CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Marcia Anne Kathleen Maynard**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2015/3872
DELIVERED ON:	5 September 2018
DELIVERED AT:	Brisbane
HEARING DATE(s):	15 May 2018, 6-8 June 2018
FINDINGS OF:	John Lock, Deputy State Coroner
CATCHWORDS:	Suicide, insulin overdose, personal stressors, nurse witness to be called in an inquest, counter-therapeutic consequences for those involved.

REPRESENTATION:

Counsel Assisting:	Mr K Fleming QC
Counsel for the family:	Mr L Tiley, i/b Hall Payne Lawyers
Counsel for Metro North Hospital and Health Service:	Mrs K Mellifont QC i/b MNHHS Legal
Counsel for Mr G Rebetzke:	Mr C Copley i/b Berrill & Watson
Counsel for Dr Laflamme:	Mr C Steele i/b Ashurst
Counsel for Ms E Smyth:	Mr S Seefeld i/b Roberts & Kane

Contents

Introduction 1
The issues 2
Cause of Death 2
  Autopsy results 2
  Report of Dr Michael Robertson 3
Investigations about the circumstances surrounding the death 4
  Queensland Police Service Investigation 4
  Workplace Health and Safety Queensland Investigation 5
  Insulin and the workplace 7
What factors or stressors combined or contributed to cause her death 8
  Physical and Mental Health Issues 8
  Weight Loss 8
  Employee Assistance Scheme counselling 9
  Woodford Correctional Centre 10
  Euthanasia 11
  Relationship with Husband and family 11
  Requirement to give evidence 12
  Meeting with solicitor and barrister 13
  Changing Will and Enduring Power of Attorney 15
  Mrs Maynard's professional reputation and the finding at the Mickelo inquest 15
Conclusions on the issues 16
Findings required by s. 45 20
    Identity of the deceased 20
    How she died 20
    Place of death 20
    Date of death 20
    Cause of death 20
Comments and recommendations 20

Introduction

1. Marcia Maynard died on 3 October 2015. Sometime between 29 September 2015 and 30 September 2015, she self-administered a lethal dose of insulin. She had booked a room at a hotel and attended there on 29 September and was found unconscious in bed by hotel staff on 30 September.

2. The Queensland Ambulance Service was called and it was noted by them that her blood sugar level was low. No drugs or drug paraphernalia were found by QAS staff on a search of the room. Mrs Maynard was taken to Redcliffe Hospital where she remained unconscious and her condition continued to deteriorate. She died on 3 October 2015.

3. Mrs Maynard was a registered nurse who was employed by Offender Health Services at the Woodford Correctional Centre (Woodford). Woodford general health care was provided by nursing staff and visiting medical officers (VMO) employed by Metro North Hospital and Health Service (Metro North), through Caboolture Hospital, as part of the Offender Health Service (OHS).

4. Mrs Maynard had provided nursing services to a prisoner, Garnet Mickelo, who died on 24 November 2012.

5. As Mr Mickelo died in custody, it was mandatory that an inquest into the circumstances of his death be held.

6. Mrs Maynard had provided a statement to the investigating State Coroner and an inquest was listed to commence on 7 October 2015. Mrs Maynard was advised she was to attend the inquest as a witness.

7. Mrs Maynard was being represented by lawyers engaged by the Queensland Nurses Union. A barrister was also engaged and Mrs Maynard attended a conference with the instructing lawyer and counsel on 1 September 2015.

8. Mrs Maynard wrote a letter dated 29 September 2015 to Miss Emily Cooper, counsel assisting in the coronial inquest. The letter appears to have been written in the context of her completing a further statement for the inquest, which may have contained material left out in an earlier statement. As Mrs Maynard stated in her letter, *I now have been told they are gunning for me.* She went on to say, *again I am sorry but am unable to take the stress of trying to answer any more.*

9. Mrs Maynard also sent or left letters for her lawyers, daughter and her husband indicating that a considerable stressor for her was related to the comment, *they are gunning for you;* giving evidence at the inquest*;* as well as a general comment about the stress of her workplace.

10. The inquest in respect of the death of Mr Mickelo was adjourned and transferred to me as the Deputy State Coroner and held on other dates.

11. The circumstances of the death of Mrs Maynard were investigated by the Queensland Police Service. Issues concerning the possible stressors existing at her workplace were referred to Workplace Health and Safety Queensland for investigation.

The issues

12. Mrs Maynard's family requested an inquest be held. A decision was made to hold an inquest and a pre-hearing conference held on 15 May 2018 determined the issues for the inquest as follows:

    i. The findings required by s. 45 (2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how she died and what caused her death.

    ii. The circumstances surrounding the death and what factors or stressors combined or contributed to cause her death.

    iii. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the *Coroners Act 2003.*

13. The following witnesses were called to give evidence:

    a. Plain Clothes Senior Constable Edward Rogers – Investigating Officer
    b. Craig Servin – Workplace Health & Safety Queensland Investigator
    c. Michael Maynard – husband
    d. Ann Clayton – director at Caboolture Hospital responsible for staffing the corrections health centre
    e. Christine Evans – work colleague of Mrs Maynard
    f. Warren Hann – work colleague of Mrs Maynard
    g. Dean Izzard – work colleague of Mrs Maynard
    h. Sushiela Kander – work colleague of Mrs Maynard
    i. Carolyn Manning – work colleague of Mrs Maynard
    j. Martha Pitt – Nurse Unit Manager, Woodford Correctional Centre
    k. Dr Sebastien Laflamme – Mrs Maynard's GP
    l. Victor-David Murray – Solicitor, prepared Mrs Maynard's will
    m. Evonne Smyth – Solicitor
    n. Gavin Rebetzke – Barrister-at-Law
    o. Ann-Marie Warren – Psychologist

Cause of death

Autopsy results

14. As there were family objections to an internal examination, an external examination only was ordered. The external examination noted a number of needle puncture wounds on the front of the elbows, around the wrist, lower abdomen and possibly around the right foot and ankle. The needle puncture wounds of the abdomen and some on the arms were consistent with injecting drugs.

15. There were no other significant external examination findings and CT scans were unremarkable.

16. The antemortem serum (1725 mU/L) and antemortem plasma insulin levels (2338 mU/L) were significantly high (normal range 2-23 mU/L). This was in keeping with the history of insulin overdose however, it was not possible to

determine the accuracy of insulin levels due to metabolism of insulin during the early antemortem period and production of endogenous insulin.

17. The forensic pathologist, Dr Rohan Samarasinghe subsequently advised that the multiple injection marks could have occurred at the scene by QAS; at the hospital; as a result of self-infliction; or all three. Dr Samarasinghe stated a pathologist cannot separate these injection marks individually (unless in some cases there is a significant period of time between producing each mark and where an internal examination of each of these wounds is performed). Injection marks can be subtle at times and can be easily overlooked. It is even difficult at post-mortem due to post-mortem changes.

