QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	Inquest into the death of **Benjamin Richard WARE**
TITLE OF COURT:	Coroner's Court
LOCATION:	Cairns
FILE NO:	2009/2059
DELIVERED ON:	28 March, 2013
DELIVERED AT:	Cairns
HEARING DATES:	8 Oct 09; 27 Oct 09; 28 Jul 10; 11 Aug 10; 20 Oct 11; 14 Aug 12
FINDINGS OF:	Kevin Priestly, Coroner
CATCHWORDS:	Coroners: inquest, apparently intoxicated person admitted to Diversionary Centre during evening, failed to wake next morning, later found unconscious, died due to head injury, quality of care, adequacy of procedures to guide staff, quality of oversight by funding authority.
REPRESENTATION:	
Counsel Assisting:	Ms S Williams, instructed by Office of State Coroner, Northern Region
For Department of Communities:	Mr B McMillan of Counsel instructed by Department of Communities

Introduction

It is important that the reader understand the statutory role of Coroner as well as the powers and limitations that affect how the Coroner discharges that role.

A Coroner is required to make findings as to how a person died, when the person died, where the person died and what caused the person to die.

A Coroner is precluded from including in his findings any statement or comment that a person is or may be guilty of an offence or civilly liable for something (s.45(5) and s.46(3) of the Coroners Act 2003).

A Coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to public health or safety and ways to prevent deaths from happening in similar circumstances in the future.

Mr Ware died while in the care of a Diversionary Centre at Cairns. At about 8pm Police found Mr Ware, apparently intoxicated outside of a hotel and lying on the footpath. He was conscious and without any apparent injury. Police offices took Mr Ware to Lyons Street Diversionary Centre and he was admitted into its care. Although ill during the first part of the night, he appeared to settle. The next morning, most of the other clients left at first light. However, Mr Ware did not wake. At about 2pm that day, he was found barely conscious and seriously ill. Later that evening he died in Cairns Base Hospital from complications of a skull fracture.

This investigation concluded with an inquest to establish more about how he died and to explore opportunities to prevent deaths from happening in similar circumstances.

My approach is to set out the narrative based on witness accounts and to explore the adequacy of the practices and procedures of the Diversionary Centre in managing the wellbeing of intoxicated clients. To the extent that there were any systemic deficiencies that might be relevant to the circumstances of Mr Ware's death, I considered the history and oversight of the Diversionary Program as well as governmental oversight to identify opportunities for improvement.

THE NARRATIVE

Police Intervention

At about 7:40 pm on 7 October, 2005 Constables Place and Howarth were tasked to attend the Grand Hotel in response to a report of a male person sleeping on the footpath. On arrival, Constables Howarth and Place were redirected to a male person in front of the Railway Hotel, situated across the road. The officers went to the corner of Shields and McLeod streets, finding a person later identified as Benjamin Ware, apparently asleep on the footpath in front of a public bench. He was wearing black jeans with a shirt on his right arm only. There was a backpack beside him. Constable Howarth introduced himself to Mr Ware who immediately woke and sat up. Constable Howarth saw that Mr Ware had no cuts or abrasions or any other visible injury. He was asked his name and Mr Ware responded "Benjamin". He was asked whether the backpack was his and he responded, "Yes". Mr Ware was also asked where he was staying although the Constable Howarth does not recall his response. Inspection of the contents of the backpack revealed paperwork with the name "Benjamin Ware". Mr Ware was asked to stand. He stood up and appeared to the officers to be

unsteady on his feet, apparently suffering the effects of alcohol. Mr Ware was assisted in replacing his shirt. The police officers had a short conversation with him as a result of which they decided to take Mr Ware to the Lyons Street Diversionary Centre as a place of safety for the night.

The police assisted Mr Ware to the rear of the police vehicle. He climbed unassisted into the rear of the police vehicle. Constable Howarth thought Mr Ware seemed reasonably capable of coordinating his movements.

Arrival and Assessment at the Diversionary Centre

Mr Ware was transported to the Lyons Street Diversionary Centre, arriving at about 8pm. The police officers spoke to Mr Gary Addo, an employee at the Centre, informing him that Mr Ware was being dropped off to stay overnight as he was found intoxicated in a public place.

The rear of the vehicle was opened. Mr Ware was sitting in a chair, awake and reasonably alert. Mr Ware was instructed to slide out, feet first, facing Constable Howarth, and to place his feet on the ground. Mr Ware who did as instructed. There was a brief discussion about a meal and then Mr Ware left with Mr Addo towards the entry ramp to the rear of the Centre.

I pause at this point of the narrative to comment on the actions of the police officers. Section 378 of the Police Powers and Responsibilities Act provides that if a person is arrested for being drunk in a public place, and a police officer is satisfied it is more appropriate for the person to be taken to a place of safety, other than the watchhouse, it is the duty of the officer, at the earliest reasonable opportunity, to take the person to the place of safety and release at that place. The section defines a place of safety to include a diversionary centre.

I am satisfied that the police acted in compliance with this provision in their assessment of Mr Ware as well as their transfer and release of him to the Diversionary Centre. There was no indication that Mr Ware was other than intoxicated at the time of their contact with him.

Returning to the narrative, Mr Addo took Mr Ware inside the Centre. Mr Ware was not known to Mr Addo. He formed the view that Mr Ware was intoxicated and noticed his clothing was wet. Mr Ware was given a towel and shown to the showers. Although he agreed to shower, Mr Ware sat down on a chair and promptly fell asleep. Mr Addo woke him and helped him to stand before escorting him into a bed without showering.

Mr Ware was placed in the first dorm known as room one. There were two others occupying that room, Mr Daniel Accoom who was awake, and Mr Raymond Missi, who was asleep.

Events During the Shift to Midnight

At about 9:30 pm Mr Accoom came out from the room reporting that Mr Ware was ‘spewing’. Mr Addo went to the room; saw Mr Ware on the floor and vomitus on the ground. Mr Addo gave Mr Ware a towel and told him to go and have a shower. Mr Addo cleaned up after Mr Ware.

About an hour later, Mr Addo saw Mr Ware standing in the hallway urinating. Mr Addo yelled out that you can't go to the toilet there. Mr Ware apologised and went back into his room. Mr Addo started to clean the hallway of urine when Mr Ware

came out of his room and spewed into the mop bucket. Mr Addo told him to run outside. Mr Ware did and spewed out past the kitchen patio. He then lay on the patio. Mr Addo offered him a blanket if he wanted to sleep out in the fresh air. Mr Ware said, “No, he was right now” and that he was ‘just grog sick’, an expression Mr Ware used a number of times.

