The Queensland Government's response to coronial recommendations 2012

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Queensland Government

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Preface

The *Queensland Government's response to coronial recommendations 2012* is a whole-of-government report responding to coronial recommendations and comments directed towards the Queensland Government during 2012. It also includes a response to any recommendation that remained under consideration in the *Queensland Government's response to coronial recommendations 2011*. This is the fifth annual report produced by the Department of Justice and Attorney-General on behalf of the Government. The report aims to provide a public response to all recommendations or comments made by Queensland coroners which have been directed to Queensland Government entities.

While nothing will compensate for the loss of a loved one, it is hoped that the families and friends of the people profiled in this report will receive a measure of comfort from knowing that recommendations aimed at preventing similar tragic deaths have been considered by Government and in most cases, adopted.

Many of the coronial recommendations profiled in this report have been implemented, or are in the process of being implemented. However, the few recommendations in this report that are still under consideration by Government will be responded to in next year's report.

As the report is a consolidation of responses that have been authored by the responsible Government agency, any questions about a particular response should be directed to the responsible agency named in the report.

Any other questions regarding the report can be directed to the Legal Services Coordination Unit of the Department of Justice and Attorney-General either by emailing LSCUMailbox@justice.qld.gov.au or by telephoning (07) 3008 8763.

Table of contents

Inquest into the death of **Robert Gary Mitchell** 3

Inquest into the death of **Lyji Vaggs** 5

Inquest into the death of **Roslyn Amelia Law** 7

Inquest into the death of **Brett Alexander Kevin McKenzie, Abigail Denise Ezzy, Nicholas James Nolan and Maxwell Ernest Thorley** 9

Inquest into the death of **Timothy John Wall** 11

Inquest into the death of **Tony William Gates** 12

Inquest into the death of **a child referred to as 'S'** 14

Inquest into the death of **Anthony Mark Perry** 23

Inquest into the death of **Antony Way, Tania Simpson, Kyla Rogers and Paul Rogers** . 26

Inquest into the death of **Jack Wallace MacNicol** 29

Inquest into the death of **Ian Robinson, Natarsha Charlesworth, Georgina Hatzidimitriadis, Sang Won Park and Seongeun Choi** 31

Inquest into the death of **Patient A** 33

Inquest into the death of **Angus William Keith Ferguson** 34

Inquest into the death of **Adam Cartledge** 35

Inquest into the death of **Isabella Wren Diefenbach** 37

Inquest into the death of **Troy Jason Howse** 51

Inquest into the death of **Mia Davies** 52

Inquest into the death of **Jennifer Ann Boon** 55

Inquest into the death of **Joshua Jai Plumb** 58

Inquest into the death of **Preston Paudel** 63

Inquest into the death of **James Leon Short** 68

Inquest into the death of **Antonio Carmelo Galeano** 70

Inquest into the death of **Elizabeth Cardwell, Isabella Cardwell and Gregory Sanderson** 85

Inquest into the death of **Julie Anne Bramble** 86

Inquest into the death of **Judith McNaught** 87

Inquest into the death of **Michael David Ley** 90

Inquest into the death of **Herbert John Mitchell** 95

Recommendations profiled in *the Queensland Government's response to coronial recommendations 2011* 98

Inquest into the death of **Graham Brown, Malcolm Mackenzie and Robert Wilson** 99

Table of contents

Inquest into the death of **a 15 month old child referred to as 'C'** 102

Inquest into the death of **Saxon Phillip Bird** 103

Inquest into the death of **an unnamed prisoner** 104

Inquest into the death of **Gregory McClellan, Yan Sun, Shengqi Chen and Dominic Chen** 105

Inquest into the death of **Graham Robert Tait** 106

Inquest into the death of **Tracey Lee Inglis** 107

Inquest into the death of Robert Gary Mitchell

On 9 July 2008, Robert Mitchell died in his cell at the Arthur Gorrie Correctional Centre having hanged himself from exposed bars above the door.

The then-State Coroner, Michael Barnes, delivered his findings on 20 January 2012.

Concluding comments, page 6

Once again the primary risk factor highlighted by this case is one that has been well known and subject of public debate and coronial comment for at least 20 years, namely the existence of hanging points in prison cells.