18. Dr Samarasinghe stated that in living subjects injection marks can also appear later with the tissue reaction progress. The abdomen is a very common site where insulin is self-administered by patients.

Report of Dr Michael Robertson

19. Dr Michael Robertson is a pharmacologist and forensic toxicologist. Dr Robertson was requested to provide an independent expert report, largely as a result of the family concerns regarding the absence of insulin and injecting paraphernalia at the hotel room. This brought into question how quickly adverse effects become apparent on overdose and whether it was possible for Mrs Maynard to dispose of the drug and any utensils before she was overcome by the effects of the insulin.

20. Dr Robertson stated that insulin is a protein hormone consisting of two polypeptide chains formed in and released from the pancreas in response to elevated glucose levels in the blood. An elevation of insulin facilitates the movement of glucose from the blood into the cells and thus results in a reduction of the circulating glucose levels assuming an absorption of glucose on the stomach is not occurring. This reduction in glucose levels may lead to a state of hypoglycaemia.

21. The adverse effects of hypoglycaemia may be mild and transient or more profound including death. The number and magnitude of adverse effects is based on a number of factors such as dose, route of administration and formulation of the insulin administered.

22. Elevated levels of insulin, either due to some natural pathology or the administration of insulin, usually via subcutaneous injection, may result in a progression of adverse effects that can include hypoglycaemia, hunger, fatigue, loss of concentration, nervousness, nausea, chills and sweats, tachycardia, seizures, shallow breathing, hypotension, coma and death.

23. The most susceptible part of the body to insulin-mediated hypoglycaemia is the brain and central nervous system more generally.

24. Dr Robertson was unable to determine from the available evidence with any reasonable scientific reliability, the amount of insulin consumed. Dr Robertson stated that the high insulin concentration in the antemortem plasma and the low C-peptide content supports the conclusion that exogenous insulin was administered.

25. Dr Robertson stated that commercially made insulin may be administered intravenously, intramuscularly and subcutaneously. Each of the routes of administration will have differing onsets of action with the intravenous most rapid and the intramuscular the slowest. Commercially made insulin is also formulated as either rapid acting insulin or long acting insulin or a combination of both and as such the onset of action also varies depending on the formulation used.

26. Dr Robertson stated that given these variables it may take between 15 minutes and 30 minutes for insulin to start to take effect depending on the route of injection and the formulation injected.

27. Dr Robertson stated that when a long acting insulin is taken via intramuscular injection, there can be delayed effects and the effects will not be as pronounced. Short acting insulin can also produce this delayed effect when injected subcutaneously or intramuscularly however, will act relatively quickly if administered intravenously.

28. Dr Robertson stated that when taking an overdose, depending on the amount of insulin administered, the route of administration and the formulation administered, the effects of the administered insulin may start to occur in 15-20 minutes, may reach peak effects after a number of hours and may have prolonged effects particularly if a long acting formulation was injected.

29. Dr Robertson therefore stated that it was reasonably possible that an individual could administer the drug, particularly if a low or long acting formulation was administered subcutaneously and then dispose of any paraphernalia prior to any significant adverse effects such as dizziness and confusion becoming pronounced.

Investigations about the circumstances surrounding the death

Queensland Police Service investigation

30. Plain Clothes Senior Constable Rogers was tasked to conduct initial investigations. He attended at the Redcliffe Hospital and received information from the medical clinicians that it appeared Mrs Maynard had overdosed on insulin and it was not expected that she would survive. At the same time he was provided with the hand written letters that were brought in by QAS and found in the hotel room.

31. PCSC Rogers then attended the hotel and met with Scenes of Crime officers and attended room 401, which had been secured. He observed the room appeared to have been cleaned and one of the beds had been stripped of bedding. A search of the room was conducted in an attempt to locate any drugs or drug paraphernalia. No items were located.

32. PCSC Rogers then attended the basement carpark where Mrs Maynard's motor vehicle was located and later obtained keys from Mr Michael Maynard, her husband, and searched the vehicle and did not find any drugs or drug paraphernalia.

33. PCSC Rogers later had a conversation with Mr Maynard and daughter Catherine Richards. He gleaned from them that Mrs Maynard had been feeling recent stress about a coronial inquest that was about to be held. They also made reference to the fact that recently she had conducted internet searches of

euthanasia websites and the methods used and specific mention of the use of insulin as a suicide method.

34. It was also noted that Mrs Maynard had arranged to have her affairs put in order including updating her will and changing her power of attorney.

35. Mr Maynard also stated that his wife had been distressed after a five hour meeting with a barrister and solicitor and the reference to her being told *they were gunning for her.*

36. Mrs Richards also handed to PCSC Rogers other letters that had been found at Mrs Maynard's home that were addressed to Mr Maynard and to herself as well as a short note addressed to another daughter.

37. PCSC Rogers also spoke with the hotel manager and cleaning staff. The only cleaning conducted was to strip the bed. Otherwise it did not appear the toilet or shower had been used and the room was completely clean when they entered. At no time did they observe or locate any medication or drug paraphernalia. It is apparent hotel cleaning staff located Mrs Maynard on the bed at about 11am. He also spoke with the QAS officers who confirmed they had conducted a search of the room and nothing relating to drug use was found, other than some Gaviscon, which is potentially used for nausea.

38. The hotel records indicate Mrs Maynard had attended the hotel on 28 September 2015 and booked a room for the next day. She checked in at approximately 1:52pm on 29 September 2015 and signed the guest registration form and book.

39. Unfortunately, PCSC Rogers did not make enquiries about hotel CCTV footage until July 2016. At that time he was advised that CCTV footage for the hotel was initially saved at the time of the incident, but due to a server crash the saved footage was lost.

40. He was also advised the swipe card device fitted to the door did not record the entry/exit data for the end of September 2015.

41. The hotel was able to advise the electric swipe card allocated to Mrs Maynard's room indicated she had entered the basement parking at 1:52pm, and used the lift to travel to the 4th floor where room 401 was situated. There is no data that indicates that Mrs Maynard used the swipe card to access any other parts of the hotel.

42. PCSC Rogers also noted there was a garbage room located on the western side of the elevator shaft, which was about 15 metres from the entrance to room 401. He stated it was a distinct possibility that Mrs Maynard used the garbage facilities or even a toilet to dispose of any drugs and drug paraphernalia. He conceded that he should have searched the garbage facilities and also the industrial bin in the basement area, which was connected to a garbage chute and he should have obtained any CCTV footage.

Workplace Health and Safety Queensland investigation

43. As has been noted, Mrs Maynard left a number of notes prior to her death and these indicated she took her own life due to a number of matters but specifically the stress as a result of an upcoming inquest proceeding she was required to give evidence at; lack of support she felt she had received from her employer in

relation to the inquest proceedings; and other steps taken by her employer, which she felt caused her additional stress (such as requesting she change her leave arrangements, changing dates of her training and being requested to return from leave taken in response to the stress she was already under).

