



QUEENSLAND
COURTS

Office of the State Coroner

Annual report 2011–2012



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29 October 2012

The Honourable Jarrod Bleijie MP
Attorney-General and Minister for Justice
GPO Box 149
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Dear Attorney

Section 77 of the *Coroners Act 2003* requires the State Coroner to provide to the Attorney-General at the end of each financial year a report for the year on the operation of the Act. In accordance with that provision I enclose the report for the period 1 July 2011 to 30 June 2012.

As required by section 77(2) of the Act, the report contains a summary of each death in custody investigation finalised during the reporting period. The report also contains a summary of other investigations of public interest and the names of persons given access to coronial investigation documents as genuine researchers.

Guidelines issued by me under section 14 of the Act are publicly available and can be accessed at <http://www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications>. Importantly during the reporting period I issued comprehensive autopsy guidelines which aim to ensure that as far possible only deaths that warrant investigation by a coroner are brought into the system and that once that occurs the autopsy is limited to the extent necessary to enable the findings required by the Act to be made. The guidelines also aim to reinforce the importance of the family members' views in relation to internal autopsies.

I advise that in the reporting period no directions were given by me under section 14 of the Act.

Yours sincerely

Michael Barnes
State Coroner

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State Coroner's overview

This report summarises the workload and achievements of coroners and their staff throughout Queensland during 2011–12. It does that mainly through reciting the relevant numbers of the various activities undertaken and by providing sterile summaries of significant cases. That does not come close to explaining how difficult or rewarding it can be to interact with bereaved family members in distress; to try and ease their passage through the foreign labyrinth of official death responses; to attempt to salvage some good from sudden death via organ and tissue donations or preventive recommendations. Much of that work is done by junior staff with minimal training but sharp focussed managers. They, and the coroners they assist, have my gratitude and admiration. I know they are appreciated by the families they help.

The Queensland coronial system continued to deal with an ever increasing workload more efficiently and effectively throughout 2011–12. While more deaths were reported to coroners than in any other year, the number finalised was also the highest on record. A clearance rate of nearly 107% was achieved.

While this is cause for some satisfaction among the many hard working members of the coronial teams in Brisbane and around the state, I also acknowledge an undesirable increase in the number of matters taking longer to complete. Coroners are aware delays in finalising coronial matters can cause distress for family members and strive to conclude matters expeditiously. However, coroners are dependent upon other agencies completing their parts of the investigative process, and must balance the benefits of timeliness against the risks of taking shortcuts. We will continue to explore mechanisms to assist all of those who contribute to coronial investigations to eliminate any avoidable delay.

The sophistication and specialisation of coronial processes continued to develop throughout this reporting period.

In the past, local police prosecutors frequently appeared at inquests to assist the coroner. These officers had little or no training in the requirements of the jurisdiction and were sometimes “outgunned” if other participants briefed experienced inquiry counsel. Now, all coroners have access to experienced in-house counsel to manage investigations and to appear at inquests. I acknowledge the collegiality of the Director of Public Prosecutions in allowing two of his staff members to undertake secondments in these roles.

A decade ago, almost all reportable deaths resulted in a full internal autopsy being undertaken, often by a general practitioner with limited training in the procedure. This year only 57% underwent this invasive, often unnecessary and expensive procedure. All internal autopsies were conducted by pathologists. I am grateful for the support of the Chief Forensic Pathologist in the pursuit of this reform.

When the *Coroners Act 2003* was promulgated, there were only two full-time coroners appointed who could deal with about only 20% of the deaths reported around the state. All other matters continued to be dealt with by local magistrate coroners who sometimes struggled to balance the competing needs of coroners' cases with the demands of their criminal and civil law caseloads. Since then, more full-time coroners

have been appointed so that last year, 70% of the work was done by them. The recently elected government has moved quickly to implement its election promise to appoint a full time coroner in Mackay. With that appointment all cases will now be dealt with by a specialist, full-time coroner. I wish to pay tribute to the dedication of the local magistrate coroners for their long standing commitment to the role despite the difficulties it caused them. I wish also to acknowledge the perspicacity of the government for finding the necessary funds to deliver the coup de grace to the outmoded part-time coroner system.

Another innovation in the reporting period was the appointment of a coronial registrar who handled all natural causes deaths reported to the Brisbane coroners during a six month trial in 2012. So successful was the trial – the registrar and the two Brisbane coroners finalised over 2000 matters in 2011–2012 – that the position has been extended for a further 12 months. I express my gratitude to the Department and the Minister for supporting the trial and to the registrar for her herculean efforts in the position.

Domestic violence is involved in nearly 50% of all homicides. Traditionally, the only response to these horrendous incidents has been a criminal investigation. In 2012, an interdisciplinary team consisting of an experienced detective, a social science researcher and an administrative support officer undertook a trial of a prevention focussed review of all such deaths. The Domestic and Family Violence Death Review Unit (DFVDRU) was housed within the Office of the State Coroner (OSC) and reported directly to the State Coroner. One of its first tasks was to analyse all homicides that had occurred over the last five years to accurately quantify the horrifying extent of this social scourge. Its other achievements are detailed later in this report. The DFVDRU trial is currently undergoing an evaluation to determine if it will be continued. I express my gratitude to the Directors-General of the Departments of Communities, Child Safety and Disability Services and Justice and Attorney General and the Commissioner of the Queensland Police Service for their support of this trial.

In November 2011, the OSC hosted the annual conference of the Asia Pacific Coroners Society. Over 150 coroners, pathologists, police officers, lawyers and academics from overseas and around Australia attended the three day event in Noosa. It was widely regarded as the most successful conference in the 10 year history of the event. No public funds were expended on hosting the event. Its success was due largely to the tireless efforts of the Director of the OSC.

By its nature, coronial work is inter-disciplinary. Although the investigating coroner has the statutory power to direct what inquiries should be made, in practice coroners are dependent upon collaboration with and cooperation from first response officers, forensic pathologists, undertakers, toxicologists, forensic scientists, disaster victim identification officers, detectives and other specialist investigators and expert reviewers from diverse specialities. I express my sincere gratitude to the many professionals from those varied vocations who continue to so willingly offer their expertise to assist my colleagues and me. I also record my appreciation for the assistance I have continued to receive from the Deputy State Coroner and the other full-time coroners without whose support I could not adequately discharge the obligations of my office.

Office of the State Coroner – role and achievements

The Office of the State Coroner (OSC) supports the State Coroner to administer and oversee a co-ordinated coronial system in Queensland. The OSC maintains a register of reported deaths and supports Queensland's involvement in the National Coroners Information System (NCIS). The office also provides publicly accessible information to families and others about coronial matters, as well as maintaining a central point of contact for the coronial system.

The OSC provides legal, investigative and administrative support to the full time coroners and to local magistrate coroners and registry staff in 16 Magistrates Courts across the state. During 2011–12 approximately 70% of reportable deaths were reported to one of five full time coroners based in Brisbane, Cairns and Southport. The remaining 30% of deaths were reported to local magistrate coroners across Central and Western Queensland.

Recent years have seen a significant increase in demand for coronial services state-wide with deaths reported increasing by 27% from 3,514 in 2007–08 to 4,461 in 2011–12. With the increasing demand for services it has become more difficult for local coroners to fit coronial work around general court duties.

To ease the pressure on local magistrate coroners, in January 2012 the Chief Magistrate allocated an additional Brisbane magistrate to coronial work. This 'Regional Coroner' has been focussed on supporting local magistrate coroners by dealing with complex investigations and inquests.

A major initiative during 2011–12 was the trial of a coronial registrar role for an initial period of six months commencing in January 2012. The registrar acts under a delegation from the State Coroner and deals with less complex investigations such as natural causes deaths. This trial has been very successful in relieving the workload of the Brisbane based coroners, freeing them up to focus on complex and protracted investigations and inquests.

During 2011–12 the OSC assisted the State Coroner with a major review of the State Coroners guidelines issued under s14 of the Coroners Act aimed at streamlining coronial practice. On 19 March 2012 the State Coroner issued comprehensive autopsy guidelines. The new guidelines ensure that as far possible only deaths that warrant investigation by a coroner are brought into the system and encourage coroners to order external autopsies or partial internal autopsies where possible. It is hoped the guidelines will improve the efficiency of the coronial system by reducing unnecessary transportation and autopsy of bodies and associated expenses. The guidelines will also minimise distress to families caused by the coronial process.

In early 2011 the Domestic and Family Violence Death Review Unit (DFVDRU) was established within the OSC staffed by a police officer and social science researcher and research assistant. During 2011–12 the DFVDRU continued its work providing investigative assistance to the State Coroner in relation to domestic and family violence related deaths. The DFVDRU provided valuable support for the inquest into the Gold Coast triple murder suicide held in June 2012. In his findings the State Coroner acknowledged the contribution of the unit to his investigation.

In November 2011 the OSC hosted the Asia Pacific Coroners Society Annual Conference which is an international conference aimed at coroners and coronial stakeholders such as police and pathologists. The conference considered the development of the coronial system 20 years on from the Royal Commission into Aboriginal Deaths in Custody which was a major impetus for coronial reform across Australia.

At the end of June 2012 the OSC comprised 32 staff members with 24 based in Brisbane, four in the Northern Coroner’s office in Cairns and four in the Southern Coroner’s office in Southport. In addition, the DFVDRU consists of three staff members including a police officer.

Courts where deaths are reported

As at 30 June 2012, there were 19 reporting centres across the state. The Deputy State Coroner and Brisbane Coroner are responsible for investigating deaths in the Greater Brisbane area including Caboolture, and Redcliffe.

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

Deaths in the area from Thursday Island to Proserpine, north to the Papua New Guinea border and west to the Mt Isa district are reported to the Northern Coroner.

Deaths are also reported to local coroners based at the following 16 Magistrates Courts.

Table 1: Magistrates courts where deaths are reported

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

In-house counsel assisting at inquests

Coroners are assisted by counsel assisting during an inquest. Outside Brisbane, police prosecutors sometimes perform this role although this is becoming more infrequent. In 2011–12, the Queensland Police Service Police Prosecution Corps assisted a local coroner in only one of the 81 inquests held.

Each of the full time coroners is assisted by a legal officer. These legal officers are increasingly performing the role of counsel assisting and during 2011–12 assisted in 64 inquests. Having in house counsel assisting is beneficial as coroners are supported

by lawyers with specialised skills and experience in the jurisdiction and inquest costs are kept to a minimum.

Managing the provision of coronial autopsy and government undertaking services

The OSC is responsible for overseeing arrangements for the transportation of deceased persons for autopsy under the Coroners Act and burials and cremations under the *Burials Assistance Act 1965*. Funeral directors and local authorities across the state are contracted to provide these services.

Ensuring the continuous and timely supply of these services presents a number of challenges in a decentralised state such as Queensland. The cost of providing these services is high especially in regional and remote areas and it is important to ensure bodies are only transported for autopsy where necessary.

The transportation of bodies for autopsy is necessitated by the Coroners Act which requires an autopsy to be performed where a reportable death is investigated by the coroner. There is an exception for cases where the coroner decides to stop investigating because, although the death is reportable, the cause of death is known and no further investigation is required. This often occurs for hospital related deaths that have been reported directly by medical practitioners using the Form 1A process. In these cases, because no autopsy is required the family can collect the body from the hospital mortuary. The State Coroner encourages the use of the Form 1A process where appropriate.

Autopsies are performed by forensic pathologists, pathologists or government medical officers (GMOs) who are credentialed to perform autopsies. As a rule, external autopsies can be performed by GMOs but pathologists perform internal autopsies. Under the State Coroner's guidelines, the more complex autopsies (e.g. multiple deaths, suspicious deaths, child deaths, deaths during childbirth and deaths in custody) are required to be conducted by a forensic pathologist. Forensic pathologists are only located in Brisbane, the Gold Coast, Toowoomba, Nambour, Rockhampton, Townsville and Cairns. Specialist pathologists who can perform other less complex internal autopsies are located in Bundaberg and Maryborough. An ongoing challenge for the coronial system is the availability of pathologists to perform autopsies in regional areas.

One of the categories of reportable death is that a death certificate has not been issued and is not likely to be issued. If police are unable to contact a doctor and decide that a certificate is not likely to be issued the death is required to be reported to a coroner and the body transported to a mortuary. Often a death certificate is issued shortly after the body has been transported.

The State Coroner has issued guidelines aimed at reducing the number of natural causes deaths unnecessarily reported into the coronial system. First response police officers who attend the scene of an apparent natural causes death may allow families to contact a private funeral director where it appears the death is expected and is not otherwise reportable. It is not necessary for the death certificate to have been issued. The new autopsy guidelines also encourage coroners to explore all avenues for

obtaining a death certificate for apparent natural causes deaths before transporting the body for autopsy.

Communication and stakeholder relations

During 2011–12, the OSC continued to engage successfully with its major coronial partners: the Queensland Police Service (QPS) whose officers investigate on behalf of the coroners and Queensland Health, which provides forensic and counselling services for coroners. Each of these agencies is represented on the Interdepartmental Working Group, chaired by the State Coroner, which meets to review and discuss statewide policy and operational issues. The OSC relied heavily on its collaborative stakeholder relationships to convene the 2011 Asia Pacific Coroners Society Annual Conference.