As this case demonstrates, it is impossible to identify with precision those prisoners who might take their own lives. Of the 552 suicides that have occurred in Australian jails since 1980, 90% have been hangings. Therefore, if jail suicides are to be minimised, it is essential all prisoners are kept in cells that do not have hanging points.

I accept the submission Queensland Corrective Services is committed to a policy of replacing unsafe cells with suicide resistant facilities as funds allow. I also accept that many unsafe cells have been closed or refurbished. Nevertheless, hundreds of prisoners remain housed in cells with exposed hanging points, despite the Royal Commission into Aboriginal Deaths in Custody recommending 20 years ago that this not occur and the State Government's public commitment to implementing the recommendation. As a result, a further five prisoners have hung themselves in Queensland correctional centres since Mr Mitchell's death.

Response and action
Agreed and implementation is partially complete
Responsible agency: Department of Justice and Attorney-General (the machinery of government arrangements in November 2013 saw Queensland Corrective Services transition from the Department of Community Safety to the Department of Justice and Attorney-General)

Queensland Corrective Services is committed to a policy of replacing unsafe cells with suicide resistant facilities, and is progressively reducing the number of hanging points in Queensland Correctional Centres with the construction of new and refurbished Correctional Centres.

Funding of $19.5 million is provided in 2013-14 to continue the $33 million cell upgrade program to modify cells in the Arthur Gorrie Correctional Centre. Work commenced on site in January 2013 with completion expected in the 2014 calendar year.

Suicide reduction measures are in place in 90% of all secure cells.

The first stage of the Arthur Gorrie Correctional Centre cell upgrade program will provide a further 112 suicide resistant cells increasing the total percentage to 93% in the 2014 calendar year.

Following completion of stage one at the Arthur Gorrie Correctional Centre, 268 cells at the Arthur Gorrie Correctional Centre and 138 cells at Townsville Correctional Centre will remain to be modified.

Inquest into the death of Lyji Vaggs

Lyji Vaggs died on 15 April 2010 at the Townsville Hospital from hypoxic brain injury. The brain injury was sustained at the Townsville Acute Mental Health Unit two days before his death when he was restrained in a prone position for a prolonged period by hospital security officers and nursing staff. During this time he was administered Olanzepine and Midazalam.

The then-State Coroner, Michael Barnes, delivered his findings on 21 February 2012.

Recommendation 1 - review of approved restraints

I recommend the Director of Mental Health give further consideration to whether flexible plastic wrist ties or hinged handcuffs should be approved for use in restraining violent mental health patients.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

The Director of Mental Health has given further consideration to the use of flexible plastic wrist ties and/or hinged handcuffs. The Director of Mental Health is comfortable clinically with the existing legislative approval for the use of wrist to waist restraints as a first line option of mechanical restraint with scope to approve the use of alternative mechanical restraint devices as a clinical scenario dictates.

Under the *Mental Health Act 2000,* the Director of Mental Health is responsible for the oversight of all episodes of mechanical restraint within authorised mental health services.

Chapter 4A, Part 1 of the *Mental Health Act 2000* states that a mechanical appliance used for mechanical restraint must be approved by the Director of Mental Health and includes a restriction of the authorisation time period for mechanical restraints (three hours) to ensure regular clinical review of the utility of the restraints.

Chapter 13 of the Safety and Security in Authorised Mental Health Services of the *Mental Health Act 2000* Resource Guide (2013) contains a definition of mechanical restraint, approved mechanical appliances, authorisation process, legislative principles, requirement for authorisation and reporting requirements.

Chapter 13 of the Resource Guide also provides that if the Clinical Director of a Mental Health Service considers an alternative mechanical appliance needs to be applied to prevent injury to a patient or someone else, the Clinical Director must immediately contact the Director of Mental Health to seek approval to use the alternative appliance. The Director of Mental Health will then determine whether the alternative mechanical appliance is approved, having regard to the individual circumstances of the case. Such approval will only apply to that individual for the period specified by the Director of Mental Health, based on the clinical information provided.

The Mental Health Act 2000 Resource Guide is subject to ongoing review to ensure its appropriateness. This includes reconsidering the specific restraint appliances authorised, and is based on further investigation of national and international evidence regarding the use of mechanical restraints and the appropriateness of their use in mental health crisis situations.