Mr Addo noticed the colour of his vomit was red like Port wine. When questioned during the inquest, Mr Addo was able to differentiate bloody vomit from port wine or alcohol vomit. He spoke of his background in pathological laboratory work for five years as well as his experience at the Centre dealing with vomitus.

Mr Ware lay on the back veranda for a while. Mr Addo recalls that Mr Ware was quite chatty and someone had given him a cup of tea. Mr Addo recalls police delivering further clients for admission to the Centre at about 11:30 pm. Although he was offered the Gazebo to sleep in, Mr Ware returned to his room at about 11:45pm.

Mr Addo completed his shift at midnight. Mr Addo said that a monitoring sheet was completed every half-hour in relation to Mr Ware. The other person rostered on the 4 to 12 shift with Mr Addo was Kay Tristam. There was normally a third worker rostered on this shift but that person was absent.

Mr Addo told the court that he completed his shift and advised Bunai Marama, the male worker on the next shift, to monitor Mr Ware closely as he was spewing heaps. Mr Addo told the court that he thought Mr Ware’s condition was improving and would continue to improve but he needed to be monitored.

Midnight to 8am Shift

Mr Bunai Marama did the midnight to 8 am shift at the Centre, along with Rachael Sailor who was the responsible for the female clients. He says that Mr Ware was in the gazebo area of the Centre and remained in this area throughout his shift. The gazebo is located directly to the rear of the main building. As to when Mr Ware moved from the dormitory to the gazebo area was unable to be established. Mr Young Marama said his practice was to check on clients every half-hour and return to tell his co-worker which clients were asleep or awake for recording on the observations sheet. By reference to the observations sheet, Mr Young Marama notes that on the occasion of each inspection, Mr Ware was asleep. It appears that throughout his shift, Mr Ware was in the Gazebo. Therefore, it would appear that Mr Ware likely went to the Gazeba shortly after Mr Addo’s suggestion. It may be that Mr Addo’s recollection of Mr Ware returning to the dorm is not correct. The change of shift is a busy period and perhaps he is mistaken, or Mr Ware had second thoughts and went to the Gazebo after returning to the dorm. Whatever the true position, it is of no great significance.

Mr Bunai Marama regularly worked weekends at the Centre. He was employed full time in Mareeba as a landscaper. He had worked a full day from 7am to 3pm that day before going home, catching up on some sleep and then presenting to work at Cairns at midnight. He recalls someone telling him that Mr Ware had been ‘a bit crook’. In any event, he says that the normal checks were done. It became apparent during the inquest that Mr Bunai Marama was unable to read and write. He relied on his co-worker to complete the observations sheet based on his reports. His statement to police, admitted into evidence, was reportedly adopted and signed after it was read aloud to him.

Mr Bunai Marama told the court that during checks on Mr Ware he did not notice any spew or vomit, otherwise he would have woken him to check if he was OK. Mr Bunai Marama said that Mr Ware was in the gazebo when he last checked on him.

Shift Commencing 8 Am on Saturday

Mr Ray Marama commenced his shift at 8 am on Saturday, 8 October, 2005. He was working with Kathleen Bulmer. On commencement of the shift, Mr Ray Marama said the midnight shift workers spoke to him about Mr Ware vomiting and being sick during their shift. He remembers there was something written in the communication book about this as well. Ms Bulmer recalls the earlier shift reporting that two clients remained in the Centre, Mr Ware and Marilyn Roughsee.

Ms Kathleen Bulmer recalled she saw Mr Ware in the gazebo area from where she was sitting on the veranda near the dining area and he looked to her to be asleep. Mr Ray Marama and Ms Bulmer started their cleaning duties. Mr Ray Marama told the court he checked on Mr Ware each half hour and found him sleeping. Ms Bulmer supported his account.

There are slightly different versions about how the condition of Mr Ware came to the attention of the workers.

Ms Bulmer said another client, Marilyn, was leaving about 2 pm and walked off the verandah. As she left, Ms Bulmer saw Mr Ware on the gazebo, tossing and turning. She saw him sit up, look around and lay straight back down. There was something unusual and concerning about his movements. She then asked Mr Ray Marama to check on him. It was then that the alarm was raised with Mr Marama calling for an ambulance.

According to Mr Marama, at about 2pm he was working in the inside dormitory from where he heard vomiting from the outside dormitory. He ran out and saw Mr Ware lying on his back and vomiting. He turned Mr Ware on to his side so we could breathe and called to another staff member to call the ambulance. Mr Ware was not breathing normally. Mr Marama remained with Mr Ware until an ambulance arrived. He kept making vomiting noises.

QAS Attendance and Transfer to Cairns Base Hospital

Paramedics attended the location of Mr Ware. Their notes record that a worker reported that Mr Ware was found unconscious in bed and that he had stopped breathing on Paramedics arrival. Paramedics found Mr Ware was unconscious with a GCS of 3 and vomitus on him and around his bed. Mr Ware went into cardiac arrest. Output was restored through resuscitation. He was intubated and ventilated before transfer to Cairns Base Hospital. Further investigation by way of a CT scan revealed Mr Ware had sustained a skull fracture with a large amount of cerebral bleeding. Discussion followed with the Neurosurgical Registrar in Townsville Hospital and it was decided by the treating team that the injuries were likely unsurvivable. The family of Mr Ware were advised of the poor prognosis. Mr Ware died at about 9pm on 8 October 2005.

Autopsy

On 10 October 2005 Professor Williams conducted an autopsy and concluded that Mr Ware died due to a subdural haemorrhage due to a skull fracture due to a fall; against a background of coronary atherosclerosis, hypertensive heart disease and fatty liver. External examination showed no obvious laceration or abrasion. Internal examination showed a skull fracture extending from the right frontal bone to the

vermis, this fracture being 10cm long. There was no obvious corresponding injury externally on the head to match the fracture. There was extradural and intradural haemorrhage adjacent to the site of the fracture. No alcohol was detected in a blood sample taken at autopsy. Police located Mr Ware about 7.40pm on 7October and he died at about 9pm on 8 October. There was more than ample opportunity for his body to metabolise alcohol in his system. Therefore the absence of alcohol in a blood sample taken at autopsy is not unusual.