The OSC convenes tri-annual meetings with funeral directors' associations, the QPS Coronial Support Unit and representatives of Queensland Health Forensic and Scientific Services (QHFSS) who provide mortuary and counselling services. These meetings provide a forum to discuss issues and develop constructive relationships aimed at improving families' experience of the coronial system.

All publications, forms, inquest findings and relevant contact details are accessible on <http://www.courts.qld.gov.au/courts/coroners-court>

Coroners and their support staff – roles and responsibilities

At the end of June 2012 there were six full time coroners: the State Coroner, Deputy State Coroner, Brisbane Coroner, Northern Coroner, Southern Coroner and Regional Coroner.

State Coroner

The State Coroner, Mr Michael Barnes, was reappointed on 1 July 2008 for a period of five years. The State Coroner is responsible for coordinating and overseeing the coronial system to ensure it is administered efficiently, and that investigations into reportable deaths are conducted appropriately.

As part of the coordinating role, the State Coroner has issued guidelines under s14 of the Coroners Act to coroners and to persons carrying out functions under the Act. The State Coroner's guidelines were issued in 2003 but are subject to ongoing review in light of developments in coronial practice.

During 2011–12 the State Coroner issued comprehensive autopsy guidelines and also guidelines regarding procedures for the release of bodies including the management of competing claims for release of the body.

The State Coroner's guidelines can be accessed at:
<http://www.courts.qld.gov.au/courts/coroners-court/fact-sheets-and-publications>

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

Only the State Coroner or Deputy State Coroner may investigate deaths in custody and deaths happening in the course of or because of police operations. The State Coroner also conducts inquests into the more complex deaths that, if dealt with by a local coroner, would take him or her out of general court work to the detriment of the local court diary.

During 2011–12, 73 matters were reported to the State Coroner. The State Coroner conducted 43 inquests and finalised 56 investigations without proceeding to inquest.

Brisbane based coroners

The Deputy State Coroner, Brisbane Coroner and Regional Coroner are all based in Brisbane. The Regional Coroner is focussed on assisting local magistrate coroners across the state. In 2011–12, 1,814 matters were reported to the Brisbane based coroners and the Registrar. The Brisbane Coroners finalised 2014 investigations including 21 following an inquest.

Northern Coroner

In 2011–12, 582 deaths were reported in the region and 621 matters were finalised including six following an inquest.

Southern Coroner

In 2011–12, 648 deaths were reported in the region and 626 matters were finalised.

Local coroners

The Coroners Act provides that every magistrate is a coroner. Other than deaths in custody, which must be investigated by either the State Coroner or Deputy State Coroner, police report deaths to the coroner nearest to the place of death. In 2011–12, 1,344 deaths (30% of all Queensland reportable deaths) were reported in the regions and 1,411 matters were finalised. Local coroners conducted 11 inquests.

Coroners' investigations

Purpose of coronial investigations

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

Autopsies

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

The Coroners Act requires coroners to specify whether the examining doctor should undertake a full internal autopsy, a partial internal autopsy focusing on the likely site

of the fatal disease or injury or an external examination only. It also recognises that many members of the community have strong objections - sometimes based on religious beliefs - to invasive procedures being performed on the bodies of their deceased loved ones. Coroners are required to consider these concerns when determining the extent of the autopsy ordered.

Although family members may not prevent an autopsy being undertaken if a coroner considers it necessary, a coroner who wishes to override a family's concerns must give the family reasons. The coroner's decision can then be judicially reviewed. No such review applications were lodged during 2011–12 and family concerns have been able to be assuaged with the assistance of coronial counsellors from QHFSS.

The Coroners Case Management System reporting functionality has improved the accuracy of data about autopsies ordered since 1 July 2009. In previous years, precise figures were not available and a sample analysis was performed. Data from 2009–10 to 2011–12 about autopsies is provided in tables two and three.

During 2011–12, there was again a reduction in the number of autopsies performed overall. This is likely to be due to the increasing use of the Form 1A process to report deaths in a medical setting. The State Coroner encourages medical practitioners and coroners to use the Form 1A process where appropriate.

There was also an increase in the proportion of external and partial or targeted internal autopsies ordered. The State Coroner has issued guidelines encouraging coroners to order external autopsies so that bodies are not transported and invasive autopsies performed unnecessarily. The increase is also attributable to the availability of a CT scanner at QHFSS that uses specialist x-ray and computer technology to produce three-dimensional images of the internal organs. This greatly improves the information available without resorting to an internal autopsy.

Table 2: Percentage of Orders for Autopsy issued by Type of Autopsy to be performed

Type of autopsy ordered	2009-10	2010–11	2011–12
External autopsy	11.64%	16.42%	20%
Partial internal autopsy	12.54%	19.83%	23%
Full internal autopsy	75.82%	63.75%	57%
Order on cremated remains	0%	0%	0%

Table 3: Number of Orders for Autopsy issued by Type of Autopsy to be performed

Type of autopsy ordered	2009-10	2010-11	2011-12
External autopsy	349	473	544
Partial internal autopsy	376	571	639
Full internal autopsy	2,274	1,836	1,559
Order on Cremated Remains	0	0	0
Total	2,999	2,880	2,742

Measuring outcomes

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

Coronial performance is measured by reference to a clearance rate (finalisations/lodgements) and a backlog indicator (the percentage of matters more than 24 months old). The national standard for coroners' courts is that no lodgements pending completion are to be more than 24 months old.

Clearance rate

There has been a significant growth in demand for coronial services since the enactment of the *Coroners Act 2003*. From 2004-05 (the first full financial year of reporting under the new legislation) to 2010-11 reported deaths increased by 40% from 3043 to 4416. Increases were particularly steep from 2007-08 to 2010-11. This is largely due to the increase in medical matters reported to coroners. In 2011-12 there was a more modest increase with deaths reported increasing by only 1% to 4,461.

The number of investigations finalised by coroners each year has also increased. In 2011-12, coroners finalised 4,771 matters (363 more than in 2010-11) achieving a clearance rate of 106.95%.

The increase in medical matters reported to the coroner since 2007-08 can be tracked by looking at the increase in Form 1As which can be used by medical practitioners to report deaths to coroners. Table 4 shows a statewide increase of 232% in the form's use since 2007-08 and a further 19% increase in 2011-12. The bulk of these matters are reported to Brisbane coroners where the state's major tertiary hospitals are located.

Table 4: Form 1As

Financial year	Form 1As Statewide	Form 1As Brisbane
2007–08	314	223
2008–09	423	295
2009–10	732	482
2010–11	880	514
2011–12	1043	571

Many matters reported to coroners are, following review of medical records and circumstances of death, found to be not reportable or reportable but not requiring autopsy and further investigation. During 2011–12 of the 4,771 deaths finalised 898 were found not to be reportable within the meaning of s8(3) of the Coroners Act.

These matters are included in the lodgement figures on the basis that the coroner performs work in considering whether a death certificate can be authorised. This may involve obtaining medical records using the powers under the Coroners Act, discussing the matter with treating clinicians and obtaining advice from doctors at the Clinical Forensic Medical Unit (CFMU), discussing treatment with family members and liaising with funeral directors. Significant time is often involved with these matters.

Backlog indicator

Coroners are aware that delays in finalising coronial matters can cause distress for family members and strive to conclude matters expeditiously. However, coroners are dependent upon other agencies completing their parts of the investigative process, and must balance the benefits of timeliness against the risks of taking shortcuts.

As at 30 June 2012, 328 or 14% of pending matters were more than 24 months old up from 320 or 12% per cent in 2010–11. This figure exceeds the national benchmarking target of 0% largely due to the increasing number of lodgements and the more rigorous investigation required under the Coroners Act. The finalisation of a coronial investigation also depends on the finalisation of autopsy and toxicology reports and the outcome of police or other expert investigations. In addition, the coronial investigation is postponed pending the outcome of any criminal proceedings.

As at the end of the reporting period, of the 328 matters that were older than 24 months, 41% (135 matters) were waiting for police or other expert investigations or the outcome of criminal proceedings. Excluding these cases, 193 matters i.e. 8% of pending matters are older than 24 months.

Appendix 1 details the lodgements and finalisations during the reporting period.

Coronial investigators – a multi-agency approach

The QPS Coronial Support Unit coordinates the management of coronial processes on a statewide basis within the QPS. Three police officers located within the OSC in Brisbane provide direct support to the Brisbane based coroners as well as assisting regional coroners as required. Officers located at the QHFSS facility at Coopers

Plains attend autopsies and assist in the identification of deceased persons and preparation of documents for autopsy. This unit also liaises with coroners, investigators, forensic pathologists, mortuary staff and counsellors. The Coronial Support Unit officers bring a wealth of experience and knowledge and are actively involved in reviewing policies and procedures as part of a continuous improvement approach.

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

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

The full time coroners have been greatly assisted by the clinical expertise provided by the Clinical Forensic Medicine Unit (CFMU). GMOs are available on an "as needed" basis to assist the coroner's preliminary assessment of a reported death, particularly those that occur in clinical settings.

GMOs from CFMU review the report of the death and the deceased person's medical records, and then alert the coroner to any clinical issues requiring further follow up or independent clinical expert opinion. GMOs are available to assist regional coroners on request.

The QPS Coronial Support Unit, the CFMU, the Coronial Counselling Service and QHFSS are integral parts of the coronial process. The dedication, commitment and professionalism of these agencies are greatly appreciated by the OSC, as well as the families of the deceased.

Monitoring responses to coronial recommendations

When a matter proceeds to inquest, a coroner may make recommendations aimed at preventing similar deaths in the future. This is one of the most important objectives of a modern coronial system. Many of the recommendations made by coroners during 2011–12 are highlighted in the Inquests section in this report.

In 2006, the Ombudsman reported that the ability of the coronial system to prevent deaths would be improved if public sector agencies were required to report on responses to coronial recommendations. In 2008, the Queensland Government introduced an administrative process for monitoring responses to recommendations involving government agencies reporting to the Attorney-General about implementation of recommendations and compilation of an annual report.

The first report considering recommendations made during the 2008 calendar year was released in August 2009. The second report in relation to 2009 recommendations was published in May 2011. The most recent report in relation to 2010 recommendations was published in December 2011.

Publishing responses to coronial recommendations enhances the death prevention role of the coronial jurisdiction by increasing the likelihood that public sector agencies will give them due consideration. It also provides an important feedback mechanism to coroners.

The report can be accessed at the Department of Justice and Attorney-General website: <http://www.justice.qld.gov.au/corporate/general-publications>

Genuine researchers

The coronial system is an important source of information for researchers who in turn provide an invaluable resource for coroners in their preventative role. Section 53 of the Coroners Act facilitates access to coronial documents by researchers.

Generally, researchers may only access coronial documents once the investigation is finalised. However, the State Coroner may give access to documents on open files if the State Coroner considers it appropriate having regard to the importance of the research and the public interest in allowing access before the investigation has finished.

The Coroners Act requires the names of persons given access to documents as genuine researchers to be noted in the annual report. The following genuine researchers were approved under s53 of the Coroners Act during the reporting period:

- Mark Stephenson and Glen Buchanan - QHFSS
- Julian Farrell - Research Officer, Agri-Science Queensland
- Associate Professor Charles Naylor - Chief Forensic Pathologist, QHFSS
- Professor Belinda Carpenter - Principal Researcher, at the School of Justice, Faculty of Law, Queensland University of Technology
- Associate Professor Gordon Tait - Principal Researcher, Faculty of Education, Cultural and Language Studies in Education, Queensland University of Technology
- Adjunct Professor Peter Ellis - Pathologist, QHFSS
- Associate Professor Alexander Stewart - Griffith University
- Professor Craig Valli - Edith Cowan University
- Keith Loft - Senior Constable, QPS, Disaster Victim Identification (DVI) Squad
- John Drayton - Coronial Counsellor, QHFSS

These new researchers bring the number of researchers authorised to access coronial documents to 64. The full list of these researchers can be found at Appendix 2.

Research projects

In addition to assisting external researchers by allowing controlled access to coronial documents, the OSC has also been involved in research into coronial issues.

Trends and predictors of suicide in Australian children

This project is being led by the Australian Institute of Suicide Research and Prevention. The State Coroner and senior officers from Queensland Health, Mental

Health Branch, the Department of Education, Training and the Arts and the Queensland Commission for Children and Young People and Child Guardian are collaborating with the lead investigator.

This project aims to gain a better understanding of factors surrounding child suicide in Australia, with a focus on Queensland, by using aggregated and individual level data to evaluate the magnitude of the problem and develop recommendations for suicide prevention among children under 15 years. The project will include an international perspective analysing aggregated time-trends. An additional component of the project focuses on the impact of the child's suicide on the psychosocial functioning of parent survivors.

The project is funded by the Australian Research Council for three years to the extent of \$78,500.