A review of mechanical restraint appliances in use within other Australian jurisdictions shows the following are used:

- NSW - belts, harnesses, manacles, sheets, straps and mittens.
- VIC - canvas blankets, ankle and wrist restraints.
- WA - ankle and wrist restraints.
- NT - do not use mechanical restraint.
- SA - hard (leather) and soft (cotton and velcro) ankle and wrist restraints, but only in Emergency Departments.
- ACT - do not use mechanical restraint.

While the *Mental Health Act 2000* Resource Guide is needed, it is important to remember that in all clinical situations, timely provision of expert clinical care and responsiveness to prevent development and escalation of risk should be the primary focus in reducing harm towards people with an alteration in their mental health or with a mental illness.

The application of various mechanical restraint devices and the monitoring of this by the Director of Mental Health is part of an ongoing quality assurance process subject to regular and ad hoc review as clinically indicated.

Inquest into the death of Roslyn Amelia Law

Roslyn Law died on 23 July 2010 at the Princess Alexandra Hospital from severe head injuries she sustained in a car accident outside Dalby two days earlier. Ms Law was the passenger in a car which collided with a herd of stray cattle that had escaped a property adjoining the Dalby-Cooyar Road.

Brisbane Coroner John Lock delivered his findings on 1 March 2012.

Recommendation 1

It is recommended the Queensland Law Reform Commission review its recommendations of the 1977 working paper concerning the abolition or retention of the rule in *Searle v Wallbank* with respect to the civil liability of owners or occupiers for damage caused by animals straying upon highways and what should be put in its place, and otherwise make such recommendations for change as it considers appropriate.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Justice and Attorney-General

The Government has recently considered whether the rule in *Searle v Wallbank* should be changed. There are strong arguments both for and against keeping the rule. On balance, however, where it is foreseeable that the abolition of the rule would impose new and additional burdens on rural landholders, and create uncertainty as to whether or not particular properties should be fenced, the government is not persuaded that there should be any change.

Recommendation 2

It is recommended that the Queensland Police Service ensure there is performed full alcohol and drug testing of all potentially culpable surviving drivers involved in motor vehicle accidents where serious injuries or deaths occur. This may require amendments to both policy and legislation.

Response and action
Not agreed and not being implemented
Responsible agency: Queensland Police Service

The Queensland Police Service acknowledges the current legislative and policy framework does not allow full alcohol and drug testing for every surviving driver involved in a traffic crash resulting in serious injury or death.

Currently, alcohol testing can be carried out through breath or blood analysis, and drug testing through blood or saliva analysis.

Generally, breath, blood and saliva specimens for analysis can only be taken:

- from a driver who has tested positive on a roadside breath test or roadside saliva test (sections 80(2) and 2(A) *Transport Operations (Road use Management) Act 1995 (TORUM Act*)), or fails to provide a specimen of breath or saliva for a roadside breath test or roadside saliva test

- if a driver is at hospital for treatment and such requirement is approved by a doctor (*TORUM Act*, sections 80(8C) and 80(10))

- if a driver has been arrested for an offence of driving while under the influence of a liquor or a drug where the person has displayed indicia consistent with alcohol/drug use (*TORUM Act*, section 79).

Blood specimens can also be taken if:

- a driver has supplied a specimen of breath or saliva for analysis and the results are inconsistent with indicia displayed by the person (*TORUM Act*, section 80(9))

- a driver has not provided a sufficient sample of breath or saliva for analysis (*TORUM Act*, sections 80(8L) and (8M)).

The effect of these provisions is that in most cases involving serious traffic crashes, a driver will only be tested for the presence of alcohol and drugs by requiring a blood specimen if it is approved by a doctor.

While the Queensland Police Service is of the view that the legislation could be changed to make it easier for police to obtain a blood specimen from drivers involved in serious traffic crashes, the Queensland Police Service does not believe there is sufficient evidence to justify such a move or that it would improve traffic safety outcomes.

The Queensland Police Service has considered the contents of section 5.7 of the Queensland Police Service *Traffic manual* which requires police officers investigating traffic crashes to breath test all drivers of motor vehicles involved in a traffic crash.