44. On 18 December 2015, the Coroners Court wrote to Workplace Health and Safety Queensland indicating a preliminary view on the basis of the above, that the death may fall within the definition of a notifiable incident under the *Work Health and Safety Act* 2011.

45. WHSQ commenced an investigation and provided the Deputy State Coroner with a report of Investigator Craig Servin. The report noted the Woodford health services unit stored medications, including insulin, to provide to inmates of the correctional centre. As a registered nurse, one of Mrs Maynard's primary tasks was to administer medication such as insulin and as such she had readily available authorised access to insulin at the health unit.

46. WHSQ largely excluded the possibility that Mrs Maynard had accessed insulin at one of her previous places of employment and a check with her usual GP revealed she was not prescribed insulin. Checks with Medicare records negated the possibility she obtained the insulin through prescription.

47. As insulin is not a drug of addiction, there was no requirement for it to be stored in a locked cabinet or refrigerator in the manner that Schedule 8 restricted drugs are stored. Unopened insulin prescriptions were stored in the medicine refrigerator at the health unit. Insulin, which had been opened and was ready for administration, was kept in a mobile medicine cabinet used by the nurses on their rounds. No records were kept on the destruction of insulin after expiration and it was ordered on an 'as needed' basis. WHSQ concluded the storage and disposal systems of the health centre were lawful according to the provisions of the *Health (Drugs and Poisons) Regulation 1996* for Schedule 4 drugs.

48. The security at the prison was such that persons, including staff, entering the centre were searched for prohibited items, which would include needles and syringes. However, personal property is not searched routinely upon departure. The scanners were set such that an insulin needle, which was primarily of plastic construction with a small metal needle insert, would not be detected.

49. WHSQ concluded that based on this evidence it was probable Mrs Maynard accessed the insulin through the course of her employment at the Woodford health unit.

50. WHSQ also took a history from Mr Maynard and Catherine Richards. They provided some specific isolated instances of generally historic conflict, which Mrs Maynard had mentioned about the individual staff. WHSQ examined these instances and considered they related to isolated personality conflicts as opposed to any repeated unreasonable behaviour, which would constitute bullying.

51. Mr Maynard told the court there had been problems at work over time with the Nurse Unit Manager (NUM) Martha Pitt and with the prison but Mr Maynard did not suggest it was an acute issue for Mrs Maynard around the time of her death.

52. Evidence was also provided that Mrs Maynard was an avid record keeper and she had retained emails from the workplace in files she kept at home. She also

kept journals and diaries. A few weeks prior to death, Mrs Maynard had begun shredding documents and emails, and her diaries and journals were never found. It is evident she also wiped her internet search history and all her emails on her personal laptop prior to death.

53. WHSQ considered there was evidence to suggest Mrs Maynard had created an apparent perception in her mind that she was being victimised and singled out in relation to the inquest and that she could not cope any further. There was evidence that there was an environment of stressors playing on her mind and she made a number of preparations leading up to her death. It was concluded that she had determined to take her own life some time prior to doing so.

54. No evidence was gleaned from the investigation of any repeated unreasonable behaviour of the employer towards her. Inspector Servin noted in his evidence Mrs Maynard had been given adequate support by her employer. She was being separately represented at the inquest; was given paid leave to seek legal advice and was encouraged to take up and received counselling support.

Insulin and the workplace

55. At some time in early October 2015, Clinical Nurse (CN) Christine Evans and CN Sushiela Kander visited Mrs Maynard whilst she was still alive at Redcliffe Hospital. It was contended by the family that at this visit there was a discussion with Mr Maynard and the two nursing colleagues to the effect that Mrs Maynard had taken an overdose of insulin. Mr Maynard further suggested that in the same conversation with the two nurses it was raised that at some point euthanasia had been spoken about by Mrs Maynard in a discussion with CN Warren Hann.

56. The family suggests that CN Evans and/or CN Kander should have provided this information to more senior personnel at Metro North and this should have prompted Metro North to undertake an audit/stocktake of the insulin stocks at Woodford and such an audit may have provided some insight into the type, amount and origin of the insulin utilised by Mrs Maynard.

57. CN Kander does not recall any discussion at the hospital about euthanasia and says she was not aware Mrs Maynard died of an insulin overdose until a week before this inquest was being held. CN Evans stated she also does not recall a conversation at the hospital concerning insulin. She believes she received information from CN Hann about a conversation he had with Mrs Maynard about euthanasia but not from the family. Mr Maynard maintained such a conversation took place.

58. This is an issue which does not need to be determined by me. The evidence is equivocal at best as to which version I should accept. In any event, for reasons set out below, making a finding the conversations took place as suggested by Mr Maynard, would not have changed anything in so far as securing better evidence about the source, amount and type of the insulin, even if an audit had occurred.

59. CN Tina Evans stated that insulin at Woodford was used on an ‘as needed’ basis and there was no specific tally of stocks other than an imprest list used for ordering of stock. Audits were not conducted for this medication as it was used all the time. There was no baseline stock recorded and insulin was not then recorded as being for a particular prisoner. When taken out of the storage cupboard it was labelled for each prisoner but no other record is entered.

60. There was and is no requirement at law for a particular storage and audit regime to be in place for insulin and Metro North did not have any specific procedure in place providing otherwise.

61. Even if an audit was conducted it is unlikely to have resulted in any further forensic information.

What factors or stressors combined or contributed to cause her death

62. There were likely a number of stressors impacting on Mrs Maynard in the period leading up to her death. Some of these stressors have been identified in her letters, with other stressors identified in other background evidence.

Physical and mental health issues

63. In one of the notes left to her husband, Mrs Maynard made reference to the fact that she had been having some health issues in the last few months and had lost 18 kilograms in weight. She referenced this to a stomach bug/food poisoning.

64. Her GP, Dr Sebastien Laflamme first consulted with Mrs Maynard on 4 March 2015. There were a total of seven consultations with the last consultation on 11 September 2015.

65. Dr Laflamme had not noted any concerns about a stomach bug or losing weight. At a consultation on 20 July, Mrs Maynard is recorded as stating she generally felt well and wanted to lose weight.

66. Mrs Maynard's main complaints expressed to Dr Laflamme were that in September 2015 she was having trouble sleeping due to working night shifts and having disturbed sleep. She was prescribed temazepam initially on 3 September and then to trial Serapax from 11 September as the temazepam had not worked. Mrs Maynard had not described to him in her appointments any anxiety issues or reference to having to appear at an inquest.

67. At no time did Dr Laflamme have any concerns for Mrs Maynard's physical or mental well-being and she did not show any concerning behaviour or give any indication she was a risk of suicide or self-harm.

68. There was some evidence that Mrs Maynard had a partially paralysed arm and this was brought up by the family as a concern as to how she could have injected herself, suggestive of some other third party assistance. Her work colleagues had not observed any signs, which indicated a concern about a paralysed arm. There is no reference in her GP notes about this as a medical issue. In a counselling appointment on 17 August 2013, Mrs Maynard is recorded as saying she was born with a paralysed arm but had developed almost full use of it over the years. Mr Maynard was unable to tell the court, which arm was the problem.