Managing family objection to autopsy in the Australian coronial system

The Coroners Act enables families to object to invasive autopsies being performed on their relatives. However a review of autopsy orders indicates the rate at which coroners now accede to family objections varies significantly by location, experience and motivation for objection, to the extent that a 14% external-only autopsy rate in urban South East Queensland can exist alongside a 1% rate in Townsville. The evidence suggests the influence of police, counsellors and pathologists in the coroner's decision-making is, at best unclear, and at worst, contradictory and inappropriate. By the use of structured, in-depth interviews with all the main stakeholders in the coronial process, this research will investigate what motivates coronial personnel to take family objections to internal autopsy into account, or conversely, to ignore them.

Researchers from the School of Justice Studies, Queensland University of Technology are collaborating with the State Coroner, the Chief Forensic Pathologist, the Senior Counsellor at QHFSS and a detective inspector from the QPS.

The project aims to establish an integrated and consistent approach to the role of family objection in coronial systems that can be applied Australia wide. This will:

- increase consistency of the death investigation process;
- enhance communication between stakeholders and the community;
- reduce unnecessary use of personnel and other resources and significantly reduce costs; and
- create a coronial practice e-resource for dealing with family objection to be used by practitioners as both a training resource and a resource to ensure consistency of approach.

The Australian Research Council has granted \$180,000 over three years to investigate these issues.

Influences on farmer suicide in Queensland and New South Wales

Researchers from the Australian Institute of Suicide Research and Prevention and the University of Newcastle will lead an investigation of the prevalence and instigators of

suicide among farmers in Queensland and New South Wales. The industry partners are the State Coroner, Queensland Health, the Department of Communities, the Centre for Rural and Remote Mental Health Queensland, the New South Wales Centre for Rural and Remote Mental Health, the Hunter New England Local Health Network, and the New England Division of General Practice.

The aims of this study are to:

- determine the prevalence of suicide within farming related occupations of Queensland and New South Wales;
- determine the risk factors (as well as cultural and attitudinal factors regarding stigma, end of life issues, and help seeking) associated with suicide in farming related occupations of Queensland and New South Wales;
- determine the developmental process, including the sequence of events and risk factors associated with suicide in farming related occupations over the life span;
- use empirically based research findings to inform existing practices in suicide prevention for farming communities.

The major outcome associated with this project will be increased understanding about suicide within the farming occupation. Of particular importance, will be the knowledge gained from the methodological approach to data collection (i.e. life-chart approach) which will illustrate the concatenation of events experienced by farmers over the life span and prior to death, as well as relationships between these events and suicide.

The Australian Research Council has approved funding to the extent of \$145,000 over three years.

Inquests

This section contains a summary of coronial investigations into all deaths in custody, as required by s77(2)(b) of the Act, and other inquests of note conducted during the reporting period. The complete inquest findings are posted on the Queensland Courts website at: <http://www.courts.qld.gov.au/courts/coroners-court/findings>

Deaths in custody

The State Coroner conducted two inquests during the reporting period into deaths that occurred in the course of a person being detained and/or restrained by police or custodial officers or in a siege situation:

Carl Antony Grillo

Carl Antony Grillo was a 42 year old man who died at the Royal Brisbane and Women's Hospital on 16 September 2009, two days after he became unresponsive while being restrained by police after a violent struggle in Spring Hill. Mr Grillo had tried to evade police who wished to question and search him on suspicion of possession of illicit drugs. One of the officers caught up to Mr Grillo and wrestled him to the ground. This officer then applied a lateral vascular neck restraint to restrain Mr Grillo. In order to manoeuvre Mr Grillo's arm from underneath him, the officer delivered three 'hammer fist' blows to the back of Mr Grillo's head which enabled the officer to fully restrain and handcuff Mr Grillo. After completing a search of Mr

Grillo, police noticed that Mr Grillo's eyes had closed and he had become unresponsive. An ambulance was called but CPR was not commenced. By the time the ambulance arrived, Mr Grillo had stopped breathing and he had no detectable pulse. Although Mr Grillo was able to be revived by the paramedics and transported to hospital, he suffered an irreversible hypoxic brain injury and died in hospital two days later.

Officers from the QPS Ethical Standards Command (ESC) attended the scene within minutes of Mr Grillo being transported to hospital. The two officers involved in the incident had already been separated and the scene secured by the District Duty Officer. The ESC investigation involved video-recorded walk-through interviews with all four officers present at the scene before the paramedics' arrival and interviews with witnesses who saw relevant parts of the incident; forensic examination of the scene, specialist toxicological opinion about the significance of the level of amphetamines detected in Mr Gillo's hospital admission blood samples and review of relevant aspects of QPS training and policy. All four officers present at the incident provided urine samples for drug and alcohol testing. The OSC supplemented the ESC investigation with additional medical specialist reports. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

Autopsy revealed coronary atherosclerosis, cardiomyopathy, indicators of asphyxia, evidence of the application of moderate force to the lateral aspects of the neck and amphetamine toxicity.

The State Coroner found that:

- Mr Grillo died from the combined effects of moderately severe physical exertion, a lateral vascular neck restraint and restraint in a prone position and a high level of amphetamine toxicity against a background of myocardial fibrosis and coronary artery atheroma;
- the officers were entitled to pursue Mr Grillo and the level and type of force used to detain him was reasonably necessary and consistent with the officer's training; and
- although Mr Grillo was not placed in the recovery position as soon as would have been highly desirable and consistent with QPS training, it could not be established that this made any difference to the outcome.

The State Coroner noted that QPS is currently reviewing the use of lateral vascular neck restraint.

Anthony John Parsons

Anthony John Parsons was a 35 year-old man who died at Moranbah on 25 January 2010 after shooting himself in the head. In the hours prior to his death, Mr Parsons had assaulted his wife and damaged property within the residence. Mrs Parsons fled the residence with their children and phoned the police. A siege situation developed once police attended the residence. Over the following eight hours, Mr Parsons remained within a cordon put in place by specialist police. On moving beyond that cordon, Mr Parsons was challenged by a Special Emergency Response Team (SERT) officer. Mr Parsons then quickly, and consistent with threats made during the incident to friends, media and police, shot himself in the head. Despite resuscitation efforts, Mr Parsons was unable to be revived.

Mr Parson's death was investigated by the QPS ESC. The investigation was informed by statements from the SERT officers, QPS and ambulance officers, medical personnel, family members, civilian witnesses and the media. The weapons of the SERT officer who challenged Mr Parson shortly before his death were seized and all members of the SERT team were breath tested. Tapes of Mrs Parsons' 000 call and telephone calls made between Mr Parsons and police negotiators were obtained, DNA swabs taken and ballistics conducted on the weapons allegedly used by Mr Parsons during the siege. All negotiator logs, police notebooks and regulatory documents related to the siege were seized. The ECS investigation obtained information about Mr Parsons' medical and psychiatric history. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

Autopsy revealed the cause of death to be a gunshot wound to the head. Toxicology detected no alcohol or other drugs.

The State Coroner found that:

- Mr Parsons had a history of mental health illness and had previously attempted suicide more than once. His last contact with a mental health clinician was on 29 October 2008 and he missed all subsequent appointments – the State Coroner was satisfied there was no basis to review the mental health care provision to Mr Parsons as there was no evidence he sought assistance after October 2008;
- the management of the siege and negotiation with Mr Parsons was done satisfactorily and in accordance with relevant policies in place at the time – there was no evidence that those policies or the practices adopted in compliance with them are inadequate or inappropriate;
- QPS officers acted professionally and appropriately for the majority of the siege – deviations from the standards required were promptly identified and rectified by the attending District Duty Officer;
- the tactics engaged by the police negotiator were adequately researched and thought through - that Mr Parsons chose to take his own life upon being challenged by the SERT officer was not a reflection of the adequacy or appropriateness of the approach adopted in this case;
- police readily and appropriately gained access to information about Mr Parsons' previous contact with the Moranbah Hospital mental health team; and
- all of the officers and other agencies involved in responding to the incident discharged their responsibilities effectively.

The State Coroner noted that SERT teams were based in Brisbane and Cairns but did not consider he had sufficient evidence on which to base a recommendation about the placement of a SERT team in Central Queensland.

During the reporting period, the State Coroner conducted one inquest into a watch house death:

Anthony Mark Perry

Anthony Perry was a 41 year-old man who died at the Rockhampton watch house on 23 March 2010, about five hours after he had been taken into police custody. At the

time of his arrest, officers were told Mr Perry had been drinking heavily throughout the day. They were not told he had ingested a morphine-based painkiller. The watch house sergeant considered no medical review of Mr Perry's fitness in the watch house was necessary as his symptoms were consistent with severe intoxication only. He was subject to a "pat down" search over the outside of his clothes. He was able to walk unaided, converse at a reasonable level and comply with directions. He was noted to be snoring and breathing when checked at 12:20am and 1:21am. When checked after 2:00am, he was found not to be breathing and could not be revived.

Mr Perry's death was investigated by the QPS ESC. The scene was secured by the Regional Duty Officer pending the arrival of ESC investigators at 3:40am. The cells in which Mr Perry had been accommodated were forensically examined. A foreign substance and small spots of blood were found in the toilet of one of those cells. All watch house officers who had been in contact with Mr Perry were interviewed, as were his family, friends and associates. The investigators seized CCTV footage, logbooks, medical records and other documentation relating to Mr Perry. Mr Perry's house and his mother's house were declared crime scenes and searched. The OSC supplemented the ESC investigation with a report from the Queensland Health Clinical Forensic Medicine Unit about indicators for medical review and an interpretation of the toxicology results. The State Coroner was satisfied the investigation was comprehensive and independent.

Autopsy revealed the cause of death as respiratory depression caused by morphine and alcohol poisoning.

The State Coroner found that:

- the arrest of Mr Perry was conducted appropriately and professionally as was his initial search and transport to the Rockhampton watch house;
- the watch house staff acted reasonably when they assumed his intoxication was due to the ingestion of alcohol alone and decided not to have him reviewed by a doctor or paramedic – the State Coroner accepted expert evidence that had a doctor been called to review Mr Perry, it is likely the outcome would not have been any different; and
- it was possible Mr Perry ingested a slow-release morphine tablet shortly prior to his arrest or was about to smuggle one or more tablets into the watch house. He could have ingested them while detained in the cell where the CCTV recording facility was not working; and
- Mr Perry was monitored adequately and once discovered not to be breathing, medical attention was prompt.

The State Coroner recommended that:

- amendments be made to the health questionnaire that watch house officers administer to prisoners to assist the determination of whether a prisoner who appears intoxicated may also be affected by other drugs;
- QPS give priority to replacing the CCTV equipment in the Rockhampton watch house; and
- officers within the Central Region be reminded of the importance of compliance with QPS policies in relation to death notification.

During the reporting period, the State Coroner and the Deputy State Coroner conducted four inquests into prisoner deaths by suicide:

Death of a prisoner

A 34 year old male prisoner was found dead in his cell at the Arthur Gorrie Correctional Centre (AGCC) with a plastic bag secured over his head. He had spent almost six months in pre-trial custody and had a sporadic psychiatric history and a history of previous suicide attempts.

The prisoner's death was investigated concurrently by the QPS Corrective Services Investigation Unit (CSIU) and the Office of the Chief Inspector, Queensland Corrective Services. Corrections officers secured the unit in which the prisoner was housed. The cell was examined forensically and letters apparently written by the prisoner were taken from the cell for further analysis. The CSIU investigation obtained all of the prisoner's prison and medical records, statements from corrections officers, prison mental health service staff and other prison staff involved in the risk assessment process and recordings of the prisoner's recent phone calls. CSIU investigators spoke to other prisoners housed in the same unit as the prisoner. The OSC supplemented these investigations with a statement from the Director of the Prison Mental Health Service and additional material from GEO Australia Ltd, the operator of AGCC. A psychiatric report commissioned by the prisoner's then criminal defence solicitors was also provided to the inquest. An external examination and toxicology confirmed the cause of death as consistent with plastic bag asphyxia. The State Coroner was satisfied that the prisoner's death was investigated thoroughly and professionally.

The State Coroner found that:

- the prisoner intentionally took his own life after despairing at the thought of serving a lengthy prison sentence and the prospect of his relationship with his wife ending and having limited contact with his children;
- prison staff could not have been expected to have realised the prisoner was at risk of suicide;
- although there was an unacceptable delay in the prisoner being seen by a psychiatrist after he arrived at AGCC, the quality of care given to him by the Prison Mental Health Service was of a high standard;
- there was no evidence that the prisoner's cessation of olanzapine 14 days prior to his death contributed to the death;
- appropriate action was taken in relation to the prisoner's immediate and on-going mental health needs once he stopped taking the olanzapine and there was no justification to alert custodial staff to this;
- it took almost 10 minutes for the plastic bag to be removed – this was in part the result of AGCC policy to prohibit cells being opened at night without shift supervisor authority and the presence of three corrections officers and in part the shift supervisor's failure to remove the bag after he entered the cell presumably because he concluded the prisoner was already dead. The State Coroner noted current AGCC policies now require an apparent death to be treated as a medical emergency requiring the commencement of resuscitation efforts unless and until health staff advise otherwise; and

- the AGCC prison manager did not give sufficient priority to notifying the prisoner's family of his death.

The State Coroner recommended that Queensland Corrective Services media policies be amended to require that before a media release is issued in relation to the death of a prisoner, the responsible officer must establish whether the deceased prisoner's contact person and next of kin have been advised of the death and if not, for no identifying information to be included in a media release until all reasonable efforts have been made to notify the family.