Professor Williams reported his findings were consistent with the head sustaining a significant blunt trauma injury. It was a type of injury that might be sustained in a fall. Professor Williams suggested that the thick hair was likely to explain the lack of an apparent external wound to the head.

Professor Williams was provided with a narrative about the movements of Mr Ware and the observations of others about his behaviour and condition. He was asked to comment on the possible interaction between reducing levels of intoxication and increasing levels of symptoms attributable to the skull fracture. Professor Williams reported:

- The developing subdural haemorrhage (from torn veins) would produce symptoms identical to that of alcohol intoxication;
- If Mr Ware was drunk at the time he was found outside the Grand Hotel, the alcohol level would have reduced at a moderate rate while there was a slow increase in the volume of subdural haemorrhage till it reached an acute level ;
- During this transition, there is likely to be a period of lucidity although it is impossible to estimate the period of lucidity;
- The volume of the haemorrhage would have reached a symptomatic level sometime on Saturday.

Professor Williams was unable to assist any further with a likely timeline. There were too many variables involved to help understand Mr Wares' likely condition if attempts had been made to wake him between 6am and 8am on Saturday morning. What level of consciousness would he have displayed? If conscious, would he have displayed any symptoms inconsistent with the after effects of intoxication? Would he have wandered off like the other clients? If so, how and where would the symptoms have impacted on Mr Ware and what medical assistance would he or others in his company have sought? The available evidence does not provide any basis for answers to these questions.

In conclusion, I find as follows:

1) The evidence from the autopsy demonstrated a head injury consistent with blunt trauma like that sustained in a fall. Although it is possible that Mr Ware suffered an unwitnessed fall at the Diversionary Centre, it is more likely that he suffered the fall prior to being found on the footpath outside the Hotel.

2) The assessments of the police officers about the condition of Mr Ware on finding him on the footpath and on delivering him to the Diversionary Centre were reasonable. There was no apparent injury to Mr Ware; he was conscious and responsive to their questions and instructions. At no time did he indicate that he had suffered an injury. His behaviour was consistent with an intoxicated person.

3) The assessment of Mr Addo that Mr Ware was heavily intoxicated was reasonable. Mr Ware was responsive to the questions of Mr Addo, he had no apparent injury and did not report an injury or any circumstances in which he may

have sustained an injury. Mr Ware's behaviour during the course of the shift to midnight was consistent with a person suffering alcoholic intoxication.

4) Although Mr Addo reported some improvement in Mr Ware's apparent intoxication, he remained concerned about his wellbeing and reported his concern to the supervisors on the shift commencing at midnight.

5) Mr Ware appeared to have settled and nothing untoward was noticed about him during this shift.

6) While almost all of the other clients woke, had breakfast and left at first light, Mr Ware remained apparently asleep when the shift finished at 8am.

7) Neither the members of the shift to 8am nor the members of the shift starting at 8am turned their minds to the wellbeing of Mr Ware beyond simply continuing the half hourly observations.

8) The reason why workers did not wake Mr Ware to check on his wellbeing was unable to be established. It appeared to be assumed that he was merely sleeping off the effects of intoxication.

9) In light of the evidence of Professor Williams, it is impossible to determine what level of consciousness and responsiveness Mr Ware is likely to have displayed if woken at about 8am. It is possible that that he may have proved difficult to rouse raising concern for his wellbeing and resulting in transfer to hospital as well as earlier detection and intervention with respect to his head injury. Even in that event, it is impossible to know whether the outcome is likely to be different. Another possibility is that Mr Ware may have woken and displayed considerable lucidity, resulting in his departure from the Centre, only later and in unknown circumstances to have suffered the acute onset of symptoms. It is impossible to know whether, and if so, when his condition might have received appropriate medical intervention. And then, what might have been the outcome?

10) Although I am unable to conclude that the likely outcome might have been different if Mr Ware was woken about 8am, it was an opportunity that he was not given and gives rise to a question about the adequacy of procedures and practices of staff for assessing and monitoring the wellbeing of intoxicated clients.

OPERATION PROCEDURES FOR ASSESSING AND MONITORING THE WELLBEING OF INTOXICATED CLIENTS

Aboriginal and Island Alcohol Relief Service Ltd (AIARS) operated a number of facilities and programs directed towards providing welfare services including alcohol and substance abuse problems encountered by indigenous people. One of the facilities operated by AIARS was the Lyons Street Diversionary Centre which it started operating in July 1997.

AIARS experienced major financial difficulties and relinquished delivery of the Diversionary Program on 31 January, 2009. It later went into receivership and was wound up.

AIARS was under external administration in the lead up to and at the time of the inquest. It was not represented at the inquest as the Administrators were granted leave to withdraw after the initial directions hearing. Exhaustive efforts were made

during the course of the investigation and prior to the commencement of the inquest to obtain access to all documentation relevant to the policies and procedures at the Diversionary Centre including a search and retrieval of documents stored in a shipping container. I am satisfied that the nature and extent of the search was adequate, in fairness to AIARS, to put before the court all relevant material. A number of witnesses employed at the Centre were able to identify the documents admitted into evidence as documents they saw during the course of their employment and those documents reflected how they were expected to perform their duties.

The nature and extent to which operational procedures were documented at the Centre was very poor. The best material investigators found in searching through a shipping container for what resembled operating procedures was admitted into evidence and marked C7. It was a folder of documents that did not carry any particular title although individual documents had headings. The pages were not numbered. To give the reader some idea of the amateurish nature of the documents the first page contained a statement of ethics; the next page outlined the objectives and focus of the Diversionary Program; the next page outlined the operational procedures for a microwave; the next page addressed how staff intervene in disturbances; the next page was headed “Operational Procedure of the Diversionary Centre” and contained one page of numbered paragraphs. Paragraph 7 stated:

> "Clients must be checked every half hourly unless specific medical conditions dictates otherwise. I.e. if a client is showing signs of sickness, monitoring must be upgraded to every 15 min and should his or her condition worsen, the ambulance should be called immediately".

The following pages were duplicitous in the sense that they appeared to address matters already addressed elsewhere although expressed in a different way but with no greater detail. There were also staff memos dealing with extraneous matters. The folder included reminders to staff about key tasks without providing any detailed guidance about how those tasks should be performed. One page was headed Medical Emergency Procedure for Diversionary Centre. It listed the sequence of actions to be taken for a medical emergency but did not provide guidance in deciding what a medical emergency was. Some of the procedures are dated variously from 1998 through to 2002 suggesting what is put forward as policies and procedures is in fact a compendium of miscellaneous documents haphazardly collected over the years.