Weight loss

69. The circumstances of Mrs Maynard's weight loss in the period before her death arose. She had not spoken to her GP about this other than to say she wanted to lose weight. On 20 July 2015 her GP records her weight as 68.5 kg and that she had lost 11 kg. Mrs Maynard told her counsellor on 6 September 2015 she had a bout of food poisoning and had lost 5-6 kgs over a couple of weeks.

70. Her nursing colleagues had noticed her considerable weight loss and she told CN Carolyn Manning she had given up sugar and was on a 1000 calorie a day diet. Mrs Maynard told CN Warren Hann the weight loss was for health reasons and told CN Kander she was on a strict diet.

71. CN Dean Izzard had asked her about her weight loss and she said it was for her husband as he told her she was obese and needed to lose weight.

72. Mr Maynard agreed that his wife had lost weight in the months leading up to her death. He also stated that his wife said it related to a stomach upset. He was asked about his wife having lost weight during the period of a previous separation but he stated he did not recall that and did not have a lot to do with her in that period.

73. At autopsy it is noted her weight was 72.8 kg with a BMI of 26.7

Employee Assistance Scheme counselling

74. Mrs Maynard also consulted with a psychologist, Anne-Marie Warren on two occasions, on 9 and 16 September 2015. Ms Warren was employed with Optum Health to provide short-term solution focused counselling as part of the Queensland Health Employee Assistance Scheme (EAS). Ms Warren stated that at neither session did Mrs Maynard indicate any suicidal ideation or intent to harm herself. Mrs Maynard had indicated she was feeling anxious about giving evidence at a coronial enquiry and she was focussed on not giving inaccurate information. At the first session they looked at some of her statement for the inquest and Ms Warren assisted her by providing some basic relaxation strategies to give Mrs Maynard time to collect her thoughts so she could answer the questions to the best of her ability. At no point did Mrs Maynard suggest someone was pressurising her to change her statement.

75. At the second appointment Mrs Maynard stated she felt better physically and reported that she had a bout of food poisoning and lost 5-6 kilograms in weight over the last couple of weeks. Ms Warren was not aware of this weight loss issue until she was told about it in the second session. Mrs Maynard had stated she found the first session extremely helpful and she had gone back to her written statement and had decided to clarify some comments. Mrs Maynard said she was quite happy to resubmit the statement with what she believes was a more accurate reflection of what had occurred. Mrs Maynard also said she had found the relaxation strategies helpful and assisted in making her feel calmer. Ms Warren thought that in the second session Mrs Maynard appeared to be more relaxed and calm and at no time in either session did she identify any sign Mrs Maynard was displaying high levels of distress or was at risk. If so, Ms Warren stated as a minimum response she would have conducted a risk assessment and proceeded to develop a suicide plan; contact the state manager for the service; and arrange a further urgent appointment.

76. A third session was booked for 29 September however, because Ms Warren was ill, that session did not proceed and a further appointment was made for early October.

77. Ms Warren was not aware that Mrs Maynard had used Optum counselling services previously. She said she specifically asked Mrs Maynard about this and Mrs Maynard stated there was no previous attendances and Ms Warren did not check any further.

78. Optum Health provided further information when requested, which indicated Mrs Maynard had attended three counselling sessions in 2011 but no records or identification of the psychologist could be located. Mrs Maynard also attended a total of four sessions in 2013 and records of these were received. These sessions indicated some concerns at that time about how she dealt with conflict at her work and difficulty in communicating with her husband. There was also reference to her having separated at one point from her husband but they were now back together after two to three years apart and were relatively happy now.

Woodford Correctional Centre

79. In one of Mrs Maynard's letters to her husband she said the problems she was experiencing did not relate to their relationship, but with Woodford. She stated she was not strong enough to stand up for what she did and she was still having problems with her memory. This comment clearly related to the giving of evidence at the inquest.

80. In a letter to her husband dated 29 September 2015, Mrs Maynard also referred to Woodford not being a healthy work site. She referred to the number of inmates increasing but with no extra support; Code Blues being called by prison officers 3-4 times a night; and until recently only one nurse being on night shift. The inquest did not explore those issues in any detail but it is evident these are perennial issues facing the medical staff at Woodford, as evidence about these types of issues have been received by me in other inquests relating to the same correctional centre.[1]

81. Overwhelmingly, the statements of Mrs Maynard's work colleagues indicated she was well liked by them and respected as a colleague and nurse. She confided with a number of them in relation to personal issues. The colleagues do not recall Mrs Maynard referring to any specific work related concerns about Woodford itself. There was evidence from some of the nurses that Codes Blue could be called for all types of things, some minor, but not to the magnitude or extent as suggested by the statement of Mrs Maynard. CN Kander stated that with two nurses now on for the night shifts she felt more confident these call outs could be responded to.

82. Mrs Maynard had never complained to her colleagues who gave evidence or provided statements about any bullying at Woodford. The main issue expressed to them at this time was about Mrs Maynard being anxious about giving evidence at the inquest. She had been offered time off to consult with her lawyers and they were aware she took up the offer of EAS counselling services.

83. The evidence of a number of staff at Woodford indicated they all shared a good relationship with Mrs Maynard and NUM Pitt referred to Mrs Maynard as a big part of their family and they had been with her through all of her stresses over the years.

84. CN Tina Evans provided Mrs Maynard with significant support as a friend over a number of years. She also assisted Mrs Maynard in the preparation of her statement and clearly CN Evans is the source of the advice given to Mrs Maynard to keep her statement short. This seems to be the basis of comments in her

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[1] *Inquest into the death of Zachary James Holstein*, delivered 20 June 2018. That inquest recommended there be additional resourcing for medical services at Woodford prison.

letters that Mrs Maynard was concerned she had left matters out. CN Evans stated she did not get the impression Mrs Maynard was concerned about the inquest itself but more about the length of time since the death and her having to provide a statement about matters that had occurred years earlier.

Research on euthanasia

85. Mrs Maynard's husband says he saw her researching euthanasia on the internet at home. She reportedly told him she was just curious to find out more about the subject given she was a nurse.

86. A nursing colleague, CN Warren Hann, also provided a statement describing an out of character conversation he had with Mrs Maynard on the evening of 4 September 2015. The conversation was said to be in the context of a concern by Mrs Maynard about a relative's use of insulin and Mrs Maynard saying it is possible to use insulin to terminate life. CN Hann stated he had no substantial concerns for Mrs Maynard's welfare (he had a history of being a mental health nurse) about this conversation at the time. He recalled it as out of character because Mrs Maynard (consistently with the evidence of other colleagues), would almost always speak about her family and specifically her grandchildren and this was a quite different topic. CN Hann did relay the content of the conversation to the Nursing Unit Manager Martha Pitt a few weeks later. This arose after NUM Pitt was having a conversation with CN Hann and in the course of this she expressed some concern about Mrs Maynard to him. He then told her about this out of character conversation. At her request, he recorded his concerns in an email to NUM Pitt, which NUM Pitt then forwarded to the Director of Nursing (DON), Anne Clayton.