The State Coroner noted that the prisoner was able to contact his wife who was the aggrieved named in a domestic violence order prohibiting him from having any contact with her. Consequently, the State Coroner recommended that Queensland Corrective Services review its policies to require all correctional centres to have in place procedures to ensure a prisoner who is the respondent to a domestic violence order has contact with the aggrieved person named in the order only after a fully informed and considered decision to allow contact is made and the contact does not contravene the terms of the domestic violence order.

The State Coroner noted evidence from the Director of the Prison Mental Health Service about the clinical desirability of an evening medication round for patients of the service but did not make any recommendation about this issue.

Tracey Lee Inglis

Tracey Inglis was a 37 year old prisoner who was found unresponsive in a pool of blood on the floor of her cell at the Townsville Women's Correctional Centre (TWCC) on 18 September 2010. She was unable to be revived.

Ms Inglis' death was investigated concurrently by the QPS CSIU and the Office of the Chief Inspector, Queensland Corrective Services (QCS). Corrections officers secured the scene and commenced a running log prior to the CSIU investigators' arrival. The cell and surrounds were forensically examined. The CSIU investigators obtained records, took statements from relevant prison staff; conducted interviews with inmates accommodated in the same unit as Ms Inglis; seized two medical request forms found in the cell; viewed CCTV footage; obtained recordings of all telephone calls made and received by Ms Inglis and obtained Ms Inglis' medical records. The QCS investigation culminated in a report containing recommendations, some of which were referred to the Queensland Health Offender Health Services, which in turn conducted a root cause analysis of the health treatment provided to Ms Inglis. The OSC supplemented these investigations with further statements and medical reports. The State Coroner was satisfied that the investigation was adequate in circumstances where the more complex medical aspects of the investigation were pursued by the OSC.

Autopsy revealed the cause of death as blood loss from incised wounds to the wrist and right elbow.

The State Coroner found:

- Ms Inglis suffered from chronic pain as a result of injuries sustained in a motor vehicle accident in 2007. This was a significant factor underlying her

mental health issues for which she had previously sought voluntary in-patient mental health treatment and contact with the Prison Mental Health Service during a prior period of incarceration at TWCC;

- the initial risk and needs assessment performed by a junior counsellor on reception at TWCC on 19 August 2010 was inadequate as it did not access all relevant information held by QCS regarding Ms Inglis' injuries, chronic pain and fluctuating doses of analgesia;
- the assessment of Ms Inglis' need for analgesia was mismanaged and consequently her pain management was inadequate for the duration of her last period of incarceration; and
- Ms Inglis intentionally took her own life – insufficient analgesia and the resulting sleep deprivation were probably factors that contributed to her decision to do so.

The State Coroner was satisfied that appropriate steps had been taken to implement recommendations arising from both the QCS investigation and the Offender Health Services root cause analysis. These recommendations focussed on amended QCS guidelines for the Initial Risk and Assessment Process to require further inquiry into historical mental health issues; automatic referral of prisoners convicted of certain serious offences to the Prison Mental Health Service and progress towards implementation of the information sharing memorandum of understanding between QCS and Queensland Health.

The State Coroner recommended that:

- QCS consider mandating culturally and gender appropriate Initial Risk and Assessment policies which prompt the prisoner to identify with a relevant ethnic group and enable the prisoner to elect to have a person of their ethnic group or gender present during the assessment;
- Queensland Health urgently develop guidelines to assist visiting medical officers to (a) assess newly received prisoners' level and source of pain and appropriate pain medications and to verify existing prescriptions in a timely manner and (b) make appropriate judgements about the assessment and treatment of chronic pain; and
- QCS require all prison operators to make information about the role and function of the Health Quality and Complaints Commission readily available to prisoners and allow free telephone calls to this agency.

Robert Gary Mitchell

Robert Gary Mitchell was a 41 year old man who was found hanging in his cell at the Arthur Gorrie Correctional Centre on 9 July 2008. Despite resuscitation efforts, Mr Mitchell was unable to be revived.

Mr Mitchell's death was investigated concurrently by the QPS CSIU and the Office of the Chief Inspector, QCS. The scene was secured and forensically examined. The CSIU investigators obtained statements from relevant corrections officers; interviewed all of the prisoners housed in the same accommodation unit and seized records relating to Mr Mitchell and movement in and around the prison on the day and night preceding his death. Investigators located lengthy notes made by Mr Mitchell which indicated mental anguish and a plan to end his life. The QCS investigation culminated in a report which was provided to the inquest. The OSC

undertook further investigation in relation to injuries noted at autopsy. The State Coroner was satisfied with the investigation and commended the QCS investigation.

Autopsy revealed injuries consistent with hanging, as well as clusters of superficial linear marks on Mr Mitchell's wrist considered to be consistent with self-harm.

The State Coroner found that the Initial Risk and Assessment gave no indication of any risk of self-harm and there was no reason for Mr Mitchell to have been categorised as an "at risk" prisoner and placed on observation and/or housed elsewhere. Mr Mitchell exhibited no other overt signs of an intention to self-harm prior to his death.

The State Coroner noted that the prison operator has taken steps to address matters including problems with the default mechanism of the electronic health questionnaire and observation checklist and previous policy requiring the presence of a manager and four officers before a cell can be opened at night.

The State Coroner yet again commented on the need for all prisoners to be kept in cells that do not have hanging points. The State Coroner accepted that QCS is committed to a policy of replacing unsafe cells with suicide resistant facilities as funding permits but noted that a further five prisoners had hung themselves in Queensland prisons since Mr Mitchell's death.

Stuart Cecil Ford

Stuart Cecil Ford was a 57 year old male prisoner who was found unresponsive in his cell at the Wolston Correctional Centre with a plastic bag over his head on 16 January 2010. Despite emergency resuscitation efforts, Mr Ford was unable to be revived. The day before his death, Mr Ford was informed of a decision to breach him and suspend his employment in the prison laundry due to complaints about his work and his tampering with laundry equipment, a decision which upset him.

Mr Ford's death was investigated concurrently by the QPS CSIU and the Office of the Chief Inspector, QCS. The scene was secured immediately after Mr Ford was pronounced dead and subsequently forensically examined. This process located notes written by Mr Ford expressing dissatisfaction with aspects of his life as a serving prisoner, his loss of employment, alleged corruption within the prison administration and failure to support him with counselling and other services. The CSIU investigation obtained statements from relevant corrections officers, prison medical personnel and Mr Ford's treating psychiatrist; medical and corrections records relating to Mr Ford and interviews with prisoners housed in the same unit. The QCS investigation culminated in a report which was provided to the inquest. The OSC obtained an additional statement from QCS regarding the implementation status of the recommendations made by the Chief Inspector's investigation. The State Coroner was satisfied that the investigation was thorough and conducted professionally.

Autopsy revealed the cause of death to be consistent with plastic bag asphyxia. During the examination, a letter addressed to the State Coroner alleging negligence, corruption and bullying was located between two pairs of underwear worn by Mr Ford.

The State Coroner found:

- nothing to support the allegations and complaints detailed in Mr Ford's notes;
- the prison appropriately identified Mr Ford as prisoner with an elevated base line risk of self harm and largely implemented the reviewing psychiatrist's recommendations for managing Mr Ford's mental health condition;
- Mr Ford was appropriately medicated and was given an unusually high level of continuity of care with nearly daily access to a counsellor; and
- Mr Ford's extreme reaction to his circumstances could not have been foreseen.

The State Coroner noted that since Mr Ford's death, the prison had taken steps to significantly restrict the availability of plastic bags within the secure unit. The State Coroner did not make any recommendations.

The remaining nine deaths in custody inquests examined the adequacy of the medical and emergency treatment provided to prisoners in a custodial setting:

John Clive Anderson

Mr Anderson was a 36 year old prisoner detained at the Arthur Gorrie Correctional Centre who died in the intensive care unit at the Princess Alexandra Hospital on 7 June 2009. From February 2009, Mr Anderson had presented regularly to the prison medical centre with symptoms of fever, sore throat and cough. The visiting medical officer first documented a diagnosis of subacute infective endocarditis on 25 March 2009 but did not refer Mr Anderson for specialist review via the Secure Unit at the Princess Alexandra Hospital until 12 May 2009. The referral was reviewed by the hospital's General Medicine Unit and an outpatient appointment was scheduled for 10 June 2009, but this information was not passed back to the prison medical centre or the visiting medical officer.

In the meantime, from 22 May onwards, Mr Anderson remained unwell with increasing shortness of breath and swollen lower limbs. He was reviewed by medical and nursing personnel and diagnosed with a possible lower respiratory tract infection and prescribed oral antibiotics, oxygen therapy and corticosteroids. His condition deteriorated further on 28 May and he was continued on his course of antibiotics. Mr Anderson refused to stay in the medical centre, preferring to return to his cell. On 30 May, Mr Anderson was diagnosed with pneumonia and transferred to the Princess Alexandra Hospital by ambulance. On examination in the emergency department, Mr Anderson was found to have pulmonary oedema and signs of cardiac failure. A provisional diagnosis of infective endocarditis was confirmed following blood cultures, ECG and review by the cardiology team. He was admitted under the cardiology team for antibiotic and other medical treatment ahead of an aortic valve replacement performed on 4 June 2009. The surgery was uneventful. Mr Anderson was initially stable but deteriorated with the development of multi-organ failure. He died on 7 June 2009.

Autopsy confirmed the medical and surgical intervention. The pathologist considered Mr Anderson could not recover from the initial heart failure secondary to infective endocarditis.

Mr Anderson's death was investigated by the QPS CSIU. The OSC supplemented the findings of the CSIU investigation with an opinion from the Queensland Health

Clinical and Forensic Medicine Unit about the adequacy and appropriateness of the medical treatment provided to Mr Anderson.

The Deputy State Coroner accepted expert opinion that infective endocarditis is a very rare condition (which the visiting medical officer was astute to have suspected as at 25 March 2009), but once it is being considered as a possible diagnosis it is incumbent on the treating doctor to promptly make and pursue a referral for specialist review to confirm or exclude the diagnosis. The Deputy State Coroner declined to refer the visiting medical officer to the Australian Health Practitioners Regulatory Agency for disciplinary action for failure to expedite the specialist referral.

The Deputy State Coroner noted evidence that the prison population is at elevated risk of developing infective endocarditis and commented on the importance of clinicians working in correctional services to be alert to the symptoms of this condition and to seek prompt specialist review once it is identified as a possible diagnosis. The Deputy State Coroner also commented on the desirability of specialists who review a prisoner referral for possible infective endocarditis to discuss the referral with the referring prison doctor. The Deputy State Coroner accepted there are security considerations which delay communication to the referring doctor and prisoner about the scheduling of hospital appointments until the day before, and commented on the need for the referring doctor to proactively monitor the progress of the referral, particularly when the possible diagnosis is a serious health condition.

Kerry-Ann Long

Kerry-Ann Long was a 42 year old prisoner serving a short custodial sentence at the Brisbane Women's Correctional Centre, who died in the intensive care unit at the Princess Alexandra Hospital on 4 February 2009. On 3 February 2009, Ms Long was seen to be distressed after a phone call in which she was told that her former partner had taken custody of one of her children, and then collapsed in the exercise yard shortly afterwards. Corrections staff immediately called a code blue and commenced resuscitation pending the paramedics' arrival. Ms Long was transported to the Princess Alexandra Hospital emergency department where a CT scan revealed an extensive subarachnoid haemorrhage and CT angiogram revealed a large anterior communicating aneurysm. Neurosurgical review determined that Ms Long had suffered irreversible brain damage. After discussion with her family, active treatment was withdrawn and Ms Long died on 4 February 2009.

Ms Long's death was investigated by the QPS CSIU. The investigation obtained Ms Long's correctional records and medical records. The investigation was informed by statements from custodial officers, prison nursing staff and prisoners who were present and responded when Ms Long collapsed, most of the prisoners accommodated in the same unit as Ms Long and Ms Long's family members. The investigating officer seized a recording of Ms Long's phone call and CCTV footage of the area where she collapsed. The Deputy State Coroner was satisfied the investigation was timely, thorough and professional. The OSC supplemented the findings of the CSIU investigation with an opinion from the Queensland Health Clinical and Forensic Medicine Unit about the adequacy and appropriateness of the emergency and medical treatment provided to Ms Long.

Autopsy confirmed the clinical findings of extensive subarachnoid haemorrhage resulting from a ruptured saccular aneurysm. The Deputy State Coroner accepted the pathologist's advice that this type of aneurysm is known to rupture spontaneously without any trauma.

The Deputy State Coroner found that Ms Long's health and medical history was adequately assessed both when she was taken into police custody and then on reception at Brisbane Women's Correctional Centre. She was given appropriate access to her regular medication while in custody and at no time prior to her collapse had she presented with any symptoms indicative of a developing intracranial bleed. The Deputy State Coroner found that Ms Long died from natural causes and the response to her sudden collapse was timely and appropriate. The Deputy State Coroner declined the application of Sisters Inside for the inquest to examine the issue of psycho-social support available to Ms Long in relation to the care of her child while she was incarcerated.

