have caused loss of control in normal circumstances.

166. He was unaware of the presence of the Department of Transport and Main Roads flood camera in the vicinity of Wyaga Creek. He did not see it on that day and did not know of its presence until later. He conceded it was an oversight. He said he had not been expecting a camera out in the middle of nowhere.

167. Senior Constable Soper confirmed he did see socks on hands in the wreckage.

168. He confirmed he was responsible for preserving the scene at the time and he directed other officers to keep the media away and managed that. He confirmed he arranged for the vehicle to be seized and transferred, but he did not retrieve other debris from the scene. Full recordkeeping was made via body camera footage and scenes of crime specialist photography.

169. Sergeant Coote is an experienced crash investigator from the Toowoomba Forensic Crash Unit. He took over the investigation from Senior Constable Soper on Thursday 26 April 2018. He reviewed the initial assessment and decided on use of the specialist robotic mapping device to prepare a precise map of the scene of the crash. Sergeant Coote went to the scene of the crash on 26 April where he took some additional photos, and himself assessed the scene before proceeding to the impoundment yard where he inspected the vehicle. He was able to retrieve the airbag module which was under the centre console. He was then able to use CDR software to access the airbag control module to download information.

170. The module is equivalent to a computer and "makes the decision whether to deploy airbags or to deploy seatbelt restraints depending on the collision and forces involved." The unit records information, similar to a black box data recorder in an aircraft. Because of the degree of damage to the vehicle, it was necessary to actually remove the module from the wreck and then conduct a benchtop download, which is later downloaded on a desktop.

171. When Sergeant Coote attended the scene, he could clearly see a path of the tyre marks leaving the road, leading to the northbound edge of the creek. All the points were measured and recorded as part of the mapping of the scene.

172. He also walked back from the point the vehicle left the road surface, some several hundred metres heading north. He did not observe any evidence attributable to the vehicle subsequently leaving the road surface. There were no markings on the fog line. There was nothing by way of physical evidence to suggest the vehicle may have left the road surface on the left-hand side of the

road prior to moving across onto the right-hand side of the road and off the road surface. He confirmed the shoulder of the road falls away for drainage purposes. He described a concrete side bank which leads down to surrounding land. He confirmed there were scrape marks on the concrete bank followed by a scrape mark consistent with the undercarriage of the vehicle. The pathway continued for some ninety (90) metres with two distinct tyre marks. There was a large distinct impact mark on the side of a very large tree.

173. After this, the tandem tyre marks ceased. The level of the ground falls away at that point and there were several trees that were actually cut off above ground level. The area of impact was some thirty (30) metres further on with a distinct gouging into the creek bed on the southern side.

174. On examination of the vehicle he confirmed "it was a mess", it was clear to him that the vehicle had been involved in a very high-speed collision. He had never seen a vehicle with so much crush damage, through the roof turrets and bonnet. He described it as a very high energy impact.

175. Subsequently, the vehicle was inspected by an authorised officer inspected and confirmed there were no identifiable underlying mechanical problems with the vehicle. Sergeant Coote had collected some components from the scene when he attended on 26 April.

176. When the vehicle was examined, the seatbelts were fastened. This was confirmed when Sergeant Coote later downloaded the airbag module. He was puzzled initially, given that one person was ejected from the vehicle. However, it was then determined that the seatbelts were only extended sufficiently to go across the seat and be engaged. There was no additional allowance for a person's width. The conclusion that was drawn was that the seatbelts were fastened, but the occupants of the vehicle were sitting on top of them, presumably to stop the audible alarm if the seatbelts remained unfastened.

177. The data from the airbag module of this particular Holden recorded up to five seconds of pre-impact data. Sergeant Coote confirmed he first validated the system internally, using evidence within the module itself. He then compared the data with scene evidence, thereby performing an external validation of information retrieved.

178. He confirmed the information established that the seatbelts were buckled, which was consistent with the physical evidence.

179. Frontal and side airbags had been deployed. The frontal pretensioner in the seatbelts was deployed.

180. No rear event was recorded on the module, which was also consistent with the findings of overall damage to the vehicle. The rear of the vehicle was the most intact. There was no evidence of any rear impact of any sort, paint transfer or dints that would indicate rearward impact. There was no evidence consistent with being rear-ended.

181. He confirmed there was significant rear left side of the vehicle impact, consistent with impact of the tree just prior to the vehicle becoming airborne after it had left the road surface. Probably, the power to the vehicle was cut at that point of impact. This was also recorded in the module download. Power is essentially retained to the module and slowly released. This enables the vehicle capacity to deploy airbags despite power being cut in a crash event.

182. Sergeant Coote explained his understanding of the download of the airbag module. The pre-crash data, five seconds prior to impact, recorded 2,624 revolutions per minute of the engine, which remained constant for two seconds whilst the vehicle was proceeding at a speed of 170 to 172 kilometres per hour. Two and a half (2.5) seconds prior to impact, the revolutions per minute increased and at two (2) seconds prior to impact the speed was calculated as 175 kilometres per hour. A trigger event understood to be impact with the large tree occurred at minus one point five (-1.5) seconds which shows the speed of the vehicle dropping to 164 and then 156 kilometres per hour at minus one (-1) second. Sergeant Coote noted this was consistent with the speedometer after the crash which was reading 156 kilometres per hour.

183. The airbag module also recorded the application of brakes at this time, but braking would have been ineffective during the period the vehicle was airborne. Sergeant Coote wondered whether there might have been a momentary application of the brake when the vehicle commenced drifting from the road surface. The speed was such that the vehicle travelled about 90 metres after it left the bitumen road surface in two (2) seconds. The vehicle then impacted very heavily with the first and largest tree, and became airborne, then striking two further trees above ground level and travelling across the creek bed and finally impacting the southern creek bank.

184. Sergeant Coote said there was effectively no capacity to control the vehicle's course after the primary impact with the tree, becoming airborne, the speed of the vehicle and no possibility of the vehicle being brought to a halt.

185. Sergeant Coote considered all of the information from the scene, the download from the airbag console, the information from the dash camera of the truck that had been overtaken previously and the visible evidence of the collision and the impact damage.

186. The underlying reason for leaving the sealed surface was not able to be conclusively established, but included the possibilities of the narrowing of the road surface as it approached the Wyaga Creek crossing, the possibility of the driver swerving to avoid an animal, or an unknown vehicle, or some other unknown circumstance, fatigue, the effect of drug consumption and the possibility of loss of control due to socks on his hands. He considered the speed that the vehicle was travelling at about 170 kilometres per hour prior to leaving the road surface.

187. The road surface itself was described by Mr Parker as "bumpy and ever varying", and this too could have been a contributing factor to loss of control.

188. Sergeant Coote conceded he had failed to identify the presence of a potential source of evidence and/or review, namely the existence and position of a flood mitigation camera at the Wyaga Creek Crossing. Although he had searched the usual list of locations of any cameras, he had not identified this camera. It was not listed under the heading of Gore Highway; it was listed under Wyaga Creek. He had no previous knowledge of the existence of that camera. It is also noted that none of the other attending police officers at the scene of the crash identified the presence of the camera in the vicinity. Locals who traverse the road, including Mr Parker and father and son Messrs Campbell were aware of the camera. Sergeant Coote apologised for the oversight, noting that he is more vigilant and had changed his approach in ensuring every check is made for the possibility of any form of surveillance cameras since this investigation.

189. In the course of his investigation at the time, he was unaware that family members were concerned that there was possible third-party involvement, and/or involvement by police in the circumstances of the crash occurring. When that became known to him, he spoke with family members and endeavoured to follow up and consider all of their concerns whilst completing his investigations.

190. He agreed with the conclusion that the crash occurred within a narrower period of time than initially raised. He agreed that the crash occurred between approximately 1:14am and 1:30am on 21 April 2018.

191. His report recorded, described and interpreted the evidence of how the crash occurred. The report contributed to information which was able to be used in formulation of recommendations to improve safety on the Gore Highway.

Family concerns and issues

Police involvement

192. The families of Master Carr and, in particular Jaylen's family, feared that police may have been involved in a police pursuit which led to the crash and the deaths occurring. They also feared a particular New South Wales police officer, with whom Jaylen had previous dealings, might have caused the crash in which the boys died.

193. As much as was possible, the evidence of the progression of the vehicle's course and sightings of the vehicle and of the occupants has been investigated and reviewed. Ethical Standards Command Detective Inspector Fadian investigated and reviewed the circumstances having regard to the family concerns.

194. Detective Inspector Fadian was briefed of the concerns on 1 June 2018 by Detective Inspector Prestidge who made inquiries through the Brisbane Police Communication Centre. The Communication Centre reviewed records and

confirmed there was no evidence discovered of any pursuits or evade police incidents for Goondiwindi on 20 and 21 April 2018. Detective Inspector Fadian spoke with the local investigators, Sergeant Coote and Detective Sergeant Walpole. They did not identify any evidence of, or reasonable suspicion of a breach of discipline or misconduct by a member of Queensland Police.

195. The Holden Commodore in which the two deceased were travelling on 20-21 April 2018 was sighted and information recorded on "street checks" on four occasions. There were some radio references for example at Gatton to the possibility of deploying stingers to stop the vehicle after it had been sighted but a pursuit did not occur. No interception was attempted.

196. DI Fadian investigated and reviewed the various communication and recording systems within the police service. He did not identify any evidence raising suspicion, concern or evidence of wrong doing by police. He checked Intelligence Tasking Analysis System for the Goondiwindi Police station and Road Policing Unit for the relevant period. From 12.30am through to 1.30am on 21 April 2018 the only Goondiwindi crew rostered for duty were attending a service call at the Royal Hotel in Goondiwindi.

197. On 16 July 2018 DI Fadian spoke with Detective Chief Inspector Jubelin from the New South Wales Police Homicide Squad. He had been contacted directly by two family members of the deceased raising their concerns and he then contacted Detective Inspector Fadian. New South Wales police reviewed their records which indicated the particular officer was logged onto a computer in the charge room of the Moree Police Station at the time the crash occurred in Queensland.

198. On 18 July 2018 Detective Inspector Fadian phoned Master Carr's mother confirming the investigation and that there was no evidence to indicate that the deaths were police related or involved any misconduct.