While evidence suggests most police do make appropriate requirements under section 80 of the *TORUM Act* where permitted, section 5.7 of the *Traffic manual* has been amended to provide that where a traffic crash results in a person being seriously injured or killed, all surviving drivers should, if a specimen of blood is obtained, also be tested for the presence of drugs in their blood in accordance with the relevant provisions of the *TORUM Act*.

It is not possible to conduct a saliva drug test on drivers involved in traffic crashes because of the current centralised testing model adopted by the Queensland Police Service. Due to its specialised nature, saliva drug testing is only conducted by the Roadside Drug Testing Unit located in Brisbane, which performs operational enforcement support to police regions statewide.

The Queensland Police Service does not propose to change this model in the foreseeable future.

Inquest into the death of Brett Alexander Kevin McKenzie, Abigail Denise Ezzy, Nicholas James Nolan and Maxwell Ernest Thorley

On the evening of 5 January 2008, four young friends died in a car accident on the Cunningham Highway north of Warwick. The Honda sedan they were travelling in attempted a u-turn from the northbound lane of the highway but unexpectedly came to a halt directly in the path of a B-Double semi trailer and the two vehicles collided.

Coroner Tina Previtera delivered her findings on 3 April 2012.

Recommendation 1

In a recent inquest into the death of Roslyn Amelia Law, the Brisbane Coroner recommended "that the Queensland Police Service ensure there is performed full alcohol and drug testing of all potentially culpable surviving drivers involved in motor vehicle accidents where serious injuries or deaths occur. This may require amendments to both policy and legislation." I repeat that recommendation.

Response and action
Not agreed and not being implemented
Responsible agency: Queensland Police Service

The Queensland Police Service acknowledges the current legislative and policy framework does not allow full alcohol and drug testing for every surviving driver involved in a traffic crash resulting in serious injury or death.

Currently, alcohol testing can be carried out through breath or blood analysis, and drug testing through blood or saliva analysis.

Generally, breath, blood and saliva specimens for analysis can only be taken:

- from a driver who has tested positive on a roadside breath test or roadside saliva test *Transport Operations (Road use Management) Act 1995 (TORUM Act*), sections 80(2) and 2(A)), or fails to provide a specimen of breath or saliva for a roadside breath test or roadside saliva test

- if a driver is at hospital for treatment and such requirement is approved by a doctor (*TORUM Act*, sections 80(8C) and 80(10))

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While the Queensland Police Service is of the view that the legislation could be changed to make it easier for police to obtain a blood specimen from drivers involved in serious traffic crashes, the Queensland Police Service does not believe there is sufficient evidence to justify such a move or that it would improve traffic safety outcomes.

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It is not possible to conduct a saliva drug test on drivers involved in traffic crashes because of the current centralised testing model adopted by the Queensland Police Service. Due to its specialised nature, saliva drug testing is only conducted by the Roadside Drug Testing Unit located in Brisbane, which performs operational enforcement support to police regions statewide.

The Queensland Police Service does not propose to change this model in the foreseeable future.

Inquest into the death of Timothy John Wall

Timothy John Wall died on 31 October 2010 from severe head injuries he sustained the previous night when he was walking across a road and was hit by a motorcyclist.

Coroner John Lock delivered his findings on 5 April 2012.

The circumstances arising from the death of Mr Wall were, at the time of publication of this report, subject to criminal proceedings. Therefore a government response to this matter is not appropriate at this time. Mr Wall's inquest will reappear in next year's report, and should court proceedings be finalised by that time, a detailed Government response will follow.

Inquest into the death of Tony William Gates

Tony Gates died overnight between 5 August 2010 and 6 August 2010 while an inmate at the Wolston Correctional Centre. He died due to acute myocardial infarction caused by extensive underlying undiagnosed coronary atherosclerosis.

Acting State Coroner Christine Clements delivered her findings on 19 April 2012.

Comment 1, page 8

It was of some concern that the registered nurse on pill parade expressed frustration about the documentation process stipulated by Offender Health Services. On my understanding of her evidence, the issue of any pain relief is now supposed to be documented, and referred for approval to the medical centre. The registered nurse said her experience in attempting to comply with this process was it was unworkable and unable to be complied with, within the time constraints of prison scheduling.