Matthew Maurice Tiers

Matthew Maurice Tiers was a 53 year-old indigenous man who died in the intensive care unit at the Rockhampton Hospital on 14 May 2011. At the time of his death, Mr Tiers was in custody at the Capricornia Correctional Centre for breaching conditions of his parole. His general health was poor due to his long term chronic alcohol abuse and resistance to medical treatment. He had been incarcerated at Capricornia Correctional Centre since 6 May 2011 and placed on an alcohol withdrawal regime. He was noted to be incontinent on 8 and 9 May and was reviewed in the medical unit on 10 May. He was transferred to hospital that day. A provisional diagnosis of pneumonia was made and intensive treatment commenced, but he developed worsening septic shock. After discussion with his family, treatment was withdrawn and he died on 14 May 2011.

Mr Tiers' death was investigated by the QPS CSIU. The investigation obtained Mr Tiers' correctional records and his most recent hospital records. The investigation was informed by statements from all QPS personnel, Queensland Ambulance Service officers, relevant custodial officers and Queensland Health staff at Capricornia Correctional Centre and interviews with fellow prisoners who Mr Tiers had been housed with at Capricornia Correctional Centre. An external examination and reviewed of medical records confirmed the clinical findings of multiple organ failure caused by sepsis. The OSC supplemented the investigation with a report from the Queensland Health Clinical Forensic Medicine Unit about the adequacy of the health care provided to Mr Tiers. The State Coroner was satisfied the matter was investigated thoroughly and professionally.

The State Coroner found that:

- the decision to hold Mr Tiers in the Rockhampton watch house on the evening of 6 May 2011 without first obtaining a medical review of his condition was not unreasonable;
- it would have been preferable for Mr Tiers to have been reviewed by a doctor on reception at the Capricornia Correctional Centre;
- the alcohol withdrawal management plan did not incorporate daily review by a doctor or use of a standardised alcohol withdrawal scale to direct the administration of medication;

- earlier medical review may have identified the infection and facilitated the administration of antibiotics sooner and may have improved Mr Tiers' chances of survival; and
- despite shortcomings in the health care provided while Mr Tiers was in prison, the health care provided was adequate.

The State Coroner recommended that Queensland Health Offender Health Services review its alcohol withdrawal policies to ensure they are the most appropriate for dealing this prevalent problem among the prison population.

Sheldon Currie

Sheldon Currie was an 18 year old indigenous prisoner who died at hospital on 20 February 2010 from the effects of severe liver failure. He had been transferred to hospital from the Arthur Gorrie Correctional Centre (AGCC) on 16 February 2010 after being found unconscious in his cell.

When medically reviewed after reception to AGCC on 12 January 2010, Mr Currie tested positive for hepatitis B and C. He was seen by the visiting medical officer on 22 January 2010. The doctor did not do a physical examination or order a liver function test or start any treatment as Mr Currie was not showing any signs of liver failure at that time. Mr Currie became unwell on 14 February and spent most of the time sleeping in his cell. He was reviewed by a nurse on 15 February, who reminded him of the need to take the antibiotics previously prescribed to treat his boils. On 16 February 2010, Mr Currie was found unresponsive but breathing on his bed. A code blue was called. Mr Currie was given a glucogen injection as his blood sugar level was very low. He was taken to the prison medical centre where he was given more glucogen and continuously observed until his condition improved. He was then moved to an eight bed ward, where he remained alert and responsive. Blood test results showed Mr Currie was undergoing complete liver failure. He was transferred immediately to the Princess Alexandra Hospital where he was admitted to the intensive care unit for treatment of acute liver failure. Tests confirmed an extremely high viral load of hepatitis B infection and antiviral therapy was commenced, but Mr Currie did not respond. After discussion with his family, treatment was withdrawn and Mr Currie died on 20 February 2010.

Mr Currie's death was investigated concurrently by the QPS CSIU and the Office of the Chief of Inspector, QCS. A further investigation was undertaken by the Health Quality and Complaints Commission in respect of recommendations made by the QCS report. The OSC supplemented these investigations with clinical expert reports regarding the adequacy of the health care provided to Mr Currie. The State Coroner was satisfied that appropriate investigations had been carried out.

Autopsy revealed the cause of death to be hypoglycaemic hypoxic-ischaemic encephalopathy due to massive liver necrosis due to hepatitis B and C infection.

The State Coroner found that:

- it was unlikely that earlier intervention and specialist involvement in the few days of illness prior to hospital admission would have changed the outcome for Mr Currie;

- nothing about the way in which AGCC staff responded to Mr Currie's illness caused or contributed to his death – he was suffering a relatively common and largely benign disease that flared without warning into a hyperacute presentation that could not be reversed;
- the visiting medical officer acted appropriately to enable Mr Currie to complete the course of Flucoxacillin commenced in the watch house – there was no evidence this drug actually caused or contributed to the subsequent liver disease;
- the equivalent health care principle required either a liver function test or specialist referral for a newly hepatitis positive prisoner – the State Coroner noted that, although it was not the usual practice of doctors working at AGCC to do so at the time of Mr Currie's death, Queensland Health Offender Health Services has since issued guidelines about when liver function tests should be ordered;
- it was most unlikely had a liver function test been ordered for Mr Currie that its results would have given forewarning of the infection that ultimately flared and caused his death;
- the eight hour delay in transfer to hospital was inappropriate per se but an earlier transfer would have made no difference to the outcome for Mr Currie; and
- the medical recording keeping was seriously substandard.

The State Coroner noted that:

- QCS was reviewing procedures for the provision of information from custodial staff to health staff who review a prisoner and the prison operator had already implemented changes to improve this information exchange; and
- QCS was in the process of implementing a process to ensure greater involvement of indigenous counsellors in the management of health care of indigenous prisoners and the prison operator had already implemented such changes locally..

Noting the high incidence of hepatitis infection among the prison population, the State Coroner recommended that Queensland Health Offender Health Services review the availability of treatment for prisoners infected with viral hepatitis to ensure reasonable steps are being taken to contain the spread of the disease by treating the carriers whilst in custody.

Leonard John Fraser

Leonard John Fraser was a 55 year old prisoner of the Wolston Correctional Centre who died at the Princess Alexander Hospital on 1 January 2007. Mr Fraser had a history of previous heart attack in 1999. In the month prior to his death, he presented to the prison medical centre a number of times with symptoms including central chest pain, excessive sweating, vomiting, rash, shortness of breath, sore throat, fever and headache. An ECG was not performed at the first presentation as the ECG machine was not working. Mr Fraser was reviewed by both nursing and medical personnel over this period and considered to have a viral infection or respiratory ailment. On 26 December, Mr Fraser presented to the prison medical centre as acutely unwell. He was transported to the Princess Alexandra Hospital emergency department, where a diagnosis of inferior myocardial infarction was confirmed. He was treated with clot

dissolving medication and admitted to the Coronary Care Unit for treatment and monitoring. Mr Fraser then developed heart failure, which required medical treatment before proceeding to a coronary angiography. Mr Fraser was found unresponsive on 1 January 2007. A code blue was called but resuscitation efforts were not commenced as it was obvious he had been deceased for some time.

Mr Fraser's death was investigated by the QPS CSIU. Interviews were conducted with prison staff and other prisoners and Mr Fraser's medical and corrections records were seized. There was a substantial delay of over two years for the investigating officer's report to be completed. The State Coroner was critical of this delay and noted the passage of time meant that the investigative process was far more difficult than it would have been otherwise with the evidence obtained less reliable. The investigating officer also failed to identify and obtain statements from the visiting medical officers who provided treatment to Mr Fraser in the weeks before his death and only did so at the direction of the State Coroner. The OSC supplemented the CSIU investigation with two reports from the Queensland Health Clinical Forensic Medicine Unit about the adequacy of the health care afforded to Mr Fraser in the month prior to his death.

Autopsy revealed the cause of death to be acute myocardial infarction which the pathologist considered occurred in two stages, the first about a week preceding the death and the second, 1-2 days preceding the death.

The State Coroner found that:

- Mr Fraser died of natural causes;
- it was likely that at his presentation on 7 December 2006, Mr Fraser was suffering from angina due to cardiac ischemia and that the three visiting medical officers who reviewed Mr Fraser at his subsequent presentations were not aware of the nature of his first presentation with chest pain and that an ECG was desirable. However, the shortcomings in Mr Fraser's treatment did not contribute to his death; and
- when Mr Fraser was seen by the three visiting medical officers his cardiac condition had probably temporarily resolved and their diagnosis of a viral respiratory tract infection was probably correct and consequently, the treatment provided was appropriate.

The State Coroner considered that the medical treatment provided at the prison failed to meet expected standards because a functional ECG and a thermometer were not available at the prison at various times, and that earlier progress notes were not brought to the attention of visiting medical officers at subsequent presentations. The State Coroner noted that, significant changes have occurred since Mr Fraser's death, with Queensland Health rather than Queensland Corrective Services, now responsible for the provision of healthcare to prisoners. The State Coroner accepted that ECG equipment is now readily available and in serviceable condition at the Wolston Correctional Centre and significant changes have been made to the management of prisoner medical records.

Tony William Gates

Tony William Gates was a 42 year old prisoner who was found unresponsive in his cell at the Wolston Correctional Centre on 6 August 2010. Mr Gates had commenced

physical exercise (using a makeshift bench press made while he and fellow inmates were working in the prison sandblasting/paint shop) in the days preceding his death and subsequently complained of chest pains. Mr Gates' pain was attributed by himself and others including his partner who was a registered nurse, to his recent physical exertion. A code blue was called when Mr Gates was found unresponsive on the floor of his cell during a head count in the early hours of 6 August 2010 but he was unable to be revived.

Mr Gates' death was investigated by the QPS CSIU. The investigation obtained Mr Gates' correctional records and his prison medical records. The investigation was informed by statements from corrections officers, prison health personnel and next of kin, and interviews with fellow prisoners with whom Mr Gates had associated prior to his death. The OSC supplemented the CSIU investigation with a report from the Queensland Health Clinical Forensic Medicine Unit about the adequacy of emergency and medical care afforded to Mr Gates while he was in prison. The Deputy State Coroner was satisfied the matter was investigated thoroughly and professionally.

Autopsy revealed the cause of death to be acute myocardial infarction due to severe coronary atherosclerosis.

The Deputy State Coroner found that:

- Mr Gates reported his pain to other inmates, his partner and a registered nurse at a routine medication parade;
- it was reasonable for his pain to be attributed to recent strenuous physical exercise and a long history of heartburn and indigestion; and
- the medical care provided to Mr Gates during his incarceration and the emergency response to the discovery of his body was adequate and appropriate.

The Deputy State Coroner recommended that:

- Queensland Health Offender Health Services review processes for documenting the administration of medication to prisoners; and
- Wolston Correctional Centre review arrangements for supervising worksites at the prison, given the ability of prisoners to construct their own physical training equipment in this case.

Richard Henry Lyne

Richard Henry Lyne was a 69 year old remand prisoner of the Maryborough Correctional Centre who died while an in patient at the Maryborough Base Hospital on 11 March 2011. Mr Lyne became unwell on 22 February 2011 and was transferred initially to the Hervey Bay Hospital and then subsequently to the Maryborough Base Hospital, where he was diagnosed with acute coronary syndrome and brachycardia. Mr Lyne declined transfer to Brisbane for specialist cardiac intervention and subsequently refused to consent to any invasive treatment related to his condition or for resuscitation in the event of acute deterioration. His capacity to make these decisions was confirmed by psychiatric review and on 4 March 2011, he was transferred back to Hervey Bay Hospital for further management, where he continued to decline medical intervention or care and refused to eat or drink. This led to a steep decline in his condition and he was subsequently placed into palliative care. His capacity was again reviewed psychiatrically and determined to be incapable of

making decisions. Next of kin were unable to be contacted and consequently, the Adult Guardian was consulted with respect to end of life arrangements. Mr Lyne died at the Maryborough Base Hospital on 11 March 2011.

Mr Lyne's death was investigated by the QPS CSIU. The CSIU investigation obtained Mr Lyne's correctional and medical records and was informed by statements from all QPS personnel, relevant custodial officers and Queensland Health staff at the prison and both hospitals, Mr Lyne's carer and fellow prison inmate. The OSC supplemented the investigation with a report from the Queensland Health Clinical Forensic Medicine Unit about the adequacy of the health care afforded to Mr Lyne. The Deputy State Coroner was satisfied the matter was investigated thoroughly and professionally.

Autopsy revealed the caused of death to be acute myocardial ischaemia due to underlying coronary atherosclerosis.

The Deputy State Coroner found that the medical care during Mr Lyne's incarceration was adequate and appropriate. The Deputy State Coroner did not make any coronial comments.

Eric Handley Watson

Eric Watson was a 75 year old prisoner of the Capricornia Correctional Centre who died at the Rockhampton Base Hospital on 17 January 2011. Mr Watson had presented to prison medical staff with deteriorating respiratory symptoms in the second half of 2010 and was diagnosed in November 2010 with advanced terminal lung cancer. Mr Watson declined chemotherapy, preferring to let the cancer take its natural course. He was allocated a prison carer and the Rockhampton Base Hospital liaised with the prison to enable the provision of palliative care to Mr Watson. Mr Watson was transferred to hospital after his condition deteriorated on 17 January 2011, where he subsequently died.