A document in the folder is headed ‘Room Checks’ and reads as follows:

> Are an important part of our work. Rooms checked over the course of the shift our setup for standard monitoring of Clients while they are staying within the Diversionary Centre grounds.
> Clients are monitored and observations made:
> A. If they are awake
> B. If they are asleep – breathing correctly
> C. If they are in their rooms
> D. If they are still on the grounds
> E. Most importantly if they require medical assistance.

> Staff must initial all that room checks completed by that staff member who completed the room check. If we need to refer back to a particular room check then we know who to talk to.

Again, no assistance or guidance is given about what to look for that might suggest a client is in need of medical assistance.

Interestingly, the next page in the folder is headed 'Shift Cancellation Procedure'. A full page sets out the requirements if a staff member is unable to work a rostered shift. The important duty of monitoring the wellbeing of clients should have received more attention than a cancellation of a shift. To my mind, this demonstrates management's failure to understand its responsibility to develop and document operational procedures that establish standards and guidelines against which workers can be trained and supervised.

Another document was described as Diversionary Centre Policies and Procedures. However, this document contained policies and procedures applicable to corporate governance of AIARS as opposed to operational procedures. It contained no information of relevance to the quality of care provided to the clients at the Centre.

Other documents obtained from AIARS or located at the Centre were of the nature of a workplace health and safety manual. The content was generic and simplistic in nature, of no practicable value. Again, that material contained no information relevant to quality of care of clients.

Workers were required to complete observations sheets during the shift, presumably as a tool for ensuring checks were made. Against the name of each client staying at the facility was a series of columns for the recording of half hourly observations. This sheet would account for the admission time and walk out time. In between, workers noted observations in half hourly increments, recording whether the client was asleep or awake.

The Centre also kept a Communication Book for the use of shift workers to record and report on any issues with particular clients that the following shift may need to know. Again, no operational procedure supported the use of the Communication Book.

In the absence of adequate operational procedures, what were the practices and how did the workers assess and monitor the wellbeing of clients including Mr Ware?

A number of the workers present during the admission of Mr Ware were asked questions about their work practices. Mr Addo, the shift worker who admitted Mr Ware to the Centre, was articulate and passionate about caring for intoxicated clients. In his statement, Mr Addo said he did not see any injury to Mr Ware nor did Mr Ware say anything to him to suggest he had an injury.

Mr Addo told the court that he had no qualifications for this job on starting and only completed a first aid course about a year or two later. He also told the court that workers were not given training in distinguishing the signs and symptoms of intoxication from those of other medical conditions such as head injuries.

Mr Addo was taken to various written procedures at the Centre, such as:

- "Clients must be checked every half hourly unless specific medical conditions dictate otherwise";

- “If a clients shows signs of sickness monitoring must be upgraded to every 15 minutes”;
- “Should his or her condition worsen the ambulance should be called immediately”;

He told the court that workers were not given any training or guidance about how to conduct the assessments that triggers the required action in each of these situations.

Mr Addo told the court the normal practice each morning was to wake all clients at about 6am, take them to the kitchen for a feed and then ‘show them the door’. He said it was rare he needed to wake anyone, most were awake and ready to move. If there was anybody left when the Manager arrived at about 8pm, you would have to explain the reason for that persons continued presence.

Mr Addo said he would not have expected Mr Ware to have continued sleeping beyond 8am. Further, it was not his experience doing the midnight to 8am shift to have someone stay after waking or being woken about 6 am.

Mr Bunai Marama, another worker, said most clients woke between 5.30 and 6am for breakfast then leave. He was asked whether he thought it unusual for Mr Ware to continue sleeping up to 8am. His response was equivocal, suggesting clients that arrived later in the night might stay beyond 6am.

Mr Savage was the manager of the Centre. He reported the occasional experience of having a client sleep beyond 8am, usually a client who had come in late or was heavily intoxicated. He told the court that if people had not woken by 6am, they would normally get a shake and told, “time to go”. Sometimes clients would ask to stay and sleep a bit longer. He had not had the experience of a client who could not be woken in those circumstances.

Other workers were asked similar questions and gave varying responses. However, the ‘normal situation’ appeared to be that a client remaining asleep beyond 6am was unusual. Even if the client was a late arrival or heavily intoxicated, it was the general expectation of management that they would be woken in any event.

Workers at the Centre were asked about completion of the observation sheets.

Mr Addo, who was working with Ms Kay Tristam and Mr Lenny Creed, completed the entries for male clients 1 to 17 when he conducted checks between 4pm and 6.30pm, Mr Creed did the observations and record keeping between 7pm and 10pm, and Mr Addo did the observations and record keeping from 10.30pm until midnight. At the end of the shift Mr Addo tallied up the number of observations on the register, a form of reconciliation, and signed off on clients numbered 1 to 17.

Mr Bunai Marama worked with Ms Rachel Saylor on the midnight to 8am shift. He said Ms Saylor completed the observation sheets for that shift.

Mr Ray Marama, who was working with Ms Kathleen Bulmer on the 8am to 4pm shift, said they would alternate between making their checks. Ms Bulmer would check the females and then Mr Marama would check males. Mr Ray Marama would report to Miss Bulmer the outcome of his checks and she would enter the appropriate record in the observations sheets.

Unfortunately, in relation to Mr Ware, there were some serious anomalies with the record keeping during the 8am to 4pm shift, particularly at or about 2pm. Mr Addo

gave evidence that on arriving at work at about 4pm on 8 October, 2005 he heard about Mr Ware's condition and looked at the observations sheets for the 8am to 4pm shift. He recalled significant parts were incomplete and an alteration was made to an entry about Mr Ware. A time of discharge was entered and then 'whited out' and corrected. Mr Ware was initially recorded as having left the Centre and someone 'whited out' the entry and corrected it to show that he hadn't left. It could never be established who made what entry, even with the benefit of handwriting comparisons and witness identification of handwritten entries. I was unable to establish who made what entry and when. All witnesses denied making the original entry or its alteration.

I concluded that, given the vagaries and unresolved questions about the integrity of the observations sheets, no reliance could be placed on the entries as corroborating the assertion that observations were conducted. As to the timing of observations of clients, I am entirely reliant on the evidence of the workers.