I consider this is a matter that should be reviewed by Offender Health Services.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Health

On 1 July 2012, independent hospital and health services were established in Queensland in line with the Government's commitment to more localised ownership of healthcare decisions. Accordingly, responsibility for offender health transitioned from the Offender Health Services Unit of Queensland Health to each hospital and health service where offender health services are geographically located. Copies of previous Offender Health Services policies were provided to hospital and health services for the purposes of transition but are now the responsibility of each hospital and health service to adopt or amend as part of their local policies and procedures.

Queensland Health wrote to each hospital and health service with responsibility for offender health services to draw their attention to the Coroner's comments in this case and requested they review their local policies and procedures accordingly.

Hospital and health services will review their local procedures and report outcomes of that review back to the Queensland Health.

Comment 2, page 8

I also consider Corrective Services should review their arrangements for supervision within the worksites at Wolston Correctional Centre. The inmates had created their own physical training equipment and environment in an apparently unsupervised place or period of time within

the prison. In Mr Gates' case, it is possible this unsupervised unusual physical exertion may have triggered the fatal event. It of course must be understood the level of undetected coronary atherosclerosis was the primary cause of his death and many people in the broader community suffer similar sudden deaths. His death could have occurred at any time.

Response and action
Agreed and implementation is complete
Responsible agency: Department of Justice and Attorney-General (the machinery of government arrangements in November 2013 saw Queensland Corrective Services transition from the Department of Community Safety to the Department of Justice and Attorney-General)

On 27 April 2012, following receipt of the Coroner's findings, advice of the findings and recommendation was forwarded to correctional centres to remind them to be diligent in their supervision of prisoners and not allow the construction of any unauthorised exercise or weight training equipment.

Further on 9 May 2012, the Department of Community Safety asked secure centres to provide advice to:

- confirm that there are no makeshift or genuine physical training equipment permitted in worksite areas within the centre
- advise what supervision processes and safeguards in place or intended to attempt to prevent similar situations occurring
- advise the searching regimen within worksite areas at the centre.

Correctional Centres, including Wolston Correctional Centre, reviewed arrangements for supervision within worksites and provided acceptable responses to which the comment was directed.

The matter was reviewed by the Queensland Corrective Services Incident Oversight Committee on 10 July 2012 and the Committee determined to endorse the completion of this recommendation.

Inquest into the death of a child referred to as 'S'

'S', a 10 year old child, died on 7 February 2009 as a result of being struck by a car after she ran away from the Rockhampton Lifestyle Solutions residential care complex.

Coroner Annette Hennessy delivered her findings on 22 May 2012.

Recommendation 1

That the Department [of Communities, Child Safety and Disability Services] review its processes in placing a child in residential care outside of a service agreement, including that a management plan be developed between the department and residential care facility to closely monitor the child's progress especially during the period before the first departmental review of the placement and that be put in place prior to the placement of the child.

Response and action
Agreed and implementation is complete
Responsible agency: Department of Communities, Child Safety and Disability Services

The Department of Communities, Child Safety and Disability Services (the department) reviewed processes in the *Child safety practice manual*, and amendments to existing procedures were included in the revised *Child safety practice manual* released on 8 July 2013.

The new content strengthens requirements for assessing the placement option best able to meet and respond to a child's needs and the need for monitoring progress especially during the period before the first placement review. Additional guidance for staff is provided in relation to legislative requirements (*Child Protection Act 1999* section 84) involving the development of a written agreement between the department and the approved carer for the child's care, when a child is being placed. This relates to all children, including those younger than 12, being placed in a residential setting and also where placements are made outside of the scope of the service agreement.

Case planning processes require regular contact with any child in out-of-home care and include monitoring progress in the placement.

Recommendation 2

That the Department [of Communities, Child Safety and Disability Services] develop a field in the Information and Case Management System (ICMS) which records any past conflict or relationship issues between other children and/or past carers which is easily accessible by Child Safety Officers and Placement Services Units for reasons including placement decisions.

Response and action
Agreed and implementation is complete
Responsible agency: Department of Communities, Child Safety and Disability Services

The Department of Communities, Child Safety and Disability Services (the department) has implemented this recommendation. The functionality of the department's Information and Case Management System (ICMS) has been expanded to record past conflict or relationship information between a child client and other children and/or past carers. This will enable departmental officers to ascertain if there has been any concerns around conflict in a past or current placement.