87. DON Clayton says she was aware Mrs Maynard was anxious about the inquest and she was aware Mrs Maynard had accessed counselling through EAS. DON Clayton was not told there had been any conversations directly about euthanasia and insulin use until after Mrs Maynard died.

88. NUM Pitt stated she had no concerns about Mrs Maynard's well-being, although NUM Pitt was aware Mrs Maynard was anxious about giving evidence at the inquest. As a result NUM Pitt offered the services of EAS counselling support, which she was aware Mrs Maynard took up. Mrs Maynard also availed herself of independent legal advice through the Queensland Nurses Union. She stated Mrs Maynard was a strong union member and supporter so this was not surprising. NUM Pitt was aware she utilised CN Evans as a support person who assisted her with her statement. NUM Pitt also invited Mrs Maynard to her house to discuss the forthcoming inquest. When she took up this offer Mrs Maynard said she had spoken to CN Evans and instead they spoke at length about her four grandchildren.

89. CN Manning stated that Mrs Maynard had not discussed the topic of euthanasia with her. However, Mrs Maynard had asked her if she wanted to go to the cinema with her to see a film *Last Taxi Ride to Darwin*, a film dealing with euthanasia. CN Manning was unable to attend but in hindsight she thought the request was unusual as Mrs Maynard had never asked her to the cinema before.

Relationship with husband and family

90. Mrs Maynard and her husband, Michael Maynard had separated for a few years before reconciling. This appears to have occurred in 2007 and they reconciled in 2009. At the time Mr Maynard had formed a personal and business relationship

with another woman. The business had been helped out financially by Mrs Maynard.

91. Mrs Maynard's work colleague, CN Christine Evans said the separation had devastated Mrs Maynard. Ms Evans stated that over the years she had many conversations with Mrs Maynard where she discussed the past family struggles, business debts suffered by Mr Maynard, the separation and financial impact on her. CN Warren Hann also said Mrs Maynard was in a state of shock after the separation and the staff rallied around her. CN Evans recalls Mrs Maynard drew down on her QSuper account to pay her husband out.

92. CN Carolyn Manning stated she was aware that after the separation Mrs Maynard took him back and this caused an estrangement with one of her daughters who disagreed with the decision to reconcile. CN Manning was aware the estrangement had deeply shaken her but Mrs Maynard consistently stated she still loved her daughter. One of the notes left by Mrs Maynard was addressed to her daughter in those terms. Mr Maynard stated in evidence that he did not really know whether or not the alienation with her daughter had caused Mrs Maynard any concern.

93. Mrs Maynard maintained a close relationship with her other daughter, Catherine Richards and adored her grandchildren. She spoke about them constantly to her work colleagues.

94. CN Manning also stated that in the months leading up to her death Mrs Maynard was worried that her husband was back in contact with the woman he had previously had a relationship with. Mrs Maynard told CN Manning he had shown her a text message from the woman and her husband had told her that this woman was trying to contact him again. Mrs Maynard told CN Manning her husband was suspicious Mrs Maynard may have been checking his computer, which Mrs Maynard admitted to CN Manning. CN Manning stated the prospect of her husband leaving her again would have been terrible for Mrs Maynard.

95. Mr Maynard agreed he had shown Mrs Maynard the text message and agreed his wife was not happy about it. He told Mrs Maynard the woman was not coming back and he said in evidence it did not occur to him that Mrs Maynard might be worried about this. The subject had not been spoken about again.

96. It is also apparent that Mrs Maynard was the main financial contributor to the family and for many years she worked at least two jobs and at times three.

97. Mr Maynard was aware his wife had some counselling in 2013 and thought this was for work-related issues. The notes from Optum certainly confirm that was one of the issues but there were some marital issues also discussed including the period apart and the financial impact that had on her. It was pointed out to Mr Maynard that his wife also told the counsellor there were some difficulties at home in communicating with him. Mr Maynard stated he does not recall this being an issue at the time.

Requirement to give evidence

98. There is little doubt that Mrs Maynard was experiencing considerable anxiety about the evidence she was to give at the inquest into Mr Mickelo's death. She also expressed concern she was the only member of nursing staff who was being called to give evidence, even though there were other staff who had some

contact with Mr Mickelo after her last contact. This was an issue that had been consistently raised within her family; with her work colleagues; with the counsellor from Optum; and is also reflected in the letters written by Mrs Maynard in the few days prior to her death.

99. In a letter directed to the coroner dated 23 September 2015, and received after her death, she also described some of the stress she was feeling. She made reference to the meeting she had with her solicitor and barrister on 1 September 2015. A letter dated 24 September 2015 and addressed to her solicitor and barrister is in similar terms. Neither of those letters evidence an intention to take her own life at that time and in fact, she makes reference to the evidence she was about to give and also references a future plan to meet with the solicitor and barrister on 6 October 2015.The letter to her lawyers also made reference to the fact she found the comment, *they appear to be gunning for you,* distressing.

100. If it is accepted the dates recorded on the letters are when she wrote the letters, then it may be inferred that sometime shortly after 24 September, Mrs Maynard's intention changed from one where she was giving evidence to one where she was now ending her life. On 28 September she attended at the hotel and booked a room for the next day and on 29 September she attended the hotel. All her subsequent letters are dated 29 September 2015 and clearly express suicidal intention.

Meeting with solicitor and barrister

101. Mrs Maynard was known to be a loyal Queensland Nurses Union member. As was her clear right she decided to use QNU appointed lawyers to represent her. She could have also used the Metro North internal lawyers. There was some issue expressed about whether Metro North or the union lawyers would represent her and she was contacted by both. This may have been confusing for Mrs Maynard but ultimately nothing turns on it and Mrs Maynard continued to utilise the union lawyers.

102. Roberts and Kane, Solicitors were engaged by the QNU on 12 June 2015 to provide legal representation for Mrs Maynard. Evonne Smyth was given carriage of the matter. Ms Smyth was provided with a draft statement prepared by Mrs Maynard.

103. On 17 June 2015, Ms Smyth had a telephone conversation with Mrs Maynard and took further instructions regarding the statement. On 19 June 2015, Ms Smyth emailed an amended version of the statement to Mrs Maynard. A signed copy was returned by Mrs Maynard the same day.

104. On 17 July 2015, Ms Smyth was informed by Mrs Maynard she was now being called as a witness.

105. An arrangement was made for Mrs Maynard to meet with Ms Smyth and the barrister, Gavin Rebetzke engaged by the solicitors, on 1 September 2015. Prior to attending his office Ms Smyth met with Mrs Maynard at her office. Ms Smyth stated she explained the reason why they were meeting with the barrister and that he would take her through her statement and seek comments about the evidence of other witnesses including any criticism of the care she may have provided to Mr Mickelo. Ms Smyth stated Mrs Maynard was surprised she may face criticism over the care she provided and was upset she was the only nurse being called to give evidence.