199. Two police officers who sighted the green Commodore at about 3.30pm on afternoon of 20 April at Gatton, and in the evening at about 9.38pm at Rangeville, Toowoomba gave evidence, which I accept. There was a question asked by radio whether there were any resources to attempt to intercept the vehicle at Rangeville. There were none available and no attempt to intercept, other than as described in evidence at Rangeville.

200. I find there is no evidence of Queensland Police pursuing the stolen green Commodore, attempting to intercept it or in some way causing the crash that occurred.

201. There is no evidence that a NSW police officer was involved, pursued or in some way caused the crash that occurred.

<u>Pursuit by black car or involvement of any other vehicle in pursuit</u>

202. The families were concerned of reports that the boys were pursued by a black car. The concern possibly starts with the account of one of the young people,

YZ, who was in the green Commodore with Master Carr and Jaylen in Toowoomba. He referred to an incident at a fuel station where they were about to attempt to get fuel. YZ said they were suddenly approached by a black car of a similar model (Commodore) which they thought was trying to block them in, aiming at the driver's door. A male person was said to have exited from the car and approached the green Commodore, including making verbal threats.

203. Jaylen immediately responded by accelerating rapidly in response and exiting the fuel station and escaping. YZ said they did not see the black car again.

204. I do not doubt this account, particularly as the boys had been driving around Toowoomba stealing fuel and fuel tanks. It is quite possible they or the green Commodore were sighted by someone in Toowoomba who may have wanted to intercept them. It did not eventuate. Two boys were dropped off and returned home and Master Carr and Jaylen left Toowoomba and proceeded towards Goondiwindi.

205. The vehicle was next recorded by registration recognition technology at 10.46pm on the Gore Highway at Southbrook.

206. At 12.35am on 21 April the green Commodore was observed by fuel console operators at the Captains Mountain fuel bowser. The green Commodore entered and went to the bowser. A second car entered at the same time and stayed back (out of the light) near the ice supply. There is CCTV footage that was retrieved and reviewed by Detective Walpole. He could identify the vehicle as a purple Honda CRV that was later confirmed to be stolen at the time. The Honda CRV left the station at speed, ahead of the Commodore, which left without the fuel being paid for. The Commodore sped off in the same direction behind the Honda.

207. There may perhaps have been confusion for the family given that the console operator could no longer remember details of the second car, and thought it was black. A review of all of this information suggests at least the likelihood that the driver of the green Commodore was not concerned about the second car at this point.

208. Most importantly, the dash cam footage from the fuel tanker driven by Mr Parker did not record any vehicle following the green Commodore after it overtook Mr Parker at very high speed.

209. It is acknowledged that the flood camera at Wyaga Creek crossing could have provided additional independent images of the passage of vehicles at the time and place where the green Commodore left the road. Unfortunately its existence was unknown to investigating police at the time. Footage had been overwritten by the time the request was made. A demonstration of the kind of images that are recorded by the flood camera was presented in the inquest. The footage only shows the glare of headlights against a black background. It is not capable of providing identification of a particular vehicle, but it could have shown the passage of vehicles and the time intervals between any vehicles travelling along the highway at the Wyaga Creek Crossing at the time when the Holden Commodore left the road surface.

210. On all the evidence available it is concluded on the balance of probability that there was no third-party involvement immediately prior to the crash.

Injuries and damage not associated with car crash

211. Other issues raised included a fear that Master Carr had sustained a bullet wound. The Forensic Pathologist who examined Master Carr's body stated there was no evidence discovered by the forensic pathologist and radiologist of a bullet wound on Master Carr. I find that there was no bullet wound.

212. Family members feared that Jaylen had suffered a Taser injury. There was no evidence discovered by the forensic pathologist who examined Jaylen's body of injury caused by a Taser. I find that there was no evidence of use of a Taser or associated injury.

213. Nor was there any evidence of bullet holes in the wrecked vehicle and there was no evidence of damage to tyres caused by a "stinger" device used to damage tyres and stop a vehicle.

Missing property

214. A gold necklace was missing from the body of Master Carr. This loss was not discovered by the family until after the release of his body and his funeral. Investigation was directed and undertaken. Police officers at Goondiwindi could recall seeing the detached necklace on the neck of the body of Master Carr when he was placed in the sealed body bag. There were photographs which recorded this.

215. The necklace was not documented at the mortuary. After CT examination his body was removed from the body bag. The pathologist who examined the deceased did not observe the necklace. Subsequently when the issue was raised a review of the CT images showed, in retrospect, a chain coiled under one shoulder which had not been recognized at the time of imaging. The chain was not recovered. It was thought the chain was caught up with the body bag and clothing which was disposed of in the usual manner due to contamination following a car crash. The pathologist and mortuary staff conveyed their sympathies to the family and apologise for any oversight. Details of the review undertaken are annexed.[1]

Other issues; whether driver inexperience, drug use, fatigue, the speed of the vehicle and the condition of the highway were contributing factors in the deaths of Master Carr and Jaylen.

216. It must first be resolved whether the identity of the driver at the time the vehicle left the road surface at Wyaga Creek crossing and subsequently crashed can be determined. I note that there is evidence from their friend YZ earlier on the

[1] Annexure 'A'

preceding Friday evening at Toowoomba that Jaylen was driving the green Commodore when YZ was picked up. At some later time YZ said his cousin was also driving for a period before Jaylen resumed driving. Master Carr was a front seat passenger according to YZ. At the inquest YZ was shown CCTV footage taken at the Coles Express on Ruthven Street in Toowoomba at about 10.15pm that evening. He did not recall being in the vehicle at that time. He identified the person who got out of the driver's position in that video as Master Carr. He was asked if he could recognize the person in the front passenger seat but he said he could not, but it was probably Jaylen, most likely.

217. Subsequently there was video retrieved after an unreported fuel drive- off at Captains Mountain at 12.35 am on Saturday morning. Sergeant Walpole reviewed that video and compared it with the earlier information thereby identifying the driver of the Commodore was Master Carr. I accept that evidence and the conclusion. He also concluded the driver of a second car, a stolen Honda CRV which was at the station with the Commodore and left immediately before the Commodore, was Jaylen. I conclude on all the evidence that it was possible that the boys were involved in taking the second vehicle and for a time Jaylen was driving the Honda. It is not necessary for me to make a finding as such. I do accept that there was no sign in Master Carr's behaviors at the fuel stop that he appeared to be concerned about the presence of this vehicle, which left the station at speed, and he followed.

218. I state this evidence in detail simply to emphasize that both Master Carr and Jaylen were driving the Commodore at different times during the evening of Friday and early Saturday morning. The last recording on CCTV footage was of Master Carr driving the Commodore at 12.35am. The vehicle crashed between 40 and 55 minutes later, between 1.14am and 1.30am.

219. The last sighting of the Commodore was by the truck driver Bradley Parker whose evidence was compelling. When his truck was overtaken by the Commodore, dash camera recorded footage of the image of the vehicle sufficient to identify it, but not the driver, and the speed of the vehicle. Mr Parker was not overtaken by any other vehicle from this point, and not before the Wyaga Creek crossing.

220. The most pertinent evidence was the position of the body of Master Carr at the scene of the crash. He was entrapped and required to be extricated from the driver's position of the vehicle. Jaylen had been ejected from the car and was found behind it on the ground. I accept the evidence indicates that although the seat belts were engaged in their clasps they were not extended sufficiently to have been secured across either of the boys. I accept the evidence of the police findings at the scene and their conclusion that Master Carr and Jaylen were seated on top of the engaged seat belts.

221. I conclude that Master Carr was the driver of the Commodore at the time of the crash and Jaylen was the passenger.

222. With respect to Master Carr's level of experience as a driver there was information that he had driven vehicles before but there was no evidence that he had ever undertaken any driving lessons or that he had ever held a driver's

licence. He was 17 years of age. While he had driven before I conclude it most likely that he was an inexperienced driver, especially in terms of experience with a high-powered vehicle being driven at extreme speed at night on a rural highway.

223. The speed of the vehicle at the time it left the sealed road surface has been established at approximately 170 kilometres per hour in the five seconds prior to impact. It is impossible to know the precise circumstances in which the vehicle left the bitumen surface. It might have been inattention, distraction, fatigue, a kangaroo, the road surface, or any other unknown circumstances, but once it occurred it, the vehicle was travelling so fast that returning to the bitumen surface was highly unlikely. The vehicle travelled about 90 metres in two seconds before major impact with the first tree. I find that speed was certainly a contributing factor in the boys' deaths.

224. The condition of the highway may have contributed to the event, as there was evidence that the Gore Highway is a notoriously bad road with frequent bumpy surface and ever varying conditions. There was conflicting evidence of whether a particular bump played any part in the vehicle leaving the road surface and I do not reach a conclusion on that.

225. The fact that the road narrowed without signage as it crossed over Wyaga Creek could also be considered a relevant circumstances, as well as the short steep culvert drop off into bush terrain and the creek bed. It must be said however that locals who used the road frequently stated the road was not dangerous if driven to the conditions. Driving at night, with elevated risk of kangaroos required skill and caution.

226. There was evidence established at autopsy that both boys had Methylamphetamine in their systems (and Jaylen also had cannabis.) Alcohol was not detected. Expert evidence cannot establish what effect this has on an individual driver, or whether it was affecting Master Carr's capacity to drive at the particular time. However, there is evidence of the general effects of the drug, including euphoria, increased risk taking, alertness, agitation, racing thoughts, irrational thinking, rapid body movements, restlessness, confusion, paranoia, fatigue, tiredness and falling asleep. None of these possible effects are likely to have assisted the physical and mental capacity of a 17 year old inexperienced male in his decision making and driving a high-powered stolen car at night on the Gore Highway. The expert witness confirmed there is evidence of increased risk of fatal motor vehicle crashes where methyamphetamine has been detected.

<u>Was the policed investigation adequate in all the circumstances?</u>

227. There were some matters that on review could have been handled better.

228. The fact that none of the attending police officers and the Forensic Crash Unit officers in particular were aware of, observed or discovered the existence of the flood event camera at the Wyaga Creek crossing was unfortunate. Ambulance, Fire and Rescue services were also apparently unaware of the camera. Sergeant Coote did his usual search of the lists of such equipment

but looked under the Gore Highway rather than Wyaga Creek which separately listed flood cameras. I accept it was a genuine oversight and that Sergeant Coote was most apologetic that this occurred and was not discovered in sufficient time to request access from the Transport and Main Road authority. Recordings are overwritten in 7 days (although it can be up to 14 days before overwritten.) Police are required to apply for access to the recording within 7 days.