Mr Watson's death was investigated by the QPS CSIU. The CSIU investigation was informed by interviews with inmates who had been in contact with Mr Watson; seizure of all relevant medical and corrections records relating to Mr Watson and a detailed statement from Mr Watson's peer prison carer. The State Coroner considered the investigation was comprehensive.

Autopsy confirmed the clinical finding of carcinomatosis due to carcinoma of the left lung as the cause of death.

The State Coroner was satisfied that Mr Watson had received adequate medical care both in prison and from the hospital in the months prior to his death. The State Coroner did not make any coronial comments.

Stephen John Dixon

Steven John Dixon was a 25 year-old prisoner who was found deceased in his cell at the Brisbane Correctional Centre on 1 July 2011. Mr Dixon had a history of epilepsy since childhood, requiring treatment with anti-convulsant medication for most of his life, but he was known to be non-compliant with his medication. On reception at Brisbane Correctional Centre, Mr Dixon was recommenced on anti-convulsant

medication and his epilepsy was considered to be under control at the time of his death. He was found unresponsive in his cell on 1 July 2011 and despite resuscitation efforts, was unable to be revived.

Mr Dixon's death was investigated by the QPS CSIU. The CSIU investigation obtained Mr Dixon's correctional and medical records and was informed by statements from all QPS personnel, relevant custodial officers, prison medical staff and Mr Dixon's de facto partner. The OSC supplemented the investigation with a report from the Queensland Health Clinical Forensic Medicine Unit about the adequacy of the health care afforded to Mr Dixon. The Deputy State Coroner was satisfied the matter was properly investigated.

Autopsy revealed the cause of death to be sudden unexpected death in epilepsy.

The Deputy State Coroner found that the medical care provided during Mr Dixon's incarceration was adequate and appropriate and his epilepsy was managed appropriately and was under control at the time of his death. The Deputy State Coroner was satisfied there was a timely and appropriate response to the discovery that he was unresponsive in his cell.

The Deputy State Coroner noted the possibility of flexible, individualised arrangements for prisoners with special health needs via an Integrated Management Plan but acknowledged there was no guarantee that co-sharing of a cell or a sleeping arrangement in a medically supervised environment could ensure safety for a prisoner such as Mr Dixon. The Deputy State Coroner noted that medication compliance remains the best preventative strategy for managing the risk of sudden unexpected death in epilepsy and commented it is imperative that education and management of medication compliance is optimised.

Inquests of Public Interest

Lyji Vaggs (State Coroner, Michael Barnes)

On the afternoon of 13 April 2010 27 year old Lyji Vaggs agreed to go with a mental health nurse to the Townsville Hospital Acute Mental Health Unit to receive treatment for his increasingly florid schizophrenia. En route to the hospital Mr Vaggs became increasingly agitated and delusional and on arrival he was no longer willing to undergo treatment. He assaulted a medical student who attempted to engage with him; security guards were called and a violent struggle ensued. Mr Vaggs was held down in a prone position by several staff members and two doses of anti-psychotic medication were injected. Police attended and handcuffed Mr Vaggs and he was administered a sedative. A short time later he was noticed to be unconscious and not breathing. The handcuffs were removed and, after extended resuscitation, Mr Vaggs was revived. The lengthy period without circulation and respiration resulted in irreversible brain damage and life support was withdrawn two days later on 15 April 2010.

The State Coroner heard evidence from 38 witnesses over nine days during the inquest. This included evidence from a large number of eminent medical specialists in relation to the cause of death and the actions of medical staff at Townsville Hospital. Although the immediate cause of death (hypoxic brain injury), was clear, the State

Coroner was required to consider the various contributory factors to Mr Vaggs' cardio-respiratory arrest. He concluded that the combination of drugs administered during restraint were more likely than not to have, in combination with the effects of that restraint, contributed to this event and, hence, Mr Vaggs' death.

As the State Coroner had found a causal link between the intentional actions of hospital staff and the death he gave consideration to referral pursuant to section 48 of the Act. He concluded, though, that no purpose would be served by referring the actions of an individual for disciplinary action, nor that there was any basis for a referral for potential criminal prosecution. Amongst other reasons for these decisions he noted that the death was not a reasonably foreseeable consequence of the action of any individual; the force used was a reasonable response to the threat posed by Mr Vaggs; the doctors involved were very junior and inexperienced and were left without adequate supervision; and, the primary contributor to the outcome was the mismanagement of the incident rather than the actions of any individual.

The State Coroner examined decisions made by various mental health practitioners in the weeks leading to Mr Vaggs' death. He concluded that a psychologist at Townsville Hospital emergency department made a serious error of judgement in not admitting Mr Vaggs as an inpatient on 28 March 2010. He found there was then an unreasonable delay in Mr Vaggs being seen by a psychiatrist. He also found that Mr Vaggs should have been admitted as an inpatient when he was assessed by a nurse on 12 April 2010, the day before his cardio-respiratory arrest.

The State Coroner was not critical of hospital security guards or police for their roles in the incident. He did find that a failure of management meant that senior psychiatric staff members were not available to provide advice to the junior doctors required to deal with the situation. He examined Queensland Health protocols regarding the use of drugs and handcuffs in sedating and restraining mental health patients. He considered the adequacy of Queensland Health protocols for the provision of leadership in circumstances involving staff from a cross-section of disciplines. The State Coroner also gave consideration to the availability of indigenous mental health workers. In each case he was satisfied with the extensive changes already made at Townsville Hospital as a result of an extensive Queensland Health review into the incident.

Saxon Phillip Bird (State Coroner, Michael Barnes)

Saxon Bird was 19 years of age when he died on 19 March 2010 while competing in the 2010 Australian Surf Lifesaving Championships ("Championships"). He was struck by an unmanned ski that had been lost by another competitor. He was knocked unconscious and submerged by the choppy surf. Attempts to locate him by other surf lifesavers, motorised craft and helicopter were initially unsuccessful and 53 minutes had passed by the time his body was found.

The inquest considered the adequacy of the arrangements and policies implemented by Surf Life Saving Australia (SLSA) to ensure the safety of competitors during competitions. It examined the way in which those arrangements and policies were applied to the 2010 Championships. Particular focus was given to the method used by officials to decide on which events would proceed in the face of increasingly adverse weather, and to the supervision of attempts to rescue Mr Bird after he was struck.

The State Coroner found that:

- Mr Bird died from drowning after suffering a head injury;
- the policies of SLSA were reasonably well suited to the safe running of major surf sports events;
- the members of the committee charged with running the Championships underestimated the size, power and turbulence of the surf as it increased in the days leading up to Mr Bird's death;
- a lack of communication between the committee and area officials contributed to their lack of accurate insight; and
- when the danger to competitors was finally appreciated there was a further brief hesitation in taking action during which the event in which Mr Bird lost his life took place.

The State Coroner acknowledged a divergence of views on how the search for Mr Bird should have been conducted. He concluded that the documented safety plan governing the manner of such searches was followed and no criticism of SLSA officials should follow. He noted that the senior police officer assigned to the Championships had no search and rescue experience.

The State Coroner recommended:

- a change to SLSA policy so it unambiguously states that safety is paramount;
- that SLSA put in place a continuing review of flotation and other safety devices for use by competitors at the Championships;
- that the senior police officer assigned to the Championships have completed advanced marine search and rescue training; and
- that SLSA investigate whether surf patrols could be used to coordinate swimmers as an alternative search method when a person is missing at sea.

Ryan Charles Saunders (State Coroner, Michael Barnes)

Ryan Saunders was two years and 10 months old when he died in Rockhampton Base Hospital on 26 September 2007. Six days earlier a general practitioner had diagnosed him with mumps but on 24 September 2007 when his condition deteriorated he was taken by ambulance to Emerald Hospital. A preliminary diagnosis of intestinal intussusception resulted in his transfer Rockhampton Base Hospital where he was initially seen by the paediatric registrar and, later, the paediatric consultant.

After arrival at Rockhampton, Ryan underwent a lumbar puncture to test for meningitis. This proved to be clear. The paediatric registrar did not consider Ryan to have a bacterial infection and decided against ordering a blood culture when such a test was suggested by a junior doctor that evening and again the following morning, 25 September 2007. Ryan underwent a chest x-ray and ultrasound to investigate a suspected abdominal source of his, by then, severe pain. The paediatric registrar overruled suggestions by a junior doctor that Ryan be administered morphine considering this may mask symptoms and make diagnosis more difficult. On her own initiative a junior doctor sent a blood sample to be tested for bacterial infection. At 3:00pm, on the request of a nurse, the paediatric registrar eventually agreed to morphine being administered to Ryan. At 3:30pm blood test results showed a C-reactive protein reading of 444mg/L – indicative of an advanced bacterial infection.

Triple antibiotics were administered to Ryan but his condition continued to deteriorate. It was determined that an exploratory laparoscopy was necessary and that this would have to be done in Brisbane. A Royal Flying Doctor Service (RFDS) retrieval team arrived in Rockhampton late in the evening. In their attempts to stabilise and intubate Ryan for the flight to Brisbane he suffered cardiac arrest. Extensive resuscitation attempts were unsuccessful and Ryan was declared deceased at 12:15am on 26 September 2007.

An initial autopsy report listed the primary cause of death as a small intestinal volvulus. Blood culture results later showed a fast-growing Group A Streptococcal bacteria had formed. This led the pathologist to find that the cause of death was in fact toxic shock syndrome due to Group A Streptococcal infection. This was adopted by the State Coroner in his findings.

An investigation into Ryan's death had been conducted by the Health Quality and Complaints Commission (HQCC) and its report was tendered at the inquest. The State Coroner examined the adequacy of the medical care provided to Ryan and found that he was given adequate care by his general practitioner; by staff at Emerald Hospital and by the Queensland Ambulance Service and RFDS. He found that the paediatric registrar at Rockhampton had made inadequate enquiries into Ryan's history, into the severity of his symptoms and the current status of his medication. The State Coroner considered contrasting expert views on the issue of whether a blood culture should have been ordered, and morphine administered, earlier than they were. He found that the paediatric registrar repeatedly made a serious error of judgement in declining to order a blood culture and another error of judgement in refusing earlier requests for morphine. The State Coroner also found it surprising that the paediatric registrar had not conducted a face-to-face examination of Ryan subsequent to the administration of morphine but before the end of the shift. Notwithstanding these criticisms he decided against referral of the paediatric registrar pursuant to section 48 of the Act stating that the purpose of professional disciplinary action is to correct and prevent aberrant behaviour rather than punish.

The State Coroner considered the 15 recommendations made by the HQCC in its report aimed at correcting systemic failures identified in Ryan's treatment. Evidence was called at the inquest from senior Queensland Health staff on the implementation of those recommendations. The State Coroner was satisfied that those recommendations were comprehensive; that nearly all had been implemented and those outstanding were being given sufficient priority.

Grace Ann Hornby, Jessica Lee Hornby, Denise Ann Mansell and Anthony Paul Thomson (Maroochydoore Coroner, Magistrate Callaghan)

The Maroochydoore Coroner held an inquest into a multiple traffic fatality that occurred at the intersection of Nambour Connection Road and Blackall Street, Woombye on 8 May 2009.

The inquest examined what caused the collision, the safety of the intersection where the collision occurred; the management of previous concerns about Mr Thomson's fitness to hold a licence; the adequacy of the management of Mr Thomson's

medication management and whether there should be any mandatory obligation on health practitioners to report concerns about a person's fitness to drive.

The Maroochydoore Coroner found that:

- the collision occurred when Ms Mansell's vehicle turned right crossing the path of Mr Thomson's vehicle - due to the lack of headlight illumination of Mr Thomson's vehicle and his excessive speed, it would have been unreasonable for Ms Mansell to have seen this vehicle approaching;
- Mr Thomson's medication, taken at the prescribed levels, would not have impaired his ability to drive – many of the drugs detected by post-mortem toxicology had been taken in excess of their prescribed levels;
- QPS has taken appropriate steps to rectify administrative processes that resulted in prior QPS concerns about Mr Thompson's fitness to drive not being forwarded to the Department of Transport and Main Roads; and
- the current legislative regime for optional reporting by medical practitioners was appropriate and adopting a mandatory obligation for health practitioners to report concerns regarding a patient's ability to drive may be of detriment to the ongoing welfare of the patient.

The Department of Transport and Main Roads provided several reports detailing the extensive investigation into the safety of the intersection where the collision occurred. A number of steps to make the intersection safer had been adopted while the Department considered whether traffic lights ought to be installed at the intersection or whether the medium ought to be closed. The Coroner recommended that the Department continue with its review of the safety of the intersection.

White water rafting deaths - Natarsha Charlesworth, Georgina Hatzidimitriadis, Ian Robinson, Seongeun Choi, Sang Won Park (Northern Coroner, Kevin Priestly)

The Northern Coroner conducted separate inquests into the deaths of five people who died as a result of becoming entrapped underwater after their rafts overturned while white water rafting. The deaths occurred during tours operated variously by Raging Thunder, Foaming Fury and RnR Adventures. Each of the five separate inquests examined issues including the circumstances of the tour, search and response by guides and emergency services and the relevant operator's management of the risk of leg entrapment. The Hatzidimitriadis inquest also examined the extent to which the river guides complied with the operational procedures of the operator.