106. Mrs Maynard said she blamed the hospital for her being called as a witness. Ms Smyth stated she explained that it was the coroner who had called her to give evidence and not the hospital, and that Mrs Maynard should not 'see anything in this'. Ms Smyth says that because of the comments about the hospital she asked Mrs Maynard 'why do you feel like they're gunning for you'. Ms Smyth stated that Mrs Maynard's reference to 'blame' was clearly in the context of the hospital 'blaming' her and Ms Smyth absolutely refuted any suggestion that the context of the conversation had anything to do with the coroner blaming her. Ms Smyth reiterated that she did not say to Mrs Maynard 'they appear to be gunning for you'.

107. In evidence, Ms Smyth stated that Mrs Maynard may have faced some criticism but Ms Smyth did not attribute any criticism to the hospital but potentially from other witnesses. Ms Smyth stated that she reiterated this again at the end of the conference. Ms Smyth stated that Mrs Maynard was nervous about the inquest, although many witnesses who give evidence at inquests are nervous. Ms Smyth said she had not seen any signs of confusion or anxiousness from Mrs Maynard and she did not have any concerns whatsoever that Mrs Maynard was contemplating self-harm or that she was unwell. Mrs Maynard was nervous and suspicious because she was the only nurse being called to give evidence. Ms Smyth stated that at no time was it suggested she should change her statement and in fact the statement that had been prepared, and based largely on her first statement, was not amended after the conference with counsel where it was discussed carefully over a four hour period.

108. Mr Gavin Rebetzke stated at no time does he recall the phrase 'gunning for you' being used during the conference with Mrs Maynard and Ms Smyth.

109. Mr Rebetzke stated this would not be a phrase he would use in a client conference, but more particularly he had not formed the view that anyone was 'gunning' for Mrs Maynard. During the conference he was not alerted by anything said that gave him concern for Mrs Maynard's well-being. He recalls discussing a plan of action with Mrs Maynard that included him rechecking her written statement in light of their discussion, and then having a discussion with counsel assisting to find out his or her attitude to Mrs Maynard's involvement and they would then hold a further conference before the inquest hearing commenced.

110. Mr Rebetzke stated he also deferred any explanation of a witness's right to claim self-incrimination privilege until after having had the opportunity to discuss the evidence with counsel assisting. He had formed the view, similar to Mrs Smyth, that having those discussions and explaining the concept and process involved in claiming privilege can in itself be especially challenging. Mr Rebetzke stated that in reviewing the brief, his recollection was that the experts suggested Mr Michelo was having a coronary event at the time Mrs Maynard last saw him and this raised the subject of possible clinical error on her part. However, he was not sufficiently worried Mrs Maynard may be adversely impacted, to have the self-incrimination privilege discussion.

111. It was suggested to Mr Rebetzke that having that discussion at the conference may have given Mrs Maynard some comfort and he responded by saying it was a balancing act and such discussions could have confused her.

Changing will and Enduring Power of Attorney

112. Mrs Maynard saw solicitor Victor-David Murray at Caboolture on 7 September 2015 during which time he took instructions regarding a Will and Enduring Power of Attorney. Both documents were produced that day and signed. Mr Murray stated that to the best of his recollection he had no discussions with her about her employer; had no concerns about her well-being and there was no indication or concerning behaviour from Ms Maynard in relation to suicide or self-harm.

113. The Will provided for her estate to be given to her husband and if he had died to her daughter Catherine Richards or her children. The instructions taken down by the solicitor noted there had been an estrangement with her other daughter and next to no contact with her in the last three years.

Mrs Maynard's professional reputation and the finding at the Mickelo inquest

114. It is evident from the views expressed by her colleagues that Mrs Maynard was an experienced nurse and a good worker. She took great pride in her career and any criticism of her professional attributes would have been of concern to her, although CN Evans felt she would back herself if criticised and NUM Pitt largely concurred. DON Ann Clayton stated she had never had to be critical of Mrs Maynard's professional abilities. Her colleagues all agreed she was a highly competent nurse and there was no evidence she was not coping with her work. Mrs Maynard had also expressed to her colleagues confidence in her clinical decision making. The anxiousness was less about her clinical judgment and more related to her having to give evidence on matters that were some years old and her concerns about her recall.

115. The issue at the Mickelo inquest concerning Mrs Maynard related to an examination conducted by Mrs Maynard on the night of 23 November 2012. He died on 24 November. Mr Mickelo complained of chest heaviness following a walk. This was in the context of Mr Mickelo having recently returned to Woodford after an admission to the Princess Alexandra Hospital (PAH) for cardiac treatment. His medical history included chronic ischaemic heart disease with previous heart attacks.

116. Mrs Maynard was the only nurse on duty over this shift. A medical assessment was conducted by Mrs Maynard by way of measuring blood pressure and oxygen saturations. She noted her observations in the nursing notes and recorded he had *'no cardiac issues'.* Mr Mickelo was also having difficulty sleeping and she received an order from the Visiting Medical Officer for him to be given diazepam and paracetamol.

117. The issue of there being *'no cardiac issues'* was ventilated at the inquest. In her statement, Mrs Maynard confirmed upon commencing her shift that she received a handover to the effect that:

- Mr Mickelo had been returned from the PAH on 22 November;
- He had not had chest pain for six days; and
- He was in the Safety Unit for operational reasons, not medical reasons.

118. Mrs Maynard's said in her statement that at approximately 1940 hours she was informed by the Safety Unit officer that Mr Mickelo had said he had a heavy sensation in his chest. She immediately requested access to the Safety Unit via the Supervisor. Mrs Maynard explained in her statement, consistent with other witnesses, that protocol required three correctional officers to be present if a cell

in the Safety Unit needed to be entered. In this instance, Mrs Maynard was given access to Mr Mickelo's cell within five minutes.

119. Mrs Maynard confirmed that when she saw Mr Mickelo, there were no obvious signs of distress and he was alert and orientated. She asked him if he was having any chest pains, any pain in his arm, jaw or neck or any trouble breathing. Mr Mickelo said 'no'. Mrs Maynard also asked him if he was experiencing pain similar to what led to his recent admission to the PAH. Once again, Mr Mickelo said 'no'.

120. Mrs Maynard recalled asking Mr Mickelo for more detail about why he had reported feeling heavy in his chest. He said that since walking up to the 'MCR2' earlier that day, he had experienced soreness but said there had been no change since. Mrs Maynard stated that 'MCR2' was about 400 metres from the Safety Unit, and involved pushing or pulling some 26 doors.

121. Two experts gave evidence at the inquest that Mrs Maynard was looking for the right things and asked the right questions.

122. For the remainder of her shift, Mrs Maynard continued to monitor and observe Mr Mickelo and provided details of her communications and observations to the Visiting Medical Officer. The Caboolture Hospital had a *Chest Pain Protocol* in place, which some considered should have been applied to Mr Mickelo and if it had, an effective review process should have triggered some further action.