229. A witness from Transport and Main Roads gave evidence that the flood camera recording had been reviewed by an employee. A friend or member of family of one of the deceased contacted TMR concerning the possibility of placement of a memorial at the side of the road. This prompted the TMR staff person to review camera footage which was still available at the time. All that was seen was a black screen. The person was not sure whether the viewing time did not include the time the vehicle passed through, or whether the camera had not captured the event.

230. If the camera had captured the passage of the vehicle at night it would only show a blur of white (being the headlight glare against a black background.) It would not identify a particular vehicle. It could however have distinguished the passage of a second vehicle, or that a vehicle was a truck for example, by the appearance of while lights along the length of the truck / trailer.

231. Sergeant Coote has since ensured that resources and training have been updated about the accessibility and time frames for this source of information.

232. The critical issue from the family's perspective is that the camera could have provided an independent recording to show conclusively whether or not there was another vehicle in the vicinity of the Commodore immediately before and at the time the vehicle left the road and crashed, assuming that the flood camera was so positioned to have captured the particular position and path of the Commodore. Some of their fears may have been resolved had the flood camera footage been available. It was a major oversight in the police investigation.

233. There was other independent evidence from Mr Parker, which I rely on and accept. The Commodore was not followed when it overtook his truck, at high speed approximately 15 minutes earlier. Nor was the truck overtaken by any other vehicle between that point and the Wyaga Creek crossing where, unbeknown to Mr Parker at the time, the Commodore had crashed.

234. The communication of the tragic deaths of these two young men caused enormous understandable grief to their families. Police had first to formally establish the identities of the two young males who were not carrying any identification. Notification had to be provided to two families, with the mother of Master Carr living interstate. Unfortunately, the information became known to Master Carr's mother via social media and passed on information before she received official police notification.

235. Whilst it is difficult for police to manage such a situation, especially with the presence of media at the site on the Saturday and the ever pervasive instant

communication available via social media, it is imperative that every effort is made to sensitively and professionally inform next of kin of the death of their loved ones, especially children. Information identifying deceased should not be released to anyone else prior to next of kin being advised.

236. Family members were fearful that the crash was caused by intervention of the police or some other outside unknown person or persons. The immediate investigating police were unaware of this concern initially. When family attended the scene of the crash they were dismayed and alarmed that proper investigation was not being undertaken because there remained so much debris and parts of the vehicle at the scene. In particular they were concerned that an item they thought was a GPS tracking device had not been retrieved or investigated. Subsequently that item was considered as not pertinent and evidence was called at inquest, about this issue.

237. Police did retrieve the air bag module from the vehicle which had been impounded and it was this device that provided reliable information of the speed of the vehicle in the five seconds prior to impact occurring and throughout the period commencing from the vehicle leaving the road surface and finally where it crashed into the creek bank.

238. From the family's perspective they considered their fears were not being investigated, whereas the police considered they had addressed what was relevant in the circumstances of the crash. The first attending officer was equipped with "body cam" which recorded the whole process of arrival, inspection, examination and review of the entire crash location over hundreds of meters and many hours. Particular items considered pertinent to the forensically trained crash inspector were identified, recorded and photographed by Scenes of Crime officers. Some items were retrieved with the wreck of the vehicle itself which was transported to Toowoomba for specialist examination. The most critical individual piece of evidence was the air bag module subsequently removed from the wreck and examined by Sergeant Coote.

239. The families themselves made various investigations including identifying and submitted a statutory declaration from a young person who was involved with the two boys and was himself a passenger in the stolen vehicle on the preceding day.

240. No follow up investigation or contact was made by police with this witness. It is noted however that the witness was an underage person at risk of self-incrimination. The coronial inquest process provided the opportunity for the person to be directed by the coroner to provide his evidence. The legislation enables such evidence to be heard but the answers not to be used to bring criminal charges against him.

241. While it has been submitted that the police investigation was inadequate, I consider it was deficient. Once the families' fears that something criminal or involving some other people had occurred causing the deaths of their sons, and this was communicated to the police, it was incumbent on them to not only investigate a motor vehicle crash, but to investigate the issues raised. I

am satisfied that eventually there was sufficient information from a variety of sources to confidently make findings.

242. There were also concerns expressed by both families regarding the Queensland Health processes as part of the Coronial process in the circumstances of their deceased children. There are practical constraints and limitations which are unlikely to be capable of improvement. A multiple motor vehicle fatality in a remote area (closest to Goondiwindi) was always going to involve the transfer of the deceased to Brisbane. There is no capacity locally for family viewing (which is generally not available even in Brisbane until the deceased are released to funeral directors.) The cause of death is required to be established if at all possible, particularly in circumstances of the deaths of two young people travelling in a stolen vehicle. The closest facility at Toowoomba is not staffed to undertake such forensic examination. The deceased required to be transferred late on the Saturday night to a mortuary.

243. The timing of autopsy examination reflected the need to communicate with family regarding their wishes concerning autopsy, other cases to be dealt with by the two pathologists and intervening Anzac Day closure.

244. There is certainly scope for review of the processes and consideration of changes which might lessen the grief and improve the communication with families. A recommendation for such review, particularly in a culturally appropriate context will be made to include Queensland police, and Queensland Health. The Coroners Court of Queensland, in its business and administration role, is also likely to be involved.

Coroners Findings pursuant to section 45(2) *Coroners Act 2003*

With respect to Master Carr,

Identity of the deceased –	The identity of the person found in the wreck of the crashed Holden Commodore was Master Carr who was born on 12 March 2001
How he died –	Master Carr died in a single vehicle car crash when he lost control of the vehicle he was driving which ran off the road at high speed, travelled through a dry creek bed and crashed
Place of death –	The crash occurred on the Gore Highway in the vicinity of the Wyaga Creek Rest Stop approximately 35 kilometres north of Goondiwindi, in Queensland
Date of death–	Master Carr died between 1.14am and 1.30am on 21 April 2018
Cause of death –	Master Carr died as a result of multiple injuries due to a motor vehicle collision

With respect to Jaylen,

Identity of the deceased **–**	The identity of the person found on the ground outside and behind the wreck of the crashed Holden Commodore was Master Close
How he died **–**	Jaylen died in a single vehicle car crash when he was ejected from the vehicle in which he was a passenger. The driver of the vehicle lost control and the vehicle ran off the road at high speed, travelled through a dry creek bed and crashed
Place of death **–**	The crash occurred on the Gore Highway in the vicinity of the Wyaga Creek Rest Stop approximately 35 kilometres north of Goondiwindi, in Queensland
Date of death **–**	Jaylen died between 1.14am and 1.30am on 21 April 2018
Cause of death **–**	Jaylen died as a result of multiple injuries due to a motor vehicle collision

Coroner's Comments pursuant to section 46 of the *Coroners Act 2003*

245. On 21 April 2018 the capacity to communicate via phone from Wyaga Creek Rest Stop, 35 kilometres north of Goondiwindi on the Gore Highway, was extremely limited.

246. It was difficult to contact emergency services. It is recommended that phone coverage be reviewed and improved. In the interim, if there is no signage at the rest stop providing information of the direction and distance to the nearest place to seek help, this should be provided.

247. Evidence from the Department of Transport and Main Roads informed the inquest that maintenance and improvement of the Gore Highway rests with the Commonwealth. The Gore Highway is remote, running through arid bush which is also prone to intermittent flash flooding with associated damage to the road surface. Experienced frequent drivers of the Gore Highway described it as a very, very bad, bumpy road with every varying conditions requiring cautious driving to those conditions. Transport and Main Roads recorded four incidents occurred at the Wyaga Creek crossing over a five year period including this double fatality. Although the existing Wyaga Creek Rest Stop crossing complies with the Brownfield standard, the safety of the driving public requires the following improvements to occur;
    (i) Prioritisation of Commonwealth funding for upgrading the (multiple) Wyaga Creek crossings, including the Wyaga Creek Rest Stop crossing
    (ii) Installation of signage indicating the road narrows through the creek crossing
    (iii) Widening of the road
    (iv) Installation of an emergency contact point, and
    (v) Review of the speed limit applicable to Wyaga Creek Crossings

248. Review and amendment of the Queensland Police Operational Procedure Manual, in association with the Transport and Main Roads, to identify and keep updated all types and locations of CCTV or other camera monitoring, including flood cameras in Queensland. Review and amendment of and memorandum of understanding or communications between QPS and TMR to assist and inform investigations of incidents occurring on the roads.

249. Transport and Main Roads review their policies to require staff to document viewing of CCTV footage, date, time, location, duration and purpose of viewing. Where the footage relates to a motor vehicle incident requiring ambulance transfer of any person, CCTV footage is to be kept for a minimum period of 60 days. If a fatality occurs, a copy of CCTV footage is to be made and retained in an identifiable and retrievable form.

250. Issues raised by family members expressed their elevated distress due to the police, health and coronial procedures not recognizing or attempting to accommodate cultural sensitivities. It is recommended that Queensland Police undertake a review of the Operational Procedures Manual regarding deaths reported to the coroner, and coronial investigations. The review is aimed to develop, amend, incorporate and train police, including the Ethical Standards Command, with respect to Aboriginal and Torres Strait Islander culture, especially concerning death. Such review requires consultation and inclusion of Aboriginal and Torres Strait Islander people. Reference is made to "Sad News, Sorry Business, Little Gungallida Girl" and the "Sorry Business" Guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islander people. (Annexure B) Additional reference is made to the requirements of the Human Rights Act 2019.

251. The review should also include Queensland Health's involvement and processes with deceased Aboriginal and Torres Strait people whose deaths are reported to the coroner. The Coroners Court administration should also be included in the review.

252. These findings now conclude the coronial investigation. I thank all those involved in investigating, appearing and attending the inquest and extend the condolences of the court to the families who have suffered the terrible loss of the deaths of their two young people.

253. I close the inquest.

Chris Clements
Brisbane Coroner

27 August 2020

Annexure 'A'

Missing item of personal property, necklace belonging to Master Carr

1. There was an issue of a missing item of personal property from the body of the deceased, Master Carr. This loss was not discovered by his family until after the release of Master Carr and his funeral.

2. Master Carr's autopsy examination occurred on Thursday, 26 April 2018 undertaken by the forensic pathologist Dr Forde. The autopsy was limited to an external examination of the deceased person together with CT imaging and toxicology testing having regard to the objection of the next of kin to an internal examination.