The department has also reviewed its referral processes and procedures to strengthen consideration of a child's past conflict/relationship issues in a placement. These actions include:

- Development of a draft placement support unit referral form to specifically record details of past conflict between children and strategies used to manage the conflict.

- Revisions to current procedures were included in the revised *Child safety practice manual* released on 8 July 2013 to strengthen requirements to gather information and take into account past conflict/relationship issues between children when assessing the placement option best able to meet and respond to a child's needs and when completing a placement agreement.

Recommendation 3

That the Department [of Communities, Child Safety and Disability Services] review its processes concerning seeking feedback from carers following a placement and implement a mechanism for feedback by providing carers with a feedback sheet which is stored in a place easily accessible for staff to relay information to future carers and in order to take that information into account for future placements of the child.

Response and action
Agreed and implementation is complete
Responsible agency: Department of Communities, Child Safety and Disability Services

The processes for seeking feedback from carers at the conclusion of a placement were reviewed. Actions completed include:

- The foster carer agreement was reviewed, as part of the Department of Communities, Child Safety and Disability Services' May 2012 ICMS release, to improve functionality and enable the identification of learning and support needs consistent with information gathered (including from the Conclusion of placement form) – for example capacity, health, development needs, or support needs following a particularly challenging placement.

- A practice skills development workshop was developed and made available to departmental staff in April 2013 with the aim of enhancing departmental compliance with legislative information provision requirements, including the importance of gathering and providing to carers all available child information and the timely completion of placement agreements for all placements.

Recommendation 4

That the Department [of Communities, Child Safety and Disability Services] review its processes concerning reporting requirements by both home based carers and care facilities as to events occurring throughout the placement and reporting processes be streamlined in both instances.

In particular for care facilities, in addition to the initial phase of operations there should be regular audits by the department of the existence of appropriate policies and procedures and compliance with best practice models for internal communications, communications with the department and staff training to deal with complex behaviours and critical incidents.

Response and action
Agreed and implementation is complete
Responsible agency: Department of Communities, Child Safety and Disability Services

The Department of Communities, Child Safety and Disability Services' (the department) review of processes concerning reporting requirements and information provided to carers and residential care staff is complete.

A key action was to revise the Positive Behaviour Support carer training (Module 5) (http://www.communities.qld.gov.au/childsafety/foster-care/carer-training/foster-carer-training/standard-training) and promote this training for residential care staff as well as all foster carers, in August 2012. This training provides education on the department's positive behaviour support policy and requirements in relation to reporting.

The Positive Behaviour Support Policy (available at http://www.communities.qld.gov.au/resources/childsafety/foster-care/positive-behaviour-support-604.pdf) promotes the use of positive behaviour responses to all children and young people in out-of-home care. The policy requires approved carers and residential care staff to:

- Report the use of 'reactive responses' (for example, temporary physical restraint, removal of harmful objects) and details of the circumstances in which it occurred to the Child Safety Service Centre of Child Safety After Hours Service Centre within 24 hours of the incident occurring.

- Immediately report the use of any 'prohibited practice' (for example, confinement, corporal punishment) in relation to a child in out-of-home care to the Child Safety

Service Centre or Child Safety After Hours Service Centre. The matter is then responded to in accordance with the departmental policy Assessing and Responding to Matters of Concern.

Since March 2013, Care Facilities are required to be certified under the Human Services Quality Framework prior to applying for, or renewing a case service licence. This includes an external audit that includes, amongst other things, policies and procedures for reporting to the department, internal communication and staff training. This audit determines if the facility meets regulated and departmental requirements. The department regularly provides facilities with its reviewed policies and procedures so that they can update their practices. Licensed facilities must participate in quarterly licence monitoring including an unannounced site visit each year. In addition, Child Safety officers have regular contact with young people placed in licensed care facilities. The frequency of these visits is determined by the young person's case plan goals at the time.

Recommendation 5

That the Department [of Communities, Child Safety and Disability Services] ensure that as part of their supervision of Child Safety Officers, team leaders or other appropriate personnel must review investigations undertaken of kinship care options and the timeframes set for renewed enquiries in that regard.

Response and action
Agreed and implementation is partially complete
Responsible agency: Department of Communities, Child Safety and Disability Services

The Department of Communities, Child Safety and Disability Services (the department) is undertaking a kinship care project that aims to improve the use of kinship care, including practices in relation to reviewing a child's placement and re-exploring kinship carer options at regular intervals.