The Communications Book was referred to earlier and it provided a process for communicating important information between shifts as well as between the shifts and management. Mr Addo said he made a note in the book telling the next shift to keep an eye on Mr Ware. He also recalls telling Mr Bunai Marama (on the midnight to 8am shift) to keep an eye on Mr Ware because he was too drunk to eat and was vomiting.

Mr Bunai Marama also provided some insight into the nature of the checks made. He reported that during the night time, there was enough lighting to see the clients in the rooms. He also carried a torch to see that clients were breathing as they slept. The lights in the rooms would remain turned off.

An issue about fatigue management of workers arose from the evidence of Mr Bunai Marama. He said that there had been occasions when staff had fallen asleep on the midnight to 8am shift and had to be woken. He does not remember falling asleep on this shift but conceded he could have been tired as he was working two jobs at that time. The other job was a landscape labourer working Monday to Friday from 7am to 3.30pm. He would normally work at the Centre on weekends and sometimes during the week. He said that on a Friday, he would go home after work and have a sleep before driving from Mareeba to Cairns (about an hours drive) to start at midnight.

The evidence of Mr Bunai Marama also raised the issue of medical fitness of workers to perform shift work. He told the court when sleeping at home he would sometimes wake up taking a big breath. On such occasions his wife reported he had stopped breathing. He had not consulted a doctor about these incidents. This description raises the possibility of sleep apnoea, a condition that might contribute to fatigue.

I must acknowledge the frankness and honesty of the evidence of Mr Bunai Marama in reporting these matters to the court. He impressed me as a caring person who was committed to his clients but faced some challenges in his capacity for shift work.

In conclusion, I make the following findings about the adequacy of guidance given to staff through operational documents, policies and procedures:

1) The documented procedures did not provide any guidance to workers about how to assess and monitor the wellbeing of intoxicated clients. On the job training merely addressed basic tasks and the routine in which they were performed. First aid training was offered haphazardly.

2) The documented procedures reflected no appreciation of the hazards to which intoxicated clients were exposed and the risks to their health and wellbeing that might need to be monitored and mitigated during their stay.
3) The practices of workers when it came to their approach to monitoring the health and wellbeing of clients relied on the individual workers life experience and common sense. The extent of observations was minimal and limited to identifying whether clients were awake or asleep. The visibly ill were assisted and other left to sleep it off. The difficulty with this approach from an organisational perspective is that the level of service will always be limited to the knowledge and experience of the individual workers. Whereas the organisation should be the repository of the accumulated knowledge and experience of its workers, constantly evolving and improving in its standards with the benefit of experience as reflected in its operational documents. Those standards then form the basis for the education of new workers and the benchmark against which their performance can be monitored.

4) These organisational shortcomings are reflected in the manner in which the care of Mr Ware was managed. The person who had most contact with Mr Ware was Mr Addo during the course of the evening shift. Clearly, he expected Mr Ware to sleep off the effects of his intoxication, wake with the other clients and leave the Centre before 8am. However, he did not wake and none of the four or so shift workers involved the next morning (a change of shift at 8am) appeared to think it unusual, or sufficiently unusual, for Mr Ware to continue sleeping to check. No-one woke Mr Ware to check on his wellbeing.

Police Procedures as at 2005

The dearth of effective operational procedures at the Centre can be compared with what Qld Police Service had in place to guide police officers and watchhouse keepers in the discharge of their duty of care to an intoxicated person in detention.

There are probably two aspects to the police management of intoxicated persons that are relevant. Firstly, the initial assessment of the condition and wellbeing of the intoxicated person on first contact; and secondly, the monitoring and care provided whilst the intoxicated person is in the custody.

The QPS Operations Procedures Manual contains the policies and procedures that police officers are expected to comply with in relation to public drunkenness.

Section 16.6.3 notes that section 378 of the Police Powers and Responsibilities Act relevantly provides that if a person is arrested for being drunk in a public place, and a police officer is satisfied it is more appropriate to the person to be taken to a place of safety, other than a watch house, it is the duty of the police officer, at the earliest reasonable opportunity, to take the person to the place of safety and release the person at that place.

A "place of safety" is defined to include a place that provides care for persons who are drunk, for example a diversionary centre.

Section 16.9.1 stipulates is policy that an officer should not arrest a person who is unconscious or apparently unconscious; or in need of or apparently in need of urgent or immediate medical treatment. The officer should assist a person obtaining medical treatment as soon as possible. A similar policy applies to a watch house manager about accepting into custody a prisoner. A receiving officer is required to inspect and assess a prisoner as soon as practicable in accordance with the guidelines

prescribed in section 16.13.1. Where a person is taken into custody, a responsible officer is required to determine how frequently the prisoner needs to be assessed, the higher the risk, the more frequent the need for assessment. Again, there are guidelines for determining the frequency of prisoner inspections: see section 16.9.5. Finally, the responsible officer is required to continue assessing the prison at regular intervals until the prisoner is transferred into the custody of another person or released.

Section 16.13 deals with health of prisoners and acknowledges that police officers in watchhouses have a duty to exercise reasonable care to protect all prisoners from illness or injury during detention. Safeguards, including monitoring prisoners, should be put in place to observe the behaviour of prisoners.

Section 16.13.1 addresses assessment of prisoners. Police are required to assess every prisoner using checklists at appendix 16.1 of that publication.
The first is a medical checklist which is designed to assist in assessing the level of consciousness and physical well-being of a person. At the foot of the workflow is a warning in the following terms:

> "Police officers in watchhouse should be aware that in some cases severe alcohol or drug withdrawal may result in death if the person does not receive medical treatment".

The second checklist is headed Health Questionnaire and Observations Checklist. Depending on the responses, the officer may be required to complete additional checklists that assist in deciding whether to seek medical attention or treatment for a prisoner and when medical advice should generally be sought. The checklists are comprehensive and provide a point of comparison with the procedures at the Diversionary Centre at the time of Mr Ware's death.

Appendix 16.12 deals specifically with drug and alcohol intoxication, overdose and withdrawal. Police officers in watchhouses are warned to be aware when assessing a person who is apparently intoxicated that they may in fact be displaying symptoms of a more serious injury or condition. The document then lists a series of conditions which may be consistent with or similar to those symptoms generally associated with intoxication. It also lists features that a person suffering from drug or alcohol intoxication may display. The document lists a number of consequences of intoxication as well is suggestions for preventing any disruptive behaviour of a person due to intoxication. The signs and symptoms displayed by a person suffering from drug or alcohol withdrawal are listed as well as the signs and symptoms of drug or alcohol overdose.