3. At the time of the examination of Master Carr there was no jewellery on the body. The coroner notes from the pictures taken at the scene of the crash, a heavy long chain, appearing to be gold, was evident on Master Carr's neck. It appeared to be loose / no longer closed / possibly broken. Subsequent to the release of his body, family members made enquiries about it. It was not recovered.

4. At the inquest, the pathologist helpfully assisted with information about this issue and provided information about the processes that occur in the mortuary and what was known about the necklace. Dr Forde confirmed the clothing had been discarded. This is the usual practice in the case of motor vehicle accidents, for safety reasons, where clothing has been contaminated and there is often broken glass trapped amongst the clothing.

5. The CT examination was undertaken prior to the physical examination of the deceased body, by a radiographer, when the body was still within the sealed, tagged body bag. The purpose of the CT scan is to identify potential injuries and possible cause of death, especially where an internal autopsy has not been ordered. Dr Forde stated that at a later time it came to her attention that there had been a necklace which was missing. Dr Forde then reviewed the CT scan again. It was evident, in retrospect that there was a metallic object underneath the shoulder of the deceased, and it is believed that this may have been the necklace.

6. Usually, items of value are removed from the body by the police at the scene, or, once they are received at the mortuary. Sometimes jewellery stays on the body for different reasons. It is not the purpose of mortuary staff roles, but they do try and remove items that may be of value to family members, and keep them if possible to hand back to police to return to the family.

7. In this case this did not occur. The coroner instructed further enquiry.

8. The Coronial Support Unit of the Queensland Police Service at the John Tonge Centre responded to the enquiry raised on behalf of Master Carr's family by ATSILS. It was confirmed that:
   - There is no documentation on the QPS information system of a gold chain

- The officer in charge, Officer McIntosh, at Goondiwindi checked with a number of police officers who attended at the scene. They confirmed that a gold necklace *was* with the deceased in the sealed body bag.
- Photos of the deceased person clearly show the gold chain with the deceased at the scene of the crash.
- A check of the Queensland Health "red property folder" showed NIL items recorded as being found during the autopsy process.
- A check of the Morgue Register shows "NIL" items recorded next to the deceased's entry for collection by funeral director.
- The deceased was collected by Queensland Funeral Transfers at 07:09 on 1 May 2018.
- The radiographer subsequently checked the CT imaging which clearly shows a gold chain underneath the deceased's left shoulder.
- The mortuary manager followed up with staff on 9 May 2018.
- The autopsy report does NOT mention a gold chain at the time of autopsy
- A check was made of the safe, in case it had been put there for some reason. It was not there.

9. Subsequently the mortuary manager confirmed the mortuary procedures regarding the deceased person's body and property, and how these procedures were applied relating to Master Carr. The information provided by the mortuary manager is as follows.

10. Master Carr's CT imaging occurred on 24 April and the autopsy examination was on 26 April. (Anzac Day intervened on 25 April.) The pathologist and mortuary assistant recorded and photographed the clothing found. It was then disposed of due to contamination. At the time of autopsy no valuables were found and therefore none recorded or handed to QPS.

11. Subsequently, queries were raised. The pathologist asked for photos from QPS taken at the place of death. These showed a detached chain resting on the neck area, prompting review of the CT scan.

12. Review of the CT scan, in retrospect, showed a chain coiled under one shoulder, unlikely to have been recognised by the pathologist reviewing the scan, unless alerted to its presence.

13. The mortuary manager stated in motor vehicle accidents there are often metal fragments and pieces of vehicle, not relevant to the medical investigation or the purpose of the scan. Examining the body is also made more difficult by contamination, as in this case.

14. In his experience as mortuary manager over 12 years, he could not recall any previous incident in which jewellery was inadvertently overlooked at autopsy.

15. The mortuary manager thought it likely that the chain was caught up with the body bag or clothing that underwent disposal.

16. The pathologist and mortuary staff conveyed their sympathies to the family and apologise for any oversight on their part.

SORRY BUSINESS

A guide to cultural competency and engagement between the Coroners Court of Queensland and Aboriginal and Torres Strait Islander people

2019

ACKNOWLEDGEMENT

This guide would not have been possible without the assistance of the Aboriginal and Torres Strait Islander families who have shared their experiences working with the Coroners Court of Queensland (CCQ).

We thank those families.

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INTRODUCTION

Sorry business is the Aboriginal English term used by the Aboriginal and Torres Strait Islander community to describe the mourning period when a family member dies and all responsibilities that follow in accordance with traditional lore and custom. Traditional lores and customs are observed and practiced by Aboriginal and Torres Strait Islander people to this day and are important to recognise.

The objects of the *Coroners Act 2003* (the Act) include requiring the reporting of particular deaths, establishing procedures for the investigation of those deaths, and to help prevent deaths from similar causes happening in the future by allowing Coroners at inquest to comment on matters connected with deaths, including matters related to:;

- public health or safety; or
- the administration of justice.

This guide will provide CCQ with a framework for navigating the concerns that Aboriginal and Torres Strait Islander people may raise when the death of an Aboriginal person or Torres Strait Islander falls within the jurisdiction of the Act.

This document contains some generalisations about Aboriginal and Torres Strait Islander people. If you are in any doubt, you should speak with the family or next of kin to identify the specific cultural protocols observed under traditional lore and custom.

LIVED EXPERIENCES OF ABORIGINAL AND TORRES STRA I T ISLANDER PEOPLE

The lived experiences of Aboriginal and Torres Strait Islander people have a direct correlation on their health and mortality outcomes. Following colonisation in Australia, policies, laws and social norms have affected Aboriginal and Torres Strait Islander people in Queensland and include:

- the dispossession from traditional lands;
- stolen generation;
- stolen wages;
- institutional racism;
- loss of identity - language, kin and culture;
- the enactment and implementation of *The Aboriginal Protection and Restriction of the Sale of Opium Act 1897* (Qld) (the Protection Act) (repealed 1984);
- exclusion prior to the 1967 referendum; and
- the effects of the Northern Territory intervention for bordering Queensland communities and transient communities.

These events have contributed to entrenching disadvantage and inter-generational trauma for Aboriginal and Torres Strait Islander people.

Entrenched disadvantage such as poorer living conditions, decreased access to health care and justice also contribute to Aboriginal and Torres Strait Islander people being more likely to be affected by major social issues in communities such as the over representation of Aboriginal and Torres Strait Islander people in the criminal justice system and in prison, issues relating to drugs and alcohol, domestic and family violence, lack of employment opportunities, intergenerational welfare dependence, as well as poorer health and education outcomes.

Inter-generational trauma occurs when a person witnesses or experiences trauma and that is transmitted across the generations. Aboriginal and Torres Strait Islander culture can be generally categorised as an oral and aural tradition where knowledge of traditional lore and custom is passed

down through the generations by Elders and those with authority to speak within their communities. That knowledge is also entwined in the lived experiences of Elders who have gone before, and those who still live today. The trauma experienced through their lives is passed down through each generation, thus creating inte r-gene rational trauma.

Aboriginal and Torres Strait Islander people may interact with the coronial system as a result of their lived experiences. The most likely areas of interaction, due to entrenched disadvantage and intergenerational trauma, include:

- deaths in custody;
- domestic and family violence;
- deaths in care;
- child protection;
- deaths in care - disabilities;
- suicide;
- missing persons; and
- health care related deaths.

FAMILY

The Act provides a wide definition of family member, including the encompassing the broad and complex relationships that exist within Aboriginal and Torres Strait Islander communities.

Schedule 2 to the Act defines family member to include:

- a particular person, where the coroner investigating the death is satisfied that the deceased person's wish would have been that a particular person be the deceased person's family member for the Act;
- spouse;
- adult child;
- parent;
- adult sibling;
- an adult who immediately before the deceased person's death, had a relationship with the deceased person that the coroner investigating the death considers is sufficient for being a family member of the deceased person for the Act; and
- an ATSI family member.

An ATSI family member for a deceased person who was an Aboriginal person or Torres Strait Islander me ans, a person who is an appropriate person according to the tradition or custom of the Aboriginal or Torres Strait Islander community to which the deceased person belonged.

Familial connections in the Aboriginal and Torres Strait Islander community include:

- grandparents;
- grandchildren;
- aunts;
- uncles;
- niece;
- nephews;
- cousins;
- cousin-sister;
- cousin-brothe r.

Relationships may also be described by the family of the deceased person in the following ways, namely:

- siblings of grandparents as grandmother and grandfather;
- siblings of parents as mother and father in addition to or in substitution of aunt and uncle;
- in addition to cousins as cousin-sister and cousin-brother;
- in addition to nieces and nephews as granddaughter and grandson.

These relationships and connections with the deceased person should be recognised in the same way that they are expressed.

It is important to recognise that these connections may also have involved the 'raising up' of the deceased person during their formative years and may also involve customary adoption practices that may not be legally recognised.

Torres Strait Islander communities also include the in-laws of the deceased person, known as a Marigeth/s. The Marigeth plays an important role in the customary protocols surrounding the death of a Torres Strait Islander person.

Extended family may also be an important relationship to the deceased person. Extended family may have no biological connection to the deceased person but may form part of the wider community that the deceased person was a member of prior to death.

DEATH IN ABORIGINAL COMMUNITIES

It is important to acknowledge that Aboriginal people in Australia are not part of a homogenous mass and are also distinct from Torres Strait Islanders. Nations, tribes, clans and languages groups make up the fabric of Aboriginal society and each person's experience may be varied depending on their personal history.

For many communities, ceremonies are conducted following a person's death. The spirit of the deceased person is believed to continue after their death and that the spirit must be given time to leave the body and rest. A person's spirit can be disrupted if traditional lore is not observed.

In some remote communities in Queensland the whole community is closed down to allow for sorry business. In some cases, people outside of the community will not be allowed to enter the community until sorry business has concluded. This can cause difficulty when there are multiple deaths in a community.

At times throughout history, Aboriginal people have been forbidden to practise traditional lore around death and dying and was particularly prevalent in Aboriginal Missions where there were a number of different tribes and clans placed in the same location. Some Aboriginal people have also embraced Christian practices which are also recognised or incorporated into the protocols around death.

REFERRING TO THE DECEASED PERSON

It is a common protocol amongst Aboriginal people to cease referring to the name of the person who has died. There are many reasons as to why this is done , including as a sign of respect and allowing the spirit of the deceased person to rest. By referring to the name , it is believed that the spirit is called back to this world and is prevented from travelling into the spirit world.