123. In my findings in the inquest decision I made the following comments[2]:

I make no adverse comment about the actions of Nurse Maynard, as it is clear that the subsequent medical opinion has been provided with the benefit of hindsight. Nurse Maynard conducted a thorough assessment of Mr Mickelo in response to his report of chest heaviness, and this included having a conversation with him to try and gain a better understanding of the complaint. She continued to monitor him closely over the remainder of her shift.

Although Dr Walters and Dr Le Ray were critical of the term "no cardiac issues" in the notes, it is my view open to find that Nurse Maynard was not discounting the fact that Mr Mickelo had serious heart disease, but simply recording that, at that point of time, in her assessment, he was not experiencing symptoms of an acute cardiac issue. With the benefit of hindsight, the chest protocol could have been considered and a further medical review considered, although it is evident from Dr Le Ray's statement that Nurse Maynard may not have received training on its use. Dr Le Ray said the guideline for nursing assessment in this regard was very subjective and relied heavily on the judgement of the nurse at the time. Dr Le Ray noted a lack of awareness, or lack of compliance with the guideline that was in place and there has now been put in place better orientation and training over this and other issues. As well, heaviness in the chest can be non-specific as a symptom and there may be other reasons, for instance fluid overload, as suggested by Dr Garrahy.

Conclusions on the issues

124. In reaching my conclusions it should be kept in mind the *Coroners Act 2003* provides that a coroner must not include in the findings or any comments or

[2] *Inquest into the death of Garnett Allan Mickelo*, delivered 6 July 201611

recommendations, statements that a person is or maybe guilty of an offence or is or maybe civilly liable for something. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths.

125. A coroner should apply the civil standard of proof, namely the balance of probabilities but the approach referred to as the *Briginshaw*[3] sliding scale is applicable. This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.

126. With respect to the *Briginshaw* sliding scale it has been held that it does not require a tribunal of fact to treat hypotheses that are reasonably available on the evidence as precluding it from reaching the conclusion that a particular fact is more probable than not.

127. As well, when determining the significance and interpretation of the evidence, the impact of hindsight bias and affected bias must also be considered. This relates to taking into account that after an event has occurred, particularly where the outcome is serious, there is an inclination to see the event as predictable, despite there being few objective facts to support its prediction.

128. Ultimately, it is uncontroversial for me to find that Marcia Anne Kathleen Maynard took her own life by insulin overdose. There had been some significant planning for the potential of such an event occurring over at least some weeks and possibly longer, although it is likely the final decision was made only after she had written her letters of 23 and 24 September 2015 to the coroner's office and to her lawyers. Those letters on the face of it confirm she was feeling anxious and stressed about giving evidence but are not overtly expressing suicidal ideation and to the contrary indicate future plans for attending the inquest.

129. The evidence is insufficient to make a positive finding about the source of the insulin and whether it was a rapid or long acting formulation or how it was administered, other than it was not oral. Accessing it from the Woodford medical unit remains one possibility high on the level of suspicion but that is far as this can be taken. I accept that even if an audit had been done of the Woodford medical unit this would not have provided a useful forensic result that would have determined the issue.

130. Having found the actual medication used would have been useful and may have given information that could have determined a source for the insulin. This was an issue that may have assisted the family in allaying some of their concerns and suspicions.

131. I can be satisfied insulin was not located in the hotel room when cleaning staff, QAS and QPS searched. Dr Robertson's evidence is whatever formulation of medication or route of administration, there would be a window of opportunity for Mrs Maynard to dispose of the insulin down a toilet or in the garbage before experiencing adverse effects. A search of the garbage area may have revealed its presence and in hindsight should have been conducted by QPS. CCTV footage should have been obtained by QPS as was acknowledged by PCSC

[3] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361

Rogers to see if Mrs Maynard did leave the room briefly and where she disposed of the insulin, as must have been the case. Why she felt the need to dispose of the evidence is unknown. There could be a variety of reasons but it remains speculation. For my purposes I am satisfied Mrs Maynard acted on her own and was not assisted by anyone.

132. I accept the findings of WHSQ that there was no evidence of Metro North HHS and its employees acting unreasonably towards Mrs Maynard or not providing her adequate support. To the contrary, it is evident Mrs Maynard had the emotional support of her colleagues with whom she had worked for many years. There are no doubt challenges working in a prison environment but this was not a major issue raised within the workplace. Mrs Maynard had worked there for 19 years since the prison opened, as had a number of other staff. Her colleagues were aware of her being an anxious individual and when it became clear the forthcoming inquest was impacting on her she was given appropriate support by way of access to her own union lawyers; collegiate assistance from CN Evans; paid leave to seek legal advice and counselling; and access to EAS counselling. She also had the support of her colleagues who impressed me with the collegiate manner in which they had emotionally supported her over many years.

133. I do not accept that the conversation CN Hann had with Mrs Maynard concerning euthanasia should have been regarded by Metro North or Mrs Maynard's immediate superiors or colleagues as a red flag to take some further action even when linked to the welfare concerns NUM Pitt expressed. In my view, linking those pieces of information, and to then find some failure on the part of Metro North to support Mrs Maynard, draws on hindsight in a situation where an objective view of the evidence does not support such a proposition.

134. Mrs Maynard was not identified by her GP or Ms Warren, her counsellor as showing high levels of distress or show any concerning behaviour. Both of them had seen Mrs Maynard in September 2015 and they saw no evidence of suicidal ideation or self-harm.

135. As to what particular stressors were playing on Mrs Maynard and which brought her to making her decision, it is possible there were a number and these have been described as best the evidence takes it. There was obviously some past marital history that impacted on Mrs Maynard at the time of separation and no doubt subsequently, but I accept it was, by this time, somewhat historic and the evidence linking marital difficulties to Mrs Maynard's decision is weak. The estrangement with her daughter was something that had been mentioned in conversation over the years but any evidence suggesting it a stressor at this point in time is also largely absent.

136. The more recent suggestion that Mr Maynard had been in contact with a former partner has more substance to it being a stressor, although the extent of this impact remains uncertain. Given the proximity of those concerns expressed by her in combination with other stressors and the events that followed, this stressor cannot be disregarded totally.

137. It is apparent Mrs Maynard was possibly showing some physical signs of stress through her weight loss, but the explanations for the weight loss and the extent of the loss as given by Mrs Maynard to various witnesses including her GP, are so varied it is difficult to say what was the cause of her weight loss and whether it was stress related.

138. What is more certain is there was a particular stressor impacting on Mrs Maynard in the context of her having to give evidence at the inquest. This had been prominent for some period of time but had changed in intensity over time. At the beginning, and it is difficult to put a time frame on this as the evidence is not clear, her concerns was not so much related to defending her own actions or her clinical judgment, but seemed more in the context of trying to put together an accurate statement dealing with matters that had occurred in 2012, some 2.5 years previously. NUM Pitt stated that Mrs Maynard was not concerned about attending the inquest as she had done so on a prior occasion, presumably without issue. CN Evans stated the only concern raised with her was the length of time of 2.5 years between her involvement and now being asked to provide a statement. CN Izzard stated much the same.