It is evident the QPS procedures are underpinned by an understanding of the potential dangers to the health and wellbeing of intoxicated persons. The procedures guide police officers about how to identify those dangers and manage the associated risks. It would have been a relatively easy exercise for the Diversionary Centre to use these procedures from which to develop and implement a basic set of operational procedures.

Finally, AIARS was not the only organisation in Qld (or Australia) operating a Diversionary Centre. Due to the poor operational documents that AIARS used, it must not have made any effort to learn from QPS procedures or any other Diversionary Centre how to care for intoxicated clients.

Why did AIARS fail to understand the abysmal level of care it was offering to intoxicated clients? Part of the answer lies in the origins of the Diversionary Program, its developmental history and the level of oversight by the 'funding authority'.

DIVERSION FROM CUSTODY PROGRAM: ITS ORIGIN, ITS HISTORYAND ITS OVERSIGHT

I am greatly assisted in my understanding of the history of the Diversion from Custody Program by a very detailed report of Mr Andrew Walker, Acting Senior Program Officer, Aboriginal and Torres Straight Islander Services, Department of Communities.

Royal Commission into Aboriginal Deaths in Custody

In October 1987 the Royal Commission into Aboriginal Deaths in Custody was established. On 15 April, 1991 the final report was handed down, making 339 recommendations. In response, the Queensland Government established an Interdepartmental Committee (IDC) responsible for coordinating and monitoring the implementation of the recommendations. The recommendations of the Commission of particular relevance to this matter are: –

- Recommendation 79: That, in jurisdictions where drunkenness has not been decriminalised, governments should legislate to abolish the offence of public drunkenness.

- Recommendation 80: That the abolition of the offence of drunkenness should be accompanied by adequately funded programs to establish and maintain non-custodial facilities for the care and treatment of intoxicated persons.

- Recommendation 81: That legislation decriminalising drunkenness should place a statutory duty upon police to consider and utilise alternatives to the detention of intoxicated persons in police cells. Alternatives should include the options of taking the intoxicated person home or to a facility established for the care of intoxicated persons.

Amongst other things, the IDC established an interdepartmental working group to report on the management of public intoxication including appropriate alternative non-custodial facilities for the care and treatment of intoxicated persons. One of the outcomes from this report was the Diversion From Custody Program which was administered by the Office of Aboriginal and Torres Strait Islander Affairs(OATSIA) within the Department of Families, Youth and Community Care.

The Diversionary Centre Handbook

In April 1993 Regional Managers of the OATSIA began community consultation in the regions to facilitate the development and delivery of the new Diversion from Custody Program that was acceptable to the Aboriginal and Torres Straight Islander communities. The Department also drafted guidelines for the operation of the centres to be circulated as part of the community discussions about organisational arrangements. Each region developed its own model best suited to the area. Regional Managers used a Service Agreement Development Kit as a basis for preparing the Service Agreement with each provider. Organisations were engaged to operate Diversionary Centres.

In July and August 1996 OATIS conducted an internal review and evaluation of the Program followed by a workshop in Cairns in November 1996. The recommendations

of the internal review were then discussed between staff from the diversionary centres and departmental program officers. Following the workshop, a best practice model was developed. A handbook for diversionary centre staff was developed providing guidance on staff duties, training and responsibilities.

The Handbook provided a template for use within Centres. Some of the content is relevant to this matter. Page 11 suggested diversionary centre workers should; –

- have ongoing basic healthcare training;
- have a basic first aid training and be able to bathe cuts and bruises, applying ointments, use bandages, etc;
- always be aware of the health condition of their clients and be alert to changes in possible warning signs in their condition;
- be able to identify important warning signs which mean a person needs urgent medical attention, or more company, counselling and support;
- understand the health risks and complications involved in heavy drinking;
- understand the effects of alcohol intoxication and the sobering up process;
- take careful records of the health of their clients;
- call the assistance of a senior or professionally trained staff member or supervisor or ambulance if in any doubt about a clients health condition.

The handbook urged diversionary centre workers to always be on the lookout for any health problems. It directs staff to get urgent medical attention to a person who:

- cannot sit, stand or walk;
- is unconscious were unable to be woken;
- becomes more vague and less sensible overtime;
- has any serious injuries, including head injuries, bleeding from the mouth or ears, for example;
- cannot stop vomiting or vomits blood;
- has an epileptic fit or faints;
- has an asthma attack;
- has difficult or noisy breathing (crackling, wheezing et cetera);
- the complaint of chest pain;
- is doubling up with stomach pain;
- has bad diarrhoea;
- shows alcohol or drug withdrawal symptoms (anxious, aggressive, irritable, cannot sleep, tremor);
- admits to taking a high and dangerous dose of drugs or alcohol; and
- is unable to answer medical or any other questions.

Another page of the handbook alerts workers to health conditions which make a person look drunk, including;

- head injury;
- epilepsy;
- confusion;
- low blood sugar;
- high blood sugar, uncontrolled diabetes;
- mixed alcohol and drug overdose;
- low blood pressure were serious heart condition;
- schizophrenia, serious depression and some other mental illness;
- blue in petrol sniffing; and
- not enough oxygen in the blood and brain because of asthma or blockage and airways.

Diversionary workers are warned, amongst other things;

"Don't just think a person is drunk just because he or she looks drunk."

"Be aware – drunkenness may also be covering the signs of other serious health problems."

The Handbook provided a very important and useful distillation of information about management of intoxicated persons. As with all publications of this nature, it was intended for use as a starting point and to evolve with the benefit of experience.

Inadequate Funding

From inception, The Diversion from Custody Program experienced funding issues. It was funded using the recurrent funding method. Funding was given for one year at a time. Grants were made in quarterly payments in advance and service agreements were entered into with each service provider. No selection process was used and agreements were renewed with existing service providers. Any breaches of the service agreement would be investigated by departmental officers and remedied before a new service agreement was finalised.

There appears to be a history of underfunding of the program. Initially, the budget allocations for the program anticipated a combination of paid and voluntary labour providing care for the clients who were admitted. However Centre operators relied on paid labour and were forced to employ less staff and pay them at under award rates.