How should I refer to the deceased person?

Ask the next to kin for instructions on how the name of the person can be used. If it is not practical to obtain this information from the next of kin, the deceased person should be referred to by their surname.

It is also important to realise that images and voice recordings of the deceased person will also cause significant distress to the family. Instructions should also be obtained about how images and voice recordings should be used.

It is important that CCQ staff make a note of the preferred name in CCMS as well as on the physical file. It may also be appropriate to include and encourage the use of the preferred naming convention for incoming and outgoing communication with third parties.

IDEN TIFYING TRADITIONAL CONNEC TION

It is important for Coroners and CCQ staff to identify where the deceased person is culturally connected to. In most cases, an Aboriginal person will identify with belonging to a traditional owner group from which they are a descendant of.

Aboriginal people feel strongly connected to the land and in most cases will wish to be returned to their traditional lands. However, this may not always be possible. In some circumstances Aboriginal people cannot return to their traditional lands because generations have been forcibly removed, the land is freehold and native title is extinguished or the person has lost connection.

Aboriginal people may also strongly identify with a particular area that does not belong to their traditional lands; which is known as a historic connection. Most notably this occurs were Aboriginal people had been forcibly removed from their traditional lands and after a number of generations their ancestral connection is unknown or has diminished over time, such that they feel a stronger connection in the communities which they lived and worked in. This includes Deed of Grant in Trust (DOGIT) communities and Christian missionary communities that were set up around Queensland and interstate. Some of the Queensland communities include Mornington Island, Yarrabah, Palm Island, Woorabinda and Cherbourg. In those communities there were a number of tribal groups that were placed in the one community in circumstances where it was forbidden to speak or practice their traditional lore and customs; particularly during the operation of the Protection Act.

Aboriginal and Torres Strait Islander people can also be transient and may have lived far away from their traditional lands when they died, including interstate.

By identifying the deceased person's connection, it is recognising their traditional or historical connection and also alerting the Coroner to any issues that may arise in relation to transportation of the deceased.

How do I identify the deceased person's traditional conn e ct ion?

Ask the next of kin if the deceased person identified with a particular traditional owner group. If so, what is the name and spelling of the group and where the traditional lands of that people are located.

Please note that the birthplace of an Aboriginal person will not necessarily identify the traditional connection of that person and should be avoided.

For assistance in identifying the nation, tribe, clan or language group a copy of the map of *Indigenous Australia* can be used online from the Australian Institute for Aboriginal and Torres Strait Islander Studies at www.a iatsis.gov.au. A copy of the maps can also be purchased.

TRANSPORTING THE DECEASED

If the Coroner has determined that an autopsy is necessary and the body must be transported, the next of kin may raise concerns. It is important that the next of kin is aware of the process involved, including that some regional centres do not have the ability to store the body or perform an autopsy, as well as explaining the role of Forensic and Scientific Services (FSS).[ii]

In some instances, Aboriginal people will want to view the body, sometimes before an autopsy has been performed. The reasoning may be that the family wish to perform a smoking ceremony to allow the spirit of the deceased person to move on. However, it may be more practical and appropriate for this to take place at the coronial mortuary following autopsy or when the body has been released to the funeral director.

Delay in viewing the body may contribute to a longer period of sorry business if preparation of the body cannot take place in accordance with traditional lore and custom.

In circumstances where the body is not suitable to be viewed, for example if there the body is not visually identifiable or there are traumatic injuries, the family should be advised as soon as possible in accordance with the State Coroner's Guidelines.[iii]

Another important issue to consider is whether weather conditions are appropriate for transporting the body to and from a community. Many Aboriginal and Torres Strait Islander communities in Queensland are regional and remote and are inaccessible at certain times of the year. If transportation occurs to or from these communities, funeral directors should speak with the local Aboriginal or Torres Strait Islander Council for advice about whether transportation is suitable at that time of the year.

Smoking ceremony

Some Aboriginal people may wish to conduct a smoking ceremony at the location of death or of the deceased person's body and belongings. Smoking ceremonies are conducted to encourage the spirit of the deceased person to pass on. If requested, families should be given an opportunity to perform a smoking ceremony if it is safe and appropriate to do so. In most instances, it would be appropriate once the body of the deceased person has been released.

COMMUNICATION

Aboriginal and Torres Strait Islander culture is predominately oral, making verbal communication highly important. Knowledge is passed down intergenerationally by storytelling, depiction through art, songs, dance and other ce re monie s.[iv]

Ofte n, the experience of Aboriginal and Torres Strait Islander people is that there is a distrust of Government for past failures and injustices committed. Therefore, it is important for CCQ staff to build rapport with the next of kin and family, as it will assist to build confidence in the coronial process.

Language and Literacy

Aboriginal and Torres Strait Islander people may speak English as their second or third language. There may be some situations where an interpreter is required to communicate with the next of kin or family. Interpreters may be difficult to locate and are often not accredited through the National Accreditation Authority for Translators and Interpreters (NAATI). If an interpreter is needed , it may be necessary to seek assistance from the deceased person's family members to assist the next of kin.

Aboriginal English is also regularly spoken and certain words have a different meaning. An example includes the word *deadly* which means *awesome* or *cool* in Aboriginal English, as opposed to an interpretation in a coronial context, such as the *use of deadly force*.

It is also important to also be aware that literacy levels vary amongst Aboriginal and Torres Strait Islander people and that not all families have access to internet or phone services.

In some cases, CCQ staff may need to spend some time over the phone discussing the coronial process, particularly if the next of kin has literacy issues or is unable to mail or email their concerns for the Coroner's consideration.

Aboriginal and Torres Strait Islander people may have a transient lifestyle. It is important to recognise this factor when letters to the next of kin that go unanswered.

What do I do if issues with langu age and literacy arise?

Contact the next of kin and confirm the preferred method of contact. If there are issues with language and an interpreter is required, seek assistance from other family members. If there are no other family members, seek permission from the next of kin to call on assistance from the local Community Justice Group located closest to them.

It is important to recognise that Aboriginal people may not want to include people from outside of their family when dealing with sorry business. Therefore, it is important to seek their consent before involving another Aboriginal or Torres Strait Islander person to assist you in achieving an outcome.

If the next of kin has literacy issues, spend time over the phone explaining the coronial process to the next of kin . Alternatively, the next of kin can be referred to a free coronial assistance legal services or the Aboriginal and Torres Strait Islander Legal Service for assistance.

If written correspondence is returned to sender or contact is lost, attempts should be made to re-establish contact with the next of kin to confirm current contact details.

Gender Iss ue s

It is important to recognise that Aboriginal culture and ceremonies includes a separation of men's and women's business which is considered secret and sacred. This will be particularly important in the context that the death is sexual in nature, including health care related deaths.

What shou ld I do if an issue arises where there is men's and women's business?

Ask the next of kin if they would prefer to speak with someone from their own gender. If the next of kin feels comfortable, ask them to explain what the particular issue is. The next of kin may also want reassurance about confidentiality of the investigation and/or findings.

If the Coroner is of the opposite gender and there is an issue raised about men's or women's business, it will be important to inform the next of kin of the gender of the Coroner and that the Coroner will be made aware of the particular concerns raised.

LGBTI Community

There are many among the Aboriginal and Torres Strait Islander community who identify as Lesbian, Gay, Bisexual, Trans and lntersex. The Trans community in the Aboriginal and Torres Strait Islander community is also described as Sistergirls and Brotherboys.

It can often be difficult for the Aboriginal and Torres Strait Islander LGBTI c ommunity , due to cultural responsibilities and religious beliefs. Culture has specific gender roles divided between women and men's business and can be rigid in the acceptance and inclusion of LGBTI members within the community. This can be particularly so in respect of initiation processes or transmission of knowledge from Elders in their community.

Some members of the LGBTI community can feel isolated in addition to the other social pressures such as homophobia, racism, sexism and discrimination. There is also a lack of recognition and support services available to the Aboriginal and Torres Strait Islander LGBTI community, however this is improving through community-based organisations such as '2 Spirits'.

2 Spirits provides, amongst other things, one-on-one cultural support, community forums, yarning circles and community outreach.

It may be relevant to consider whether the next of kin is fully accepting of a deceased person's identity within the LGBTI community. This may pose an issue if the deceased person's spouse wishes to participate in the coronial process and there is conflict with other members of the deceased person's family.

DEATH IN TORRES STRAIT ISLANDER COMMUNITIES

Torres Strait Islanders have a distinct culture and customs from Aboriginal people and have unique mourning and funeral practices. Torres Strait Islander culture also embraces Christianity through the Coming of the Light. Christian beliefs have been integrated into cultural practices and are observed with equal importance.

Similar to Aboriginal people, business in a community will not take place during the period of sorry business. Reference to the deceased person should also be avoided. However, if in doubt seek clarification from the next of kin or Marigeth/s.

Issues in Aboriginal communities relating to communication and transportation of the deceased person's body may arise in Torres Strait Islander communities. Communication will assist CCQ staff to navigate issues that may arise. If there are language difficulties, ask the next of kin if there are translators who may be able to assist.

MARIGETHS

When a Torres Strait Islander person dies, it is the responsibility of the deceased person's in-laws of both genders to make arrangements to assist the deceased person to pass on into the spirit world. This person is known as a Marigeth *(spirit hand).* The responsibility of a Marigeth includes communicating with family, handling of the body at the mortuary, preparation and dressing of the body and burial.

The Marigeth is responsible for informing families of the 'sad news' of the person's passing and to provide support and meals for those who visit the deceased person's family. This is particularly relevant to the role of next of kin and communication with CCQ staff.

Koey Marb

Koey Marb describes the journey of the deceased person into the spirit world and translates to 'the long walk home'.

It is the role of the Marigeth to prepare the body for burial as they are the *spirit hand* who guides the deceased person on their long walk home. A Marigeth of the same gender is also responsible for dressing the body in preparation for burial.

On the Island of Mabuiag, dancing ceremonies are performed, and a feast is arranged in the weeks following death to assist the spirit to travel on.v

Why is the role of a Marigeth important?

The Marigeth may not be the spouse, parent, child, sibling or grandparent of the deceased person who is ordinarily nominated as next of kin. The role of the Marigeth should not be disregarded as having authority to engage with CCQ. By not including the Marigeth, it may cause disharmony for the family and protocols to assist the deceased person to travel into the spirit world may not be completed, causing further distress to the family.