139. CN Evans helped Mrs Maynard complete her statement, which must have been around early June 2015. CN Evans stated Mrs Maynard had a template to use that had been provided by the QNU. By the time Ms Smyth was engaged on 12 June this draft statement which was dated 8 June was made available to Ms Smyth. The subsequent statement provided by Ms Smyth appears to very largely reflect the statement provided by Mrs Maynard other than paragraphs being numbered.

140. It was not until around 17 July 2015 that Mrs Maynard told her lawyers she was now required to given evidence.

141. On 1 September 2015 Mrs Maynard had the meeting with Ms Smyth and Mr Rebetzke. Prior to the meeting Mrs Maynard and Ms Smyth had some discussions. It is uncertain if this was the first occasion that Mrs Maynard understood she may be facing some criticism of the care she provided, as Ms Smyth thought she was surprised. Mrs Maynard told Ms Smyth she was also upset she was the only nurse being called. Mrs Maynard told Ms Smyth she blamed the hospital for her being called. It was in that context Ms Smyth said *"Why do you feel like they're gunning for you".*

142. Ms Smyth was particular about this statement/question being in reference to the hospital. Ms Smyth was not challenged on this issue and was adamant it was in the form of a question and not a statement *"they're gunning for you"* or *"they appear to be gunning for you."* What is now evident this is how Mrs Maynard likely either misunderstood the discussion or has otherwise cogitated over the conversation on the back of a four hour conference and, as submitted by Mr Fleming QC, converted it into something it was not.

143. It is from here that matters must have escalated for Mrs Maynard. She changed her will on 7 September. She commenced seeing counselling services on 9 September. In counselling it was clear she was anxious about not giving inaccurate evidence. By the time of her appointment on 16 September she informed Ms Warren she had gone back to her written statement and had decided to clarify some comments and complete a further statement providing a more accurate reflection of what had occurred. Her next step was to indeed provide that amended statement as reflected in the letters addressed to the coroner on 23 September and to her lawyers on 24 September. The words *"they're gunning for you"* feature prominently thereafter in the various correspondence Mrs Maynard left. Some days later she took her own life.

Findings required by s. 45

Identity of the deceased – Marcia Anne Kathleen Maynard

How she died – Marcia died after taking an overdose of insulin with an intention to take her own life. She did so in the context of possibly a number of personal stressors, the most prominent of which was her anxiousness about having to give evidence in a mandatory Death in Custody inquest. Initially her anxiousness related to having to recall accurately events that had occurred 2.5 years prior, however by the time of her death it is probable she had formed a view she was being blamed for the death and her clinical judgment as a nurse was under scrutiny. Mrs Maynard was provided with appropriate support by her employer. Her experienced nursing colleagues were aware of her anxiety about giving evidence but held no concerns for her overall welfare. She had consulted with her GP and a counsellor and they had seen no signs of serious distress or suicidal ideation in the immediate period prior to her death. Her family were not aware of any major concerns she was experiencing, other than in relation to anxiousness about the inquest. This was despite being aware she had researched websites about euthanasia; had been losing weight; was having difficulty sleeping and had made a new Will. These indicia on their own could be considered relatively innocuous and even if linked together, would not, even with hindsight, give cause to her family to have concerns she was at serious risk. Similarly conversations with her colleagues about euthanasia, albeit unusual, should not have put them on notice to have concerns about her welfare. Although Mrs Maynard may have put in place her affairs over a period of time it may not have been until a few days prior to taking the overdose that Mrs Maynard made her final decision.

Place of death– Redcliffe Hospital QLD AUSTRALIA

Date of death– 3 October 2015

Cause of death – 1(a) Consistent with insulin overdose

Comments and recommendations

The death of a witness due to give evidence in a pending inquest is a shocking reminder of the potential counter-therapeutic impacts that not only family members may experience but also others who become involved in the coronial process, such as

witnesses. In the case of health professionals, research has found the more personal involvement an individual had with the deceased, the higher the level of stress they reported from coronial investigations and inquests – including severe anxiety, long term emotional impacts, stress leave from work and change of employment.[4]

In the case of Mrs Maynard she was receiving support in the form of counselling provided confidentially through her employer. She was also being represented by lawyers engaged by her union, who could take her through the coronial process and explain it to her. However, even with those supports in place, Mrs Maynard still experienced distress at the prospect of giving evidence. There may have been some other personal stressors impacting on Mrs Maynard but it is clear the major stressor was her concerns about giving accurate evidence at an inquest. It is illuminating that Mrs Maynard's letter to her lawyers referred to the forthcoming inquest in these terms*:* *"I am still feeling stressful at times e.g. you saying that Barrister will yell, I need to listen carefully to the question and to think and answer the question asked – I am known to have issues with this but will do as am requested – take 3 deep breaths before answering."*

It is inevitable that some measure of distress will be caused to parties, family members, witnesses and others, in the course of an investigative process, which has a statutory role to determine the facts and to explore whether there are feasible ways to avoid comparable, avoidable deaths. This is a necessary part of the adjudicative process of the coroner's inquest.

The challenge is to fulfil that statutory role but at the same minimise the potential for the process to generate counter-therapeutic consequences for parties.

At the time of Mr Mickelo's inquest there were no direct counselling services available to support those involved in the coronial process outside of families. Queensland Health Forensic and Scientific Services in 2013 did and still does have experienced counsellors as part of its Coronial Family Services, but it is fair to say with the resources it has available[5], their priority is to support next of kin, particularly through the initial period after a death is reported. That service is not able to provide ongoing counselling support to families, and certainly not for potential witnesses. The counsellors can and do provide referrals to other support agencies if they felt there was a need.

Since 2016 the Office of Industrial Relations has provided funding and facilitation for grief and trauma counselling for people affected by work related fatalities. My understanding this includes potential witnesses as well as affected families. A referral brings with it automatic approval for 10 hours of counselling. I am advised most take up of the service is by family members although it is available to others potentially impacted across the jurisdiction of work related fatalities.

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[4] Sweeney Research *'A Qualitative Research Report for the Coronial Council of Victoria' (Report, 2011)*

[5] Since 2014, the number of full-time counsellors dropped from seven to five and at times of staff leave is reduced even further.

It is of course accepted that some employers already facilitate access to counselling services, as was the case for Mrs Maynard, but that is not universally available.

It is therefore recommended that the Queensland Government facilitate and fund a program that provides counselling for families as well as witnesses or others who may be involved in and impacted by a coronial investigation and/or inquest, similar to the program currently being facilitated by the Office of Industrial Relations.

I close the inquest and offer my condolences to the family and friends of Marcia Maynard for their loss in these tragic circumstances.

John Lock
Deputy State Coroner
Brisbane
5 September 2018