In this series of inquests, the Northern Coroner found that:

- the design and serviceability of the raft was adequate and did not contribute to the incident (Charlesworth, Robinson, Choi and Park);
- the personal flotation device worn by the deceased was suitable and serviceable for use in white water rafting on the Tully River (Charlesworth, Robinson, Choi and Park);
- the briefing and instruction given to the deceased about assuming the white water float position in the event of entering the water was adequate (Charlesworth);
- the river guide on the raft did his best to safely navigate the rapids (Charlesworth);

- the equipment used by Ms Hatzidimitriadis while participating in the rafting tour was appropriate and in serviceable condition;
- the tour guides were appropriately qualified to conduct the tour in which Ms Hatzidimitriades participated;
- Ms Hatzidimitriadis was noticed missing immediately and located relatively quickly - there was no issue with the quality of the first aid administered to Ms Hatzidimitriadis;
- due to a limited understanding of English, Ms Hatzidimitriadis and her nephew did not attain the required level of proficiency from guide briefings to raft the 'Three Ways' rapids - that limited proficiency, and the absence of tight group control, created a situation where the pair paddled into midstream not appreciating the danger to which they were exposed;
- the response of the guides to the entrapment in locating, extricating and administering first aid was reasonable and of a high standard (Robinson, Choi and Park);
- the river guide on the raft was appropriately qualified and experienced to guide the raft (Robinson, Choi and Park); and
- the proficiency of the other rafters did not contribute to the flip over (Robinson).

In each inquest, the Northern Coroner made recommendations directed to the relevant tour operator aimed at educating the operator in, and improving, safety management.

This series of inquests concluded with a joint inquest which examined the adequacy of the current standards and regulations of the white-water rafting industry in light of the findings peculiar to each death and the risk of entrapment. The joint inquest heard evidence from investigators, inspectors and managers from Maritime Safety Queensland and Workplace Health and Safety Queensland on the benefit of a Code of Practice to support their monitoring and interventions including enforcement if necessary.

The Northern Coroner concluded that a change in operators' approaches to the management of safety specific to entrapment requires the support of a Code of Practice. Consequently, the Northern Coroner recommended that a Code of Practice be developed for commercial white water rafting operations under the *Safety in Recreational Water Activities Act 2011* to be developed in consultation with the operators. As a minimum the code should require the development of safe operational procedures specific to each set of rapids by conducting formal risk assessments identifying hazards, selecting appropriate control measures that mitigate the risk to a defined acceptable level and which are periodically reviewed for effectiveness. These documented procedures should be incorporated into training and auditing programs.

Ross Phillip Schumacher (Brisbane Coroner, John Lock)

Ross Philip Schumacher was found deceased in his home office in Auchenflower on 11 May 2006, with gunshot wound to the back of his head. A gun was located in the same room as Mr Schumacher. Mr Schumacher's death was initially treated as a potential homicide and investigated as a major incident, however within several weeks of the death, the investigation was transferred to a single detective.

The inquest examined how the gunshot wound was inflicted and the adequacy of the police investigation of the death.

The Brisbane Coroner found that:

- when the investigation was transferred to a single investigating officer, there were unusual/suspicious circumstances that should have been investigated to determine whether the gunshot wound was inflicted by another person – there were multiple failures by the investigating officer to investigate these matters and provide a timely investigation report. The Coroner noted he would have referred the investigating officer to the QPS for consideration of disciplinary action however this had already occurred during the course of the inquest; and
- although there was evidence supportive of the gunshot wound being self-inflicted, there were still other unusual and suspicious circumstances and a possibility that another person caused Mr Schumacher's death - this could not be determined as there were substantial delays in the gathering of evidence and although subsequent investigations had resolved most of the gaps, the delay had a detrimental impact on witnesses' memories.

Darryl Robert Smith (Brisbane Coroner, John Lock)

Darryl Smith was a 34 year old man who died as the result of acute complications which developed during an elective surgical repair of his fractured right collarbone performed at the Sunnybank Private Hospital on 11 June 2009. The orthopaedic surgeon was using a new trial drill he was not familiar with and a plating system he had not used before. During the surgery Mr Smith's right subclavian vein was perforated. This caused profuse bleeding, an air embolism, and ultimately cardiac arrest. Despite resuscitation efforts, Mr Smith was not able to be revived.

The inquest examined issues including how the right subclavian vein came to be perforated during the surgery; whether the surgical equipment provided the necessary safeguards for the surgery; whether the surgical equipment was used appropriately during the surgery; the adequacy of the management of the complications which arose from the perforated right subclavian vein; and the adequacy of the policies and procedures of the hospital.

The Brisbane Coroner found that:

- despite caution by the surgeon, the perforation occurred when the drill passed through Mr Smith's clavicle and impacted with but unexpectedly was not stopped by a Bristow elevator (mental retractor) – it was uncertain whether this was caused by miscalculation of the depth or trajectory of the drill; excess pressure on the drill or trigger; the Bristow being placed in the incorrect position; or a shift in the Bristow elevator. Assuming the Bristow elevator was in the correct place, the expert evidence concluded there was some human error in relation to what occurred;
- there was no evidence of any problem with the surgical equipment, though the coroner noted there may be some capacity for drill stops to be used if such a product was available;
- while the equipment used in the procedure was found to be appropriate, the orthopaedic surgeon was not aware of the specifications, functions and uses of the drill before he used it – this was not considered to have been a factor in Mr Smith's death; and

- the management of Mr Smith's resuscitation was reasonable under difficult circumstances where the diagnosis was unclear and multiple causes might have contributed and if the outcome was unlikely to have been any different had an earlier diagnosis of an air embolism been established.

The Coroner referred his findings to the Royal College of Surgeons, the Royal College of Anaesthetists of Australia and New Zealand, and to the Shoulder and Elbow Society of Australia as a case study for discussion and learning amongst its members. The Coroner also requested Synthes Australia (distributor of the drill) and Smith & Nephew Surgical (distributor of the plate and surgical equipment) consider referring the case to their research and development departments to assist them in informing future design choices for drill bits and particularly in relation to the commercial and technical feasibility for the design of drill stops for orthopaedic surgery.

Gregory McLellan, Yang Sun, Shengqui Chen and Dominic Chen (Deputy State Coroner, Christine Clements)

The Deputy State Coroner held an inquest into a multiple marine fatality that occurred on Moreton Bay on the afternoon of 1 September 2007 involving a collision between two vessels, one returning to shore and the other travelling across the bay to the mouth of the Brisbane River. All four deceased were aboard the vessel returning to shore, from which there was only one survivor. The 16 year old licensed driver of the larger vessel was charged with an offence under the *Transport Operations (Marine Safety) Act 1994* in relation to the incident but was not committed for trial following a committal hearing before the Children's Court.

The inquest examined issues including how the collision occurred and the adequacy of training, licensing and supervision requirements for recreational boat licensees, particularly minors in charge of vessels.

The Deputy State Coroner found that:

- the driver of the smaller vessel returning to shore did not see the larger vessel prior to the collision due to driving in the direction of the setting sun and reflected glare from extremely calm conditions on Moreton Bay late in the afternoon;
- the driver of the larger vessel did not see the smaller vessel prior to the collision occurring, probably due to only occasionally and briefly looking to the portside of his own vessel – he was concentrating on the course ahead and his responsibility to give way to any vessel approaching from his starboard side;
- the two vessels were travelling on converging courses across the bay and neither took evasive action to avoid the collision.

The Deputy State Coroner noted significant changes (announced during the course of the inquest) made to boat licensing which include higher standards of boat operator skills for new licence holders of larger recreational boats and advanced training for night and electronic navigation training.

The Deputy State Coroner recommended that:

- the desirability of a renewed emphasis in recreational boat licence training on the precautions that must be taken when navigating in conditions of reduced visibility and the obligation to keep a proper lookout and situational awareness;
- Maritime Safety Queensland consider a recreational boat licensing scheme that requires the demonstration of a higher standard of boat operation skill for new licence holders of large recreational boats and progressive licensing over minimal intervals to enable the licence holder to gain experience and maturity in developing the requisite skills over time;
- current education and training programs encouraging the use of personal floatation devices be properly resourced; and
- Maritime Safety Queensland continue to actively review the circumstances of marine fatalities and consider the incidence of deaths which can be attributed to failure to wear a personal floatation device – any consideration of legislative change to mandate wearing of floatation devices must also consider providing capacity for public education and awareness and capacity to enforce such law change.

Graham Robert Tait (Innisfail Coroner, Magistrate Brassington)

Graham Robert Tait was a 65 year old man who died after he came into contact with fallen powerlines near his home at Mission Beach on the evening of 21 March 2007 while he was investigating the possible cause of reduced power supply to his residence. The incident involved infrastructure owned by Ergon Energy Corporation Ltd compromising a section of low voltage network supplied from distribution substation 1522 which fed from the El-Arish Feeder from the Tully Zone substation. The incident was the subject of concurrent investigations by the coroner, Fair and Safe Work Queensland and Ergon.

The inquest examined issues including what caused the powerlines to fall; what action, if any, could have been taken by Ergon Energy prior to Mr Tait's death to protect the aerial low voltage lines involved in the incident from electrical fault damage; Ergon Energy's response to the initial system fault report; the adequacy of the emergency services response to the incident and the adequacy of the Workplace Health and Safety Queensland investigation into the incident.

The Coroner found:

- wildlife impact was the probable cause of the conductors clashing and falling to the ground;
- the Ergon call centre response to the initial fault call was appropriate;
- the Ergon control centre staff acted diligently and professional in a very difficult situation – immediate de-energisation by Ergon upon receiving notification of the electrocution would not have saved Mr Tait;
- the absence of a telegraphic link stick and insulated gloves from the attending QFRS truck did not contribute to the fire crew's inability to remove Mr Tait from the fallen powerlines;
- an earlier incident of wildlife impact in the same section of line in 2006 should have triggered an assessment by Ergon of the risk of clashing conductors causing a conductor failure;

- the Workplace Health and Safety investigation of the incident was inadequate; and
- there was satisfactory evidence that Ergon had instituted a program of electrical fault prevention measures across its network.

The Innisfail Coroner noted that Ergon had already made changes to its call centre scripting to recognise the critical danger posed by fallen powerlines and improvements to its 'wires down' policy. The coroner also noted significant changes made by the Office of Fair and Safe Work Queensland to the investigation of electrical fatalities.

The Coroner recommended that:

- Office of Fair and Safe Work Queensland progress legislative amendments to mandate reporting to the Electrical Safety Office of all incidents in which low voltage conductors fall to the ground and remain energised;
- electrical entities review their call centre scripting to include a specific warning reminding callers where there is a total or partial loss of supply, brown out or other emergency, one cause of that situation may be fallen powerlines and fallen or hanging powerlines should be treated as live;
- electrical entities review and if necessary develop and document procedures to guide control centre staff and field crews to deal with emergency situations involving downed live wires including de-energisation policies where urgent rescue and/or imminent threat is involved;
- improvement of liaison between the QPS, Office of Fair and Safe Work Queensland and electrical entities to enhance the process of scene preservation and the identification and collection of evidence at, and effective investigation of, fatal incidents involving electricity supply networks; and
- the then ongoing Office of Fair and Safe Work Queensland review of the investigation of serious electrical incidents consider matters including appropriate lead agency allocation to the Electrical Safety Office where the incident occurs in a workplace or non-domestic premises but does not involve work-related activity.

S (Rockhampton Coroner, Magistrate Hennessy)

S was a 10 year old girl under the care of the Department of Communities – Child Safety, who died after being struck by a car after she had run away from the care facility where she had been placed. All other foster placements had been exhausted due to her complex behavioural issues and history of absconding. She left the facility with a fellow resident, following an altercation with a third resident. The child and her friend were lost and seeking telephone assistance from the police when the collision occurred.

The inquest examined issues including the appropriateness of the child's placement given her history of previous conflict with another resident; the experience supervision and training of the child's case manager; appropriateness of the action taken by the facility and the Department to manage the conflict between these two children; management of the incident leading to the child's departure from the premises and adequacy of the police search for the missing children.

The Coroner found:

- the speed with which S was placed at the facility led to potentially less than ideal information and active management of her issues being identified to the facility;
- no evidence of a risk assessment being conducted in relation to the child's history of absconding so that strategies could be put in place or at least staff made aware of this issue;
- no evidence of any genuine consideration of the suitability of the children she was to reside with at the facility;
- the facility did not notify the Department of any of the eight incident reports generated in respect of S, many of which involved her being the subject of physical violence by the other child;
- although strategies were developed to deal with the conflict between the two children, their carers were not made aware of these agreed strategies;
- the facility's internal communications was flawed and there was a clear breakdown in communication between the facility and the Department;
- the facility's policies and procedures were lacking and staff training was limited; and
- police responded promptly to the final altercation between the two children and subsequent notification that the child and her friend were missing. However, a lack of coordination between patrols, not escalating patrols to a 'Search and Rescue' and poor internal communication (between the Communication Coordinator and the District Duty Officer regarding the allocation of police units) contributed to the police not locating the girls in a timely manner.