The role of the Marigeth is extremely important in relation to the need to view the body. If the body is not suitable for viewing, this will become an issue for the Marigeth, as a Marigeth of the same gender as the decease is responsible for preparing the body for burial, including dressing the body.

If viewing of the body is not appropriate, the next of kin and family should be informed with the assistance of Coronial Counsellors. Strong reactions are likely to follow from the decision, with possible anger from the Marigeth/s as it is likely they will feel that they haven't performed their cultural responsibility to the deceased person.

KULAW GUDPUDAY

Another protocol that is observed by Torres Strait Islanders is Kulaw Gudpuday (tombstone unveiling). This can occur anywhere between 12 months to five years after burial of the deceased person and represents the conclusion of the mourning period.

The Marigeth is responsible for covering the cost of the tombstone and engraving which is presented to the deceased person's family. The tombstone is also covered in colourful fabric and money envelopes. [vi]

When will a tombstone unveiling be re levant to the role of *CCQJ*

It is important to recognise the date when the proposed kulaw gudpuday will take place. Kulaw gudpuday may be delayed in circumstances where the next of kin or the family are waiting for an autopsy report to be provided, the conclusion of the investigation, inquest or findings.

It is also important not to hold an inquest or deliver findings on the date or anniversary of the kulaw gudpuday.

CCQ staff should ask the Marigeth when kulaw gudpuday is planned or has taken place.

NEXT OF KIN

Aboriginal and Torres Strait Islander families have diverse and complex relationships. It may be difficult to navigate who the appropriate person is to liaise with depending on how cultural protocols are observed. Some family members may have greater cultural responsibility than the immediate family members which can include the responsibility of liaising with CCQ.

WHO IS THE NEXT OF KIN AND WHO HAS AUTHORITY?

As outlined above, Torres Strait Islander communities rely on the Marigeths to organise the transportation, preparation and burial of the deceased person. The Marigeths are the in-laws of the deceased person, meaning there may be multiple people who have cultural responsibility to liaise with the CCQ.

Whilst a Marigeth has primary responsib ilit y, it should not prevent other immediate family members from contacting the CCQ for accessing information during the coronial process. Alternatively, if it is clear that there is only one senior next of kin and CCQ staff are inundated with communication from a variety of family members, it may be appropriate for the family to be informed to obtain information from the senior next of kin.

Appointing multiple senior ne xt of kin

Where CCQ has been informed that there are Marigeths appointed to represent the family, the Marigeths should be appointed as the next of kin.

It may be appropriate for the Coroner to allocate one or two people who have status as the senior next of kin. There may be particular issues relating to gender that may be uncomfortable to discuss with members of the opposite gender. This can occur for either Aboriginal or Torres Strait Islander families. In such cases it may be necessary to have a senior next of kin for each gender.

What should I do if someone raises the issue of Men's or Women's Business?

Whilst gender issues may not be openly raised by the next of kin with CCQ staff, comments referring to 'men's business' or women's business' are strong indicators of gender issues. As a result, only men or women can speak about those issues with their respective gender. This includes discussing the issue with any CCQ staff from the opposite gender.

The staff member should ask whether there is men's business or women's business that the Coroner should be mindful of and whether the person would prefer to speak to someone of their own gender.

Nominated spoke sperson

Under Aboriginal traditional lore, an Elder or a family member may be nominated by the next of kin to speak on their behalf by way of a cultural responsibility. In circumstances where the next of kin nominates a spokesperson, that person has authority to communicate with CCQ on behalf of the family. However, if the nomination is withdrawn at any point by the next of kin, the nominated person should be advised that they are no longer the appropriate person to speak on behalf of the next of kin, as it has been withdrawn.

There may be instances where there is conflict between families, however CCQ should refer the issue back to the family to resolve. It may also mean that a Coroner has to consider whether multiple persons as the next of kin. If conflict cannot be resolved, families should be referred to free coronial assistance legal service or the Aboriginal and Torres Strait Islander Legal Service. It is not appropriate to involve community Elders or Community Justice Groups unless the family has requested this.

Kupai Omasker

As part of Torres Strait Islander culture, the practice of traditional adoptions ('Kupai Omasker.') continues today. Kupai Omasker is not legally recognised, however the Queensland Government has committed to recognising the practice. [vii]

What issues arise where there has been kupai omasker?

The most common issue for children that have been adopted through Kupai Omasker is that records held by Births, Deaths and Marriages (BDM) do not record the child on documents relating to the adoptive parent such as birth and death certificates. At times it can be the first time the adopted person becomes aware of Kupai Omasker. The result can mean that they cannot establish requisite standing as next of kin, despite Ailan Kastom and connection to their parent, siblings, nieces or nephews.

Alternatively, where a child's birth parent has died, other siblings that remained with the birth parent may have objections to including the other sibling because of Kupai Omasker. This is because they were not raised up with their birth parent and are not recognised as their sibling.

These issues may be resolved when Parliament enacts legislation formally recognising the practice which is likely to include legal recognition on records maintained by BDM.

CONFLICT BETWEEN FAMILY MEMBERS WITH CO MPETING I NTERESTS

As with any family, some Aboriginal and Torres Strait Islander families can be dysfunctional and there may be long standing or recent issues that are exacerbated by the death of their loved one.

Issues may arise at various times and include whether or not an autopsy should be performed. It may also relate to who the body of the deceased person can be released to for funeral arrangements. Other issues that impact on this include where the deceased person should be buried or whether they should be cremated.

Some families may be able to resolve these issues. However, there may be a need to inform families that they will need to make an application to establish priority of standing in the Supreme Court of Queensland. In most cases, families will not have the financial means to bring an action in the Supreme Court of Queensland let alone the cost of funeral and burial or cremation.

If conflict cannot be resolved, families should be referred to free coronial assistance legal service or the Aboriginal and Torres Strait Islander Legal Service. It is not appropriate to involve community Elders or Community Justice Groups unless the family has requested this.

A Coroner may also choose to invite submissions, about release of the body, from each claimant and provide reasons in accordance with Chapter 6 of the State Coroner's Guidelines. If the Coroner decides it is necessary, the Coroner may seek submissions be made in person before the Coroner. By doing this, it may facilitate a discussion between family members or prompt families to seek legal or community assistance.

Consideration should also be given to the deceased person's cultural connection to country and any funeral preparations that should be observed as previously outlined above.

In circumstances where a decision has been made to cremate the deceased person, issues may arise if a suggestion is made to distribution the ashes among disputing family members. Most Aboriginal people believed that splitting the ashes will split the spirit of the deceased person.

NEXT OF K IN CONCERNS

Next of kin concerns may assist an investigation and provide the family with an opportunity to provide a glimpse of the deceased person's life. However, it may not be possible for Aboriginal and Torres Strait Islander people to provide written concerns due to access to internet and/or literacy issues. In cases where written concerns cannot be provided, it may be appropriate for the next of kin to outline their concerns over the phone to a CCQ staff member.

If operational issues restrict a CCQ staff member from taking concerns of the next of kin over the phone, the next of kin should be referred to a service provider who may be able to assist.
Consideration should be given to whether there are any service providers available to the next of kin's and they have the means of accessing those services. Limitations may include disabilities of the next of kin or if issues of confidentiality have been raised by the family.

Issues of confidentiality may arise in small communities where staff at the service provider may be closely linked or are part of same the community as the deceased person or their next of kin. There may be details of the deceased person's death or family dynamics which should not be disclosed to other members of the community. If this is the case, CCQ should takes steps to assist the next of kin to outline their concerns over the phone.

E.g. The death of the deceased person is believed to have been caused by her de facto spouse in circumstances where there was domestic violence. The de facto partner's

mother is the Director of the local Aboriginal Medical Service which is the only other service provider in the remote community, besides the Police. The next of kin , the deceased person's father, has a disability and regularly attends the medical service. The next of kin is angry with Police and unwilling to speak to them about his concerns, because he has raised allegations that they failed to follow up a complaint he made about his daughter's relationship. There is no ability for the next of kin to receive assistance from the other service providers.

BURIAL ASSISTANCE

Some Aboriginal and Torres Strait Islander communities do not have financial capacity to pay for burial. Where possible, Aboriginal and Torres Strait Islander people should be informed of the Burial Assistance scheme, including the eligibility requirements and the conditions of the assistance provided. Other issues that are important to discuss relate to the extent of assistance and the limitations regarding tombstones, flowers and whether a smoking ceremony could be performed. Again, CCQ staff should be mindful of the person's ability to access information about burial assistance depending on their literacy levels or access to internet and should be assisted accordingly.

Where an application for burial assistance has been approved, it is important to explain what is and isn't included.

Issues around transporting the body may be relevant for families to understand, particularly where the deceased person is being returned to a remote community and whether burial assistance provides for transportation. Other issues, such as whether transportation of the body has to be delayed due to poor weather (i.e. during wet season), may also arise.

AUTOPSY EXAMINATION

Aboriginal and Torres Strait Islander people may object to an autopsy being performed, or request that a less intrusive examination be performed. For some communities an internal autopsy will cause significant trauma to the family and is believed that it will not allow the spirit of the deceased person to pass on, particularly if retention is necessary.

However, there may be a next of kin who demands an autopsy be performed. This may be in the context of distrust of Police due to longstanding historical tension with Aboriginal and Torres Strait Islander people.

There are some also Aboriginal societies that have practised autopsies under traditional lore. This may have involved an Elder who holds authority to determine whether a person had been spiritually harmed (e.g. payback). This may involve examining the body to identify whether there are items that are not meant to be there, such as a feather, stone or bone. An examination may also involve taking a sample of blood or hair of the deceased pe rson. viii

If the family of the deceased person has made a request for a sample of the hair, it may be appropriate to release the sample. If it is not appropriate or practical during the coronial investigation process, it may be appropriate to inform the family that this can be done upon release of the body to the funeral director following autopsy.

INTERNAL EXAMINATION

The process of internal examination may be confronting for any next of kin. The concerns of Aboriginal and Torres Strait Islander people may be intensified in this situation because of cultural beliefs.

Some Aboriginal societies believe the deceased person should not be interfered with in any way or have any parts of the body re moved , even temporarily.

Alte rnative ly, families may feel strongly that an autopsy should be performed. This is more likely to occur in circumstances where there is a sudden death or where there is tension between the family and Police.