In 2001 a review of the program identified this mistake and sought to resource the centres with appropriate staffing levels, paid award rates which required funding of the next to $1 million.

Bama Healing – The Initial Operator of the Centre from 1992

In late 1992 Bama Healing Centre Aboriginal and Torres Strait Islander Corporation was appointed to run the diversionary centre on a trial basis the six months from Alluna Hostel. That organisation was the only to express an interest in running the program. Reviews were conducted in early 1993, 1994 and January 1995 into the operation of the diversionary centre. The reviews consistently found issues with financial records and the appropriate acquittal of the grant funds as between the different services performed by the organisation. In 1996 an internal review of all diversionary centres highlighted continuing issues with funding, staffing levels, staff training and suitability of the Alluna hostel as a diversionary centre facility. In August 1997, Bama Healing was given a show cause notice after departmental officers became aware of financial irregularities and of other problems relating to the operation of the service.

OATSI decided not to continue funding Obama Healing and suspended the diversionary centre program pending the outcome of an expression of interest sent to eligible community organisations to apply for funding to run the diversionary centre. Two applications were received and ultimately Aborigines and Islanders Alcohol Relief Service (AIARS) was successful in the selection process. AIARS was established in 1978 when it set up a residential treatment centre for alcoholics and thereafter diversified its services into the broader indigenous welfare sector.

Aborigines and Islanders Alcohol Relief Service : Operator from 1997

In July 1997 AIRS began operating the diversionary centre in Cairns. Departmental officers worked with AIARS to develop a service model that operated within the budget. Administrative support was provided to AIARS.

In 1999 responsibility for the Diversion from Custody Program was transferred to the Department of Aboriginal and Torres Straight Islander Policy and Development. The department entered into a service agreement with AIARS.

In 2000 AIARS was subjected to an internal review to investigate issues concerning health and safety, financial management, staff training, competing levels of demand on resources, and the future direction and operation of the centre. The review was a short-term measure to assess immediate risk and the viability of the centre pending a review of all diversionary centres commencing later in the year. In the same year, a reference group was formed to investigate the establishment of a new diversionary centre in Cairns. Construction of the new centre at Lyons Street was completed on 24 May, 2002. It had a 30 bed capacity with separate male and female accommodation. AIARS continued to operate the diversionary centre from the new premises until about by 2003 when it again experienced financial difficulty. The department began managing the operation of the diversionary centre through monthly advances and closer monitoring. The department had concerns that there were no alternative service providers and departmental operation of the centre was not desirable. The department took the view that as AIARS was totally Commonwealth and State government funded, a large employer of indigenous people in Cairns, and the only available service provider; the government had an obligation to support the organisation.

In September 2003 AIARS appointed an Administrator at the request of the Department.

In March 2004 department staff suggested that the department should develop standard operating procedures for diversionary centres. However, Mr Walker reports that the Department took the view that this function should remain the responsibility of AIARS and through 2005, the departmental officer responsible for monitoring the diversionary centre regularly visited the facility to offer support and assistance to the CEO and staff.

In August 2005, it was reported that AIARS was reworking their procedures and submitted a copy to the Department for review and comment. The draft documents included a statement of ethics for diversionary centre workers and the redrafted operational procedures of the diversionary centre.

Following the death of Mr Ware, the department conducted an internal audit of AIARS resulting in an action plan containing 18 recommendations. These addressed aspects involving continued financial viability, robust monitoring of financial performance and renegotiating client needs and service outcomes to ensure clients were appropriately serviced through amendments to the service agreement. A departmental project officer assigned to AIARS reported in February 2006 that the overall position had improved.

In January 2006, a staff member from the diversionary centre made allegations about substandard administration and management practices that had contributed to the

death of Mr Ware in October 2005. The Department investigated the allegations within the limited powers permitted under the service agreement with AIARS.

On 1 July 2006 responsibility for the diversionary centres was transferred to the Department of Communities. From 13 September, 2006 the Department of Communities took over responsibility for all DATSIP Department of Aboriginal and Torres Strait Islander Policy service provision functions.

The Department commissioned a forensic audit of AIARS and engaged external consultants to undertake a comprehensive review of the human resource issues and to produce manuals and policies to support it is in improving its management. The board and senior management team was replaced, staff received governance training and new policies and procedures were put in place. Additional funding was provided to allow the service to continue for the 2006-2007 year.

The Department of Communities negotiated a substantial three-year service agreement and the service plan with AIARS. The service plan referred to the diversionary centre as a place that provides short-term accommodation, a safe and culturally appropriate place for people to sober up and includes beds, laundry and hygiene facilities and meals provided to 35 clients at a time. The service plan anticipated the centre was operational 24 hours per day for police referrals as well as walk-in clients and referrals from other agencies. The service plan set out particular aspects of the service to be provided including half hourly observations for the duration of the clients stay. It also set out various staffing requirements as well as mandatory processes including the existence of the risk management policies and procedures as well as appropriately trained staff. The department also appointed a Diversionary Measures Project Officer to work closely with the centre in monitoring, compliance and capacity building. The department expected AIARS to work with a project officer to restructure the service, develop policies and procedures and identify training opportunities.

In early 2008 a departmental audit report on AIARS found several financial irregularities. On 20 January, 2009 AIARS advised it was relinquishing delivery of the Diversionary Program as at 31 January, 2009.

AIARS later went into receivership and then liquidation.

Departmental Oversight of the Diversionary Centre

Mr Linnan, Regional Executive Director of Far North Region, Department of Communities, Child Safety and Disability Services, provided a reference table to the hearing that outlined key documents relevant to the standard of care required of diversionary service providers from October 2005 to the present. It was conceded that the agreements between the Department and AIARS outlined the services to be provided but did not specify any performance measures by which the standard of service might be measured. Further, there was no assessment of the standard of service provided in the terms of protecting clients from harm.

Mr Linnam gave evidence about administration of the contract with the current service provider Anglicare North Queensland. The Contract started on 1 April 2010 and finishes on 31 March 2013.

The service agreement sets out the services to be performed in a Service Plan and requires Anglicare to implement the Standards for Community Services. The service plan describes the services in a manner similar to past agreements including those

with AIARS. However, this service plan also incorporates Mandatory Processes, including the requirement that the Diversionary Centre must comply with guidelines provided by Qld Police Service in *Cell Visitors, Diversionary Centre Workers and Watch Houses: A guide and information kit*. I will return to this publication shortly. The service plan also addresses performance measuring and reporting.