The Coroner made a number of recommendations aimed at:

- improving police communication and search procedures;
- improving procedures for the placement of children in the care of the Department, such as obtaining feedback from previous placements and allowing for past conflict/relationship issues to be identified; and
- ensuring the care facility has appropriate policies and procedures that deal with internal communications and communication with the Department.

Inquest into the deaths caused by the south-east Queensland floods of January 2011 (State Coroner, Michael Barnes)

Between 10 and 13 January 2011, flooding in south-east Queensland led to 22 people losing their lives and another three disappearing without having been seen again. Although the loss of life and damage to property was widespread, the community of Grantham suffered most with 12 of its residents deceased or missing.

The State Coroner flew to the affected areas with police in the days following the worst of the flash flooding in the Lockyer Valley. A detailed police investigation into the circumstances of each of the deaths and disappearances was undertaken by a specially formed task force. This investigation was independent of the more far-reaching Queensland Floods Commission of Inquiry (QFCOI).

The State Coroner liaised at an early stage with the QFCOI Commissioner to clarify their respective roles. Section 4A of the *Commission of Inquiry Act 1950*, under which

the QFCOI was formed, excises from the usual jurisdiction of a Coroner those matters into which the Commission has been directed to inquire pursuant to its terms of reference. The wide ranging terms of reference of the QFCOI necessarily, therefore, restricted the scope of the subsequent coronial inquest.

Counsel assisting led evidence in the form of an extensive package of audiovisual material prepared by QPS investigators. The circumstances of each death were examined as were the meteorological events leading to the tragedy and the scope of the extensive search conducted in the weeks following the floods. More extensive evidence was heard in relation to one of the deaths, that of four year old Jesse Wickman. Jesse was lost from the grasp of a QFRS Swift Water Rescue technician during an attempted rescue at Minden. In this case the State Coroner examined evidence concerning the adequacy of rescue equipment, appropriateness of the rescue plan and the qualifications of the rescue officers involved. He concluded that both QFRS officers involved in the rescue had acted appropriately and should not be criticised. The State Coroner was not in a position to make recommendations pursuant to section 46 of the *Coroners Act 2003* due to the excise of jurisdiction referred to above.

In response to media articles in the months following the floods which inferred a link between that event and an increased incidence of suicide in the affected areas, the State Coroner commissioned a report from Professor Diego De Leo, a world renowned expert in the study of suicide and self harm. Professor De Leo and a team of researchers examined all available data relating to the possible link. At the inquest Professor De Leo spoke to that report which concluded that no such link could be established from the empirical evidence. He noted that academic literature in this area left open the possibility that such a link might emerge in future.

Gold coast triple murder-suicide – Antony Way, Tania Simpson, Kyla Rogers and Paul Rogers (State Coroner, Michael Barnes)

Late at night on 15 May 2011, Paul Rogers went to the home of his recently estranged partner, Tania Simpson. He broke in and stabbed Ms Simpson and her friend Antony Way to death. Mr Rogers then carried his five year old daughter Kyla to his car and drove south into New South Wales. Early the next morning, he pulled off the Bruxner Highway just west of Casino and killed his daughter and himself.

The inquest analysed the disturbing behaviour of Paul Rogers in the months leading to his homicidal and suicidal actions. This evidence was measured against studies and academic literature on the links between domestic violence and homicide in order to identify effective preventative measures. The inquest was assisted by the Domestic and Family Violence Death Review Unit (DFVDRU) within the Office of the State Coroner. Members of that team compiled a report setting out the findings of relevant academic studies and applied those findings to the facts in this case. They also gave oral evidence at the inquest.

The State Coroner examined the actions of several people who were contacted by Tania Simpson in relation to her concerns about Mr Rogers' actions. These include a police officer, a psychologist and a counsellor from Relationships Australia. In each case the State Coroner was satisfied that they acted appropriately and gave sound advice given the information available to them individually.

The State Coroner found that 21 people were aware of factors that, when aggregated and analysed with expert insight, indicated Paul Rogers was manifesting most of the indicators associated with deadly domestic violence. Mr Rogers' behaviour, although disturbing, was non-violent. The expert evidence suggested some specific non-violent types of behaviour in a domestic setting are at least as relevant as indicators to the risk of homicide as those involving violence. He also cited statistics showing that between 2006 and 2011, of the 306 homicide victims in Queensland, 144, or 47%, died in circumstances that involved domestic or family violence.

In this context the State Coroner made three recommendations aimed at preventing similar deaths in future, namely that:

- the DFVDRU be given funding to continue its role of providing intensive expert scrutiny of deaths linked to domestic and family violence;
- members of the QPS Domestic and Family Violence Unit liaise with the DFVDRU to review the categorisation of some of the risk factors that are currently used in an assessment tool provided to police officers; and
- the DFVDRU liaise with the Department of Community Safety to consider whether the evidence presented at the inquest should inform a public awareness campaign about the risks posed by non-physical domestic and family violence.

Daniel William Paton (Deputy State Coroner, Christine Clements)

Daniel William Paton was a 45 year old man who died in the Royal Brisbane and Women's Hospital on 28 May 2008, five days after being found unresponsive on the ward after elective surgery to remove a wrist plate. Mr Paton's post-operative pain was being managed with Patient Controlled Analgesia (PCA). The background level of morphine in the PCA was turned off by the nurses in the 23 hour ward when they considered he was too drowsy. His oxygen saturation levels dropped. Mr Paton became aggressive after his garden fork backscratcher was removed. After this incident of aggression, he was reviewed by the surgical ward call doctor who prescribed Temazepam and Phenergan. At no time prior to his transfer to the ward, was the hospital's Acute Pain Management Service consulted about the situation. He was then transferred to the ward where he was found unresponsive. Mr Paton died in the intensive care unit five days later.

The inquest examined issues including the adequacy and appropriateness of Mr Paton's post-operative pain management and the appropriateness of the hospital's pain management guidelines.

The Deputy State Coroner:

- found the recording of nursing observations during the post-recovery ward period was unreliable;
- found it was not possible to pin point the cause of the hypoxic event that caused Mr Paton's death – respiratory depression in the context of obstructive sleep apnoea, morbid obesity, coronary atherosclerosis, possible respiratory infection, anaesthetic and pain relief medication including morphine, Phenergan and Temazepam were significant factors;

- highlighted the importance of review of the integrated assessment process regarding anaesthetic risk and the critical importance of astute and properly documented nursing observations;
- noted ongoing work at both a local hospital and Queensland Health level to implement formal systems of patient monitoring; and
- referred her findings to the Royal Australian and New Zealand College of Anaesthetists to inform ongoing discussion about anaesthetic and pain management practices.

Jack Wallace MacNicol (Northern Coroner, Kevin Priestly)

Jack Wallace MacNicol a 15 year old boy who died on 15 December 2009 from head injuries sustained in a fall from a 250cc motorbike while mustering cattle on the family cattle station two days earlier.

The inquest examined issues surrounding the advisability of rural workers wearing helmets and the regulatory framework for the wearing of helmets by rural workers. The Northern Coroner was concerned about the number of reported deaths associated with the failure to wear a helmet. It was his view that the advisory nature of the requirement for young rural workers to wear helmets did not seem to be well appreciated within the sector, even by the relevant Manager of Fair and Safe Work Queensland.

The Northern Coroner found that the risks associated with the wearing of helmets do not appear to outweigh the risks from not wearing helmets and recommended the introduction into law of the proposed amendments to *Rural Plant Code of Practice 2004* requiring the wearing of helmets on motorbikes.

Higher courts decisions relating to the coronial jurisdiction

During the reporting period an application was made to the District Court for an order directing an inquest be held into the death of Antoine Chakra. The application was dismissed by DCJ Reid in *Dupois v State Coroner of Queensland Michael Barnes* [2012] QDC.

Appendix 1: Number of Coronial cases Lodged and Finalised in the 2011–12 financial year and the number cases pending as at 30 June 2012

Court location	Number of deaths reported to the Coroner	Number of coronial cases finalised			Number of coronial cases pending			
		Inquest held	No inquest held	Total	Less than or equal to 12 months old	Greater than 12 and less than or equal to 24 months old	Greater than 24 months old	Total
Brisbane	1887	64	2049	2113	496	117	128	741
Bundaberg	135	1	156	157	35	9	3	47
Cairns	582	6	615	621	326	99	95	520
Caloundra	69	0	68	68	24	7	2	33
Charleville	27	0	30	30	9	3	2	14
Dalby	43	0	48	48	18	0	3	21
Emerald	34	0	39	39	19	3	0	22
Gayndah	6	0	8	8	1	2	0	3
Gladstone	45	0	42	42	23	6	2	31
Gympie	43	1	42	43	15	1	4	20
Hervey Bay	65	0	62	62	25	3	0	28
Innisfail	0	1	0	1	0	0	0	0
Ipswich	135	0	129	129	64	25	8	97
Kingaroy	28	0	31	31	15	5	1	21
Mackay	108	0	102	102	53	8	6	67
Maroochydore	213	5	222	227	54	9	6	769
Maryborough	35	0	39	39	19	1	2	22
Murgon	13	0	13	13	4	0	1	5
Rockhampton	152	3	159	162	38	7	10	55
Southport	648	0	626	626	327	60	54	441
Warwick	193	0	210	210	67	8	1	76
Total	4461	81	4690	4771	1632	373	328	2333

Appendix 2: Register of approved genuine researchers

<i>Person/position</i>	<i>Organisation</i>
Chairperson	Queensland Maternal and Peri-natal Quality Council - Queensland Health
Chairperson	Queensland Paediatric Quality Council - Queensland Health
Chairperson	Committee to Enquire into Peri-operative Deaths - Queensland Health
Director (Rob Pitt)	Queensland Injury Surveillance Unit
Director (Prof Diego De Leo)	Australian Institute of Suicide Research and Prevention
Director (Prof Nicholas Bellamy)	Centre of National Research on Disability and Research Medicine
Director (Assoc Prof David Cliff)	Minerals Industry Safety and Health Centre
Dr Douglas Walker	Not applicable
Deputy Team Leader Safety and Education Branch	Australia Transport Safety Bureau
Director (Prof Mary Sheehan)	Centre for Accident Research and Road Safety – Queensland
Dr Charles Naylor Chief Forensic Pathologist	Queensland Health Forensic and Scientific Services (QHFSS) funded by Australian Research Council (ARC)
Dr Belinda Carpenter Criminologist	QUT School of Justice Studies funded by ARC
Dr Glenda Adkins Criminologist	QUT School of Justice Studies funded by ARC
Director (Assoc Prof Robert Hoskins)	Clinical Forensic Medicine Unit – Queensland Health
Dr Ben Reeves	Paediatric Registrar Mackay Base Hospital
Dr Beng Beng Ong	QHFSS
Dr Nathan Milne	QHFSS
Dr Peter O'Connor / Ms Natalie Shymko / Mr Chris Mylka	National Marine Safety Committee
Dr Nathan Milne	QHFSS
Dr Beng Beng Ong	QHFSS
Manager (Strategy & Planning)	Maritime Safety Queensland

Dr Luke Jardine	Royal Brisbane & Women's Hospital
Dr Yvonne Zurynski	Australian Paediatric Surveillance Unit -The Children's Hospital at Westmead
Director of Neonatology - Dr John Whitehall & Dr Yoga Kandasamy	Department of Neonatology - Townsville Health Service District
Professor Ian Thomas - Director of CESARE	Centre for Environmental Safety and Risk Engineering
Dr Margot Legosz	Crime & Misconduct Commission
National Manager for Research & Health Promotion (Dr Richard Charles Franklin)	Royal Life Saving
Lance Glare (Manager BCQD Building Legislation & Standards Branch)	Building Codes Queensland Division
Michelle Johnston masters student	School of Pharmacy, University of Queensland
Dr Damian Clarke	Paediatric Neurology Department Mater & Royal Children's Hospital
Professor Grzebieta, Hussein Jama & Rena Friswell	NSW Injury Risk Management Research Centre
Director - John Lippmann OAM	Divers Alert Network Asia Pacific (DAN AP)
Dr Michelle Hayes	Department of Communities
Associate Professor Alexander Forrest	QHFSS
Professor Tim Prenzler, Doctor Louise Porter, Kirsty Martin & Alice Hutchings	ARC Centre of Excellence in Policing & Security
Professor Christopher Semsarian	Centenary Institute - Molecular Cardiology Group
Ms Donna McGregor, Dr Laura Gregory, Mr Matt Meredith, Miss Nicolene Lottering	QUT / QHFSS
Mark Stephenson - Team Leader / Glen Buchanan - Snr. Chemist	QHFSS
Julian Farrell - Research Officer	Agri- Science Queensland
Professor Belinda Carpenter & Associate Professor Gordon Tait	QUT
Adjunct Professor Peter Ellis, Associate Professor Alexander Stewart & Professor Craig Valli	QHFSS, Griffith University and Edith Cowan University
Keith Loft	QUT / QHFSS
John Drayton, Senior Counsellor	QHFSS