Where a deceased person has been examined and there is a need for retention, the family may raise issues about the deceased person's spirit not being able to properly move on. Furthe r, the family may say that the deceased person's spirit is split between this world and the spirit world, if an internal examination or retention takes place.

If a Coroner or the Pathologist believes it is necessary to perform an internal examination where there is an object ion by the next of kin, they should be referred to the Coronial Counsellors to assist in navigating whether the next of kin has strong views about identifying the cause of death and whether the internal autopsy will assist.

In circumstances were an internal examination has been ordered , and the Pathologist requires partial retention of the body; the issue of rete nti on should be explained by the Coronial Counsellors to the next of kin and possibly the wider family group to ensure proper understanding and the correlation with determining cause of deat h. The next of kin should also be informed of the consequences of not performing further investigations for which retention becomes neces sary.

It may be appropr iate to refer the next of kin and/or family to obtain legal advice in relation to the need for retention under section 24 of the Act .

RELEASE OF THE BODY

Aboriginal and Torres Strait Islander people have complex family relationships that extend beyond the stereotypical immediate relationship structures such as mother, fat he r, hu sband, wife , brot he r, siste r, child/ren and grandparents.

There is also potential for multiple members of the immediate family to request release of the body depending on how closely connected the deceased person was to that family member. It is important to recognise the importance of ' raising up' someone where a parent or guardian has not had an active role in the deceased person's formative years. In circumstances where a child has been raised up by another family member, it is highly likely that family member will seek equal or higher recognition than the parent.

If possible, information should be sought from the family about the kinship relationship of the deceased person growing up and as an adult, as the case may be. Further discussion is outlined below under the heading next of kin.

DECEASED PERSON'S BELONGINGS

Aboriginal and Torres Strait Islander people may request that all belongings of the deceased person be re t urned , including clot hing and jewellery. This may be in the conte xt of wanting to cleanse the spirit .

In circumstances where clothing cannot be returned for safety reasons, it is important that this is explained to the family as soon as possible. It may be necessary to explain that these items may be destroyed, particularly if it poses a risk of contagion.

Where belongings have been lost or destroyed unintentionally, next of kin should be notified as soon as possible explaining what has happened and any measures taken to ensure it does not occur again.

A UTOPSY REPORT

An autopsy report can cause distress to a family from any ethnic background. However, there are particular issues that may cause distress to Aboriginal and Torres Strait Islander people .

Delays in releasing the autopsy report can cause issues for family, as it may be viewed that the deceased person cannot pass on into the spirit world until the report is released. This may arise in the context of the deceased person's name being used or that the family have concerns about the cause of death.

It is also important that the autopsy report is not released on the anniversary of the death or of the tombstone unveiling. Delays in releasing the autopsy report may also cause delay of the tombstone unveiling.

INVESTIGATING DEATHS

Where the Coroner believes that the death should be investigated, issues may arise in relation to access to justice and understanding the process and issues that arise where Police investigate a death on behalf of the Coroner.

As part of an investigation into the death of an Aboriginal or Torres Strait Islander person, research or expert evidence should be obtained to assist the Coroner to understand the cultural and social issues that may be relevant to the deceased person.

ACCESS TO JUSTICE

One of the major issues that arise for Aboriginal and Torres Strait Islander people and the legal system in Australia is the availability of access to justice. Whilst there is information about the coronial process on the Courts website, some families may not have access to the internet. Further, that whilst families may have access to phones, they may not have finances to call CCQ.

Aboriginal and Torres Strait Islander families should be encouraged to access free coronial assistance legal service through the following service providers:

- Caxton Legal Centre; and
- Townsville Community Legal Service.

Alternatively, families should be referred to other independent legal services, including the Aboriginal and Torres Strait Islander Legal Service.

UNDERSTANDING THE PROCESS

When families do not have the financial capacity to engage legal representation during the coronial process or at inquest, it is important to ensure that families understand the coronial process. Understanding the coronial process may include understanding the delays involved, the decision

and timeframes around requests for inquest, as well as what happens when a decision to hold an inquest has been made.

RELATIONSHIP WITH POLICE

From time to time the Queensland Police Service provides assistance to the Coroner as part of the coronial investigation. Police officers may be required to gather statements and evidence from witnesses in order to assist the Coroner during the coronial investigation.

The relationship between Police and the Aboriginal and Torres Strait Islander community is at times strained due to historical and recent interactions. This strained relationship may be exacerbated if the death is a death in custody or a family believes that there is police involvement or a lack thereof.

If there are circumstances where there is a strained relationship with Police, it may be appropriate to prompt the family to:

- outline their concerns in writing or over the phone;
- access free coronial assistance legal service; or
- seek other independent legal advice.

It is important to recognise that Aboriginal and Torres Strait Islander Police Liaison Officers (PLO) are there to assist Police in performing their duties and can often be associated with representing Police, rather than representing their community. If a PLO is being engaged to assist the coronial investigation process, it will be important to ascertain the family's views about that engagement, as there may be circumstances of kinship or community relationships or issues around confidentiality in the community.

INQUESTS ISSUES

In circumstances where a Coroner decides to hold an inquest, it is important that the next of kin and families are aware that they can seek leave to appear at inquest.

Families should be encouraged to access free coronial assistance legal services to provide advice and assistance at the Pre-Inquest Conference and Inquest.

When an inquest has been listed and there has been no communication with the next of kin following written correspondence being sent, it may be useful to phone the next of kin.

Issues that may be relevant for the Coroner and Counsel Assisting to consider during the inquest should include:

- using the name of the deceased person;
- using voice recordings or images of the deceased persons;
- giving the family an opportunity to give evidence at the start of the inquest either on oath or informally;
- whether there are aspects of the inquest that may relate to men's business or women's business;
- whether the scope of the inquest should be expanded to consider the issue of specific cultural or social issues such as institutional racism.[ix]

If a brief of evidence is being provided to the family in preparation for the inquest, and contains voice recording and images, the family should be notified of this before receiving the brief of

evidence. Again, literacy and language issues may make it difficult for families to read the brief of evidence, increasing the need to refer families to obtain legal advice.

In circumstances where an Aboriginal and Torres Strait Islander families are unable to engage legal re prese nt at ion, families should be informed that they can still seek leave to appear at the Pre-Inquest Conference and/or Inquest.

If a death occurs in a remote community, consideration should be given to whether it is appropriate and possible to hold an inquest on country or whether it is more appropriate to hold the inquest in a neutral location. Consideration should be given to the number of family members who may wish to attend the inquest and their ability to attend the inquest if it is held elsewhere.

FINDINGS

When preparing findings, consideration should again be given to the use of the deceased person's name. The appropriate naming convention should be used throughout the finding.

Information relating to the deceased person's identity as an Aboriginal or Torres Strait Islander person should also be noted and include whether the deceased person identified with a specific nation, tribe, clan or language group.

Another relevant issue is whether it is necessary and appropriate to publish findings, particularly in circumstances where men's or women's business is a relevant issue for findings. Guidance from the family should be sought prior to publishing.

LEADING CAUSES OF DEATH IN ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLE

In the 2017 census, the Australian Bureau of Statistics (ABS) recorded the leading causes of death in Aboriginal and Torres Strait Islander people residing in New South Wales, Queensland, South Australia, Western Australia and the Northern Territory. The data is a key input into the Closing the Gap strategy led by the Council of Australian Governments (COAG). The annual Closing the Gap report sets targets across key social and justice priorities, namely:

- families, children and youth;
- health;
- education;
- economic development;
- housing;
- justice, including youth justice; and
- land and water.

In 2017 the ABS reported that there were 2,988 recorded deaths of Aboriginal and Torres Strait Islander people (1,631 men and 1,357 women) at a rate of 976 per 100,000 pe rsonsx. ABS data showed that life expectancy was the highest in Queensland reporting 72.0 years for men and 76.4 years for wome n. xi

The ABS reported that the 20 leading causes of mortality amongst Aboriginal and Torres Strait Islander people were:

- ischaemic heart disease (344 deaths);
- diabetes (226 deaths);
- chronic lower respiratory diseases (202 deaths);
- malignant neoplasms of the trachea, bronchus and lung (184 deaths); and

- intentional self-harm - suicide (165 deaths)
- cirrhosis and other diseases of the liver (98 deaths)
- dementia, including Alzheimer disease (97 deaths);
- cerebrovascular diseases (96 deaths);
- accidental poisoning (78 deaths);
- land transport accidents (77 deaths);
  certain conditions originating in perinatal period (66 deaths);
  symptoms, signs and ill-defined conditions (64 deaths);
  malignant neoplasm of pancreas (60 deaths);
- malignant neoplasms of lymphoid (57 deaths);
- influenza and pneumonia (53 deaths);
- malignant neoplasm of liver and intrahepatic bile ducts (53 deaths);
- diseases of the urinary system (52 deaths);
- malignant neoplasm of colon, sigmoid, rectum and anus (50 deaths);
- malignant neoplasm of breast (35 deaths); and
- cardiomyopathy (32 deaths).

Non-communicable diseases

The ABS reported the following average age-specific death rates for non-commun ica ble diseases:

Selected Age Grau	2008-2012	2013-2017
30 years - 39 years	104.2 eo le er 100,000	90.512eo12le 12er 100,000
40 years - 49 years	291.7 eo12le 12er 100,000	293.2 peo12le 12er 100,000
50 years - 59 years	706.8 er 100,000	**686.6** er 100,000
60 years - 69 years	1,518.0 eople per 100,000	1542.4 er 100,000

Several of the non-communicable chronic diseases have common preventable risk factors including a lack of physical exercise, alcohol consumption, smoking and poor nutrition.

Suicide

The ABS reported that 165 Aboriginal and Torres Strait Islander people died as a result of suicide at a rate of 25.5 deaths per 100,000 persons. By comparison, the rate of intentional self-harm deaths of Aboriginal and Torres Strait Islander people was 5.5% compared with 2.0% for non-Indigenous populations. [xii]

Suicide was ranked as the 2nd leading cause of death for Aboriginal and Torres Strait Islander men with 39.6 deaths per 100,000 persons and 7th for women at 11.9 deaths per 100,000 persons. For non-Indigenous people suicide was ranked at 10th and 21st leading cause for men and women, respectively.

The median age at death for suicide across the Aboriginal and Torres Strait Islander population was 29.5 years compared with 45.4 years in non-Indigenous population. Aboriginal and Torres Strait Islander people aged 55 years and over recorded lower age suicide rates than non-Indigenous people.