The department prepared a pro-forma document to support its personnel in auditing performance against the service plan. The document is headed Assessment – Compliance and Performance. It looks at each of the elements of the service agreement and identified compliance issues and the criteria against which performance is to be assessed. Although the document is comprehensive in scope, there is opportunity for improvement, particularly when it comes to addressing the issue of management of intoxicated persons and their risk of harm. I consider this a core activity of the service. Although compliance with the QPS Guide and Information Kit is mandatory, those procedures don't appear to be subject of specific auditing. The reason would appear to be that the QPS Guide and Information Kit is to support and guide Cell Visitors and Diversionary Centre Workers while working with police and visiting police watchhouses. However, the Kit provides a wealth of material that may equally apply to guide workers at the Diversionary Centre. It could be used as an informational resource and guide for training. There is a whole chapter on General Health Information including the Basic Health Check. There is a detailed list of important physical and mental signs and symptoms relevant to assessing the condition of a person's health. There is a section about symptoms that require medical attention as well as a section dealing with intoxication, short term and long term effects. The signs of alcoholism and withdrawal are addressed. The masking effect of alcohol is briefly addressed. Health conditions which may manifest themselves in an appearance of drunkenness are detailed. Guidance is provided about how to manage and treat a person who is drunk as well as how to monitor their wellbeing through observations. Mental health is covered in some detail as is a variety of other conditions such as epilepsy, heart disease, lung disease and management of medications. The material is very detailed. It is sufficient to note that any worker with a comprehensive knowledge of the material contained in this Kit would be sufficiently alert to signs that a client needs medical attention. Nothing like this information was found in the procedures at the Diversionary Centre under the management of AIARS. No material was found that addressed these matters except in the broadest and simplest manner.

In conclusion, I make the following findings:

1. In 1996 the Office of Aboriginal and Torres Strait Islander Affairs facilitated the production of a Diversionary Centre Handbook to guide staff on duties, training and responsibilities. The material contained in that handbook greatly exceeds the guidance that AIARS provided to its staff as reflected in its documented procedures and the practices as the Centre in 2005.

2. The standard of care provided by Qld Police Service to intoxicated persons in custody as reflected in its Operational Procedures Manual exceeded the standard of care provided by AIARS as reflected in its documented procedures.

3. The documented procedures provided no guidance to staff about what are the hazards to health and wellbeing of intoxicated persons and how to manage those hazards and associated risks while in its care.

4. There is nothing in the documented procedures of AIARS to suggest that it accessed the Diversionary Handbook or the QPS Operational Procedures Manual with a view to learning how it might manage the health and wellbeing of intoxicated persons.

5. AIARS relied solely on the experience and knowledge of individual staff members gained on the job without taking a leadership position and developing a corporate standard of care.

6. The history of the Diversion from Custody Program suggests that funding was the focus of most attention and was a distraction from the issue of quality of care which was allowed to languish as a priority.

7. The guidelines developed by Qld Police Service *Cell Visitors, Diversionary Centre Workers and Watch Houses: A guide and information kit* is another opportunity for the review of documented operational procedures applicable at the Centre. However, that review should take a safety risk management approach to ensure all potential hazards to intoxicated persons are identified, the risks assessed, appropriate control measures selected and implemented. While it is useful to adapt and modify what might be considered to be the better approach of another organisation, the effectiveness of that approach should be tested by application of the risk management process before incorporation into standard procedures.

Findings Required by s.45 of Coroners Act

Who died: The deceased name is Benjamin Ware.

When he died: Mr Ware died on 8 October 2005.

Where he died: Mr Ware died at Cairns Base Hospital.

What caused he death: Mr Ware died due to a subdural haemorrhage sustained in a fall.

How he died:

At about 7.40pm on 7 October 2005 Mr Ware was found apparently intoxicated and lying on the footpath at the front of a Hotel in Cairns. Police attended and found Mr Ware conscious and co-operative. He was taken to and admitted into the care of the Lyons Street Diversionary Centre. Although he vomited during the evening, Mr Ware settled and was allowed to sleep it off. He relocated to an outside Gazebo during the night. Other clients of the Centre woke and left the next morning between 6 and 7am. Although regular observations were made of Mr Ware, it was thought he was asleep. At about 2pm, he was found unconscious and transferred by ambulance to Cairns Base Hospital. He was found to have sustained a serious head injury from which he later died.

Comments and Recommendations

There is a need for a set of minimum standards about the quality of care provided at Diversionary Centres to intoxicated clients. The Diversionary Handbook published in 1997 was a valuable tool to providers in the early stage of development of the

service. Unfortunately, the quality of care reflected in the standards and expectations articulated in the Diversionary Handbook did not continue to improve and evolve in so far as it was applied at Lyons Street. Indeed, few of the standards and expectations of the Handbook were translated into action at that Centre while AIARS was the provider.

While the present provider of services at the Lyons Street Centre is Anglicare and no criticism is made of its management of the safety and wellbeing of its clients, broader issues of oversight and standards require attention.

It is possible to discern a trend, starting from publications like the Diversionary Handbook through to the Qld Police Service "*Cell Visitors, Diversionary Centre Workers and Watch Houses: A guide and information kit",* of an increasingly sophisticated approach to managing and caring for intoxicated people.

There is much to be learnt from the available publications as well as those that have had the experience of caring for intoxicated indigenous people through the Diversion from Custody Program.

The process that was embarked upon to develop the Diversionary Handbook in 1997, involving extensive consultation, is a process that I believe should be repeated. The many years of experience in managing facilities of this nature can be reviewed in the context of current best documented practices then captured and published as standard. The Department of Communities could incorporate this publication, a new Diversionary Centre Handbook, as a minimum performance standard into the funding arrangements and create audit tools for its staff to use in monitoring compliance.

I recommend that:

1. **The Department of Communities facilitate a collaborative project with current providers of Diversionary Centres to review and update of the Diversionary Centre Handbook to provide guidance about the standards of care and how they are to be achieved.**

2. **The new Diversionary Centre Handbook be incorporated into the funding arrangements so as to be enforceable.**

3. **The Department develop new auditing tools based on the Handbook to assist Departmental officers in monitoring and measuring compliance with the new standard..**

Coroner Kevin Priestly