Suicide of Aboriginal and Torres Strait Islander children and young people occurred at a rate of 10.1 deaths per 100,000 persons, compared with 2.0 per 100,000 for non-Indigenous persons. Children

aged between 15-17 years contributed to 94.4% of all suicide deaths in young Aboriginal and Torres Strait Islander people .

Alcohol-induced deaths

The ABS recorded that Aboriginal and Torres Strait Islander males died from alcohol-induced conditions at five times the rate of non-Indigenous men at a rate of 36.5 deaths per 100,000 persons. Aboriginal and Torres Strait Islander women died at a rate six times higher than that of non-Indigenous women and 1.7 times higher than that of non-Indigenous men.[xiii]

In Queensland, the Protection Act prohibited the sale and supply of liquor to 'Aboriginal or half-cast' people. Prior to the 1967 Referendum, which amended the Australian Constitution to include Aboriginal people in the census, Aboriginal people were 'wards of the state'.[x] iv The Protection Act was repealed in 1984.

The Queensland Government created canteens in government-controlled outlets in partnership with Aboriginal Shire Councils. This placed restrictions on the sale, consumption and possession of alcohol in those communities. The canteens were a source of revenue for local infrastructure, projects and services and created the economic sustainability for communities. This resulted in high levels of alcohol consumption, excessive violence and hospitalisations.[xv]

In 2000, The Aboriginal and Torres Strait Islander Women's Taskforce on Violence found that alcohol was a self-medicating response to trauma and the cause and contributor of violence in community. Further, the 2001 Cape York Justice Study by Justice Tony Fitzgerald found that strict adherence to the *Liquor Act 1992* in order to end the illegal serving of alcohol to intoxicated people. Further that official inspection and compliance take place for all canteens in Cape York communities. Justice Fitzgerald recommended suspension or cancellation of licences for failure to comply with regulations and licence conditions.[xvi]

The Queensland Government introduced measures to transfer canteens to community-based boards. Community Justice Groups (CJG) took on the responsibility for the canteens. CJGs are made up of Elders and respected community members. Alcohol Management Plans (AMP) are developed by CJGs and include designating dry areas, restricted areas, operating hours of licensed premises and any relevant decisions made by the CJGs.

AMPs in Queensland include the following communities:

- Pormpuraaw;
- Aurukun;
- Woorabinda;
- Lockhart River;
- Mornington Island;
- Napranum;
- Wujal Wujal;
- Palm Island;
- Cherbourg;
- Hope Vale;
- Yarrabah;
- Doomadgee;
- Northern Peninsula Area; and
- Mapoon.

Deaths in custody

It has been over 25 years since the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) in 1991-92. One of the findings of the RCIADIC included that Aboriginal and Torres Strait Islander people were no more likely than non-Indigenous people to die in custody , however that they represented a greater number of arrests and prison population.

In 2019, the Australian Institute of Criminology (AIC) reviewed 2,044 deaths in custody from data gathered across each State and Territory between 1991-1992 and 2015-2016 financial yea rs.vx ii

The AIC study showed that 247 of the 2, 044 deaths reviewed were Aboriginal and Torres Strait Islander deaths in custody and accounted for 19% of all prison deaths in the study. It showed that whilst the number and proportion of Aboriginal and Torres Strait Islander people in prison had increased, the proportion of deaths in custody had been smaller than the proportion of prisoners.

The data indicated that men outnumbered women in all Aboriginal and Torres Strait Islander deaths and all non-Indigenous deaths amounting to 96% of the deaths reviewed. A review of the ages of deceased prisoners shows the average age of 37.8 years compared with 45.3 years for non-Indigenous prisoners. The study showed that 89% of deaths occurred before the age of 55 compared with 69% among non-Indigenous prisoners. Almost one in five Aboriginal and Torres Strait Islander deaths involved a prisoner less than 25 years of age.

The most common causes of death included:

- natural causes ;
- ha nging ;
- drugs and/or alcohol; and
- external trauma.

The data also indicated that 73% of Aboriginal and Torres Strait Islander deaths between 1991-1992 and 2015-2016 involved sentenced prisoners and 27% involved unsentenced prisoners.

The study could not accurately report the rates of deaths in police custody due to the absence of reliable data on the number of Aboriginal and Torres Strait Islander people in custody and the number of those who came into contact with police in custody-related operations. However, on the available data there were 146 Aboriginal and Torres Strait Islander deaths in police custody which accounted for 20% of the total police custody deat hs. Again, male deaths outnumbered female deaths in police custody and comprised of 86% of all Aboriginal and Torres Strait Islander deaths and 95% of all non-indige nous deaths.

The most common causes of death for those in police custody included:

- external/multiple tra uma ;
- motor vehicle pursuits ;
- natural causes; and
- hanging.

Traumatic or sudden death

Slow deteriorating health related deaths are more likely to be accepted by Aborigina l and Torres Strait Islander people. However Aboriginal and Torres Strait Islander people may associate traumatic and sudden death with sorcery, such as paybackx.v iii

Why does traumatic or sudden death raise questions for Aboriginal and Torres Strait Is la nde r people?

Coronial staff should anticipate strong reactions from next of kin and family members and allow time for the concerns to be ventilated. This may also trigger a response by families to perform a ceremony, such as a smoking ceremony, to cleanse what has believed to have been done or an autopsy performed under traditional lore.

The family may also request an autopsy be performed in circumstances where it is not necessary. Families should be encouraged to provide further information about the particular cultural issue that would require an autopsy be performed.

COMMUNITY RELATIONSHIPS

In order to build effective relationships between CCQ and the Aboriginal and Torres Strait Islander community, it is important to be visible and accessible.

Another mechanism for improving relationships with the Aboriginal and Torres Strait Islander community is to increase the capacity of Coroners and CCQ staff to develop their understanding and capacity to work with Aboriginal and Torres Strait Islander people. Cultural learning is a lifelong lesson for Aboriginal and Torres Strait Islander people and should be an ongoing commitment for non-Indigenous people to develop their understanding and abilities throughout their lives.

It is important that CCQ builds its capability and engagement with the Aboriginal and Torres Strait Islander community by increasing awareness of the coronial process in circumstances when engagement is not triggered by a death in community. This engagement with community can be through relationship building with the local Community Justice Groups or Murri Court elders that exist in Queensland.

In circumstances where a death has occurred, it will not be appropriate to involve Aboriginal or Torres Strait Islander people who are outside the family of the deceased, unless informed otherwise by the next of kin . Confidentiality of family sorry business is important to maintain and can be jeopardised by the involvement of Aboriginal or Torres Strait Islander people who have no authority within the familial relationship to the deceased person. Consent must be obtained from the next of kin before involvement of Murri Court elders or Community Justice Groups. Most Departments create community 'Liaison' positions to assist Departments to increase their relationship building with the Aboriginal and Torres Strait Islander community. However, no such position exists within CCQ.

PAR TNERS HI PS WITHIN THE DEPARTMENT OF JUSTICE AND ATTORNEY-GENERAL

The Department of Justice and Attorney-General (DJAG) is committed to implementing the Magistrates Court Reconciliation Action Plan (RAP). The RAP can be actively implemented by working with other parts of the Department.

An avenue for engagement would include attending community events throughout Quee nsl and . Important events in the Aboriginal and Torres Strait Islander communities include Reconciliation Week and NAIDOC Week celebrations. By providing access and information to communities, they will be more willing to engage in the coronial process. There are opportunities for Departments to access funding to host Reconciliation Week and NAIDOC Week events.

[i] Section 3 of the *Coroners Act 2003* (the Act).

[ii] Part 4.2 of the State Coroner's Guidelines at page 5.

[iii] Part 4.6 of the State Coroner's Guidelines at page 12.

[iv] Queensland Health (2015), *Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying (version 2),* Queensland Government. Available at https://www.health.qld.gov.au/data/assets/pdf file/0023/151736/sorry_business.pdf, [Accessed 16 June 2019].

[v] Cordell, John; Fitzpatrick Judith (1987) *Torres Strait: Cultural Identity and the Sea,* Cultural Survival Quarterly (11.2).

[vi] Ibid

[vii] Department of Aboriginal and Torres Strait Islander Partnerships, Queensland Government, *Traditional Torres Strait Islander Child Rearing Practises (Public Consultation Paper),* October 2018.

[viii] Queensland Health (2015), *Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying (version 2),* [online], Queensland Government. Available at https://www.health.qld.gov.au/data/assets/pdf file/0023/151736/sorry business.pdf, [Accessed 16 June 2019].

[ix] Miki Perkins, 'Coroner agrees to consider role of racism in Tanya Day's Custody Death' *The Age* (online) 27 June 2019 < https://www.theage.com.au/national/victoria/coroner-agrees-to-consider-role-of-racism-in-tanya-day-s-custody-death-20190627-p521vm.html>.

[x] Australian Government Department of Prime Minister and Cabinet (2019). *Closing the gap: Prime Minister's Report 2019.* Commonwealth of Australia. Available at: http://ctgreport.pmc.gov.au [Accessed 11 June 2019].

[xi] Australian Bureau of Statistics (ABS) Causes of Death, Australia, 2017. Cat no. 3303.0. [Accessed 14 June 2019]. Available at: https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/3303.0~2017~Main%20Features~Leading%20causes%20of%20death%20in%20Aboriginal%20and%20Torres%20Strait%20Islander%20peoples~9.

[xii] Ibid.

[xiii] Ibid.

[xiv] University of Melbourne (2019), *The Alcohol Management Plan at Pormpuraaw, Queensland, Australia - An Ethnographic Community-Based Study,* [online] http://fare.org.au/wp-content/uploads/The-Alcohol-Management-Plan-at-Pormpuraaw.pdf, [Accessed 28 June 2019].

[xv] Ibid.

[xvi] Ibid.

[xvii] Gannoni, Alexandra; Brickell, Samantha, *Indigenous deaths in custody: 25 years since the Royal Commission into Aboriginal Deaths in Custody,* 21 February 2019, www.aic.gov.au, https://aic.gov.au/publications/sb/sb17, [Accessed 22 June 2019].

[xviii] Queensland Health (2015), *Sad News, Sorry Business: Guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying (version 2),* [online], Queensland Government. Available at https://www.health.qld.gov.au/data/assets/pdf file/0023/151736/sorry business.pdf, [Accessed 16 June 2019].