The program description for kinship care defines the kinship care program in Queensland and specifies the elements that ensure it is effective and responsive to children's needs.

Current procedures in the *Child safety practice manual* regarding re-examining kinship care placement options at regular intervals have been strengthened in the revised *Child safety practice manual* released on 8 July 2013.

In addition, the kinship care initial and renewal assessment reports were revised and new user guidelines developed. These practice resources were made available in the release of the *Child safety practice manual* on 8 July 2013.

An evidence-based literature review on kinship care (available at http://www.communities.qld.gov.au/resources/childsafety/foster-care/kinship-care-literature-review.pdf) was completed and informed the development of a departmental operational policy and program description. The kinship care policy (http://www.communities.qld.gov.au/

resources/childsafety/foster-care/kinship-care-632.pdf) and program description (http://www.communities.qld.gov.au/resources/childsafety/foster-care/pd-kinship-care.pdf) became effective on 20 December 2012. These resources are available for internal staff and external stakeholders on the department's website.

The revised procedures were included in the *Child safety practice manual* released on 8 July 2013.

The final kinship care project deliverable is the development of a kinship care practice skills development workshop of approximately three hours duration that will target frontline Child Safety officers. The workshop will focus on the department's partnership with kinship carers and will aim to enhance the practice of engaging with, and supporting, kinship carers.

Recommendation 7

That the Queensland Police Service ensure all officers acting as District Duty Officer or equivalent have completed Incident Command Training prior to acting in such positions if possible but at least that officers have completed the SAP module preparatory to such training.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

In July 2013, the Queensland Police Service introduced a policy which requires all district duty officers to complete an approved incident command course, including those officers that perform district duty officer duties on a temporary basis. The incident command course consists of face-to-face training between two to ten days duration. If it is not practicable for an officer to complete an approved incident command course, an officer performing duties on a temporary basis should complete the Incident Command Competency Acquisition Program module until such time as they complete the incident command course. The Queensland Police Service also progressed changes to the district duty officer position description which makes completion of an approved incident command course a desirable criteria.

Recommendation 8

That the Queensland Police Service revise the Operational procedures manual (OPM) section 12.5 and 17.5 (including the Risk Assessment Guidelines) and map the Rockhampton Search and Rescue Standard Operating Procedure (SOP) against it to ensure:

(i) the management of medium risk incidents are more clearly articulated, including when an incident should be escalated to a high risk

(ii) the relevant procedures are consistent with each other (SOPs with the OPMs)

(iii) the relevant Queensland Police Service officers responsible for managing patrols to locate a missing person, rather than a full scale search, have the necessary training to coordinate the patrols and manage the incident in an efficient manner.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Coroner's recommendation relates to the Rockhampton Criminal Investigation Branch Search and Rescue (SAR) Standard Operating Procedure which has subsequently been cancelled. Since 14 August 2008, Rockhampton Police District utilise the search and rescue plan for Yeppoon SAR area as the guiding document for the local police response to search and rescue incidents including marine incidents or land searches. Land searches include lost or missing persons or vehicles.

The Queensland Police Service revised sections 12.5 and 17.5 of the Queensland Police Service *Operational procedures manual* against the search and rescue response plan, resulting in amendments to the plan, including:

(i) explicit mention of missing children within the scope of SAR incidents

(ii) warning that a missing child should be treated seriously and expeditiously from the outset

(iii) reference to sections 12.5.1 and 17.5 of the *Operational procedures manual* which includes the 'Risk assessment guidelines for missing persons' in appendix 12.2

(iv) requirement for the responding officer to advise a SAR trained officer and the Regional 'on-call' Commissioned Officer in all cases

(v) requirement for the responding officer to complete a search urgency assessment form for all SAR incidents. This form involves scoring various profiles of the incident, with the total score indicating whether the police response should be an emergency response, measured response or routine.

In regards to managing incidents such as missing persons generally, the Queensland Police Service implemented mandatory incident command training for district duty officers. Where practicable, officers performing district duty officer duty within the Rockhampton District have undertaken formalised incident command training.

Recommendation 9

That the Queensland Police Service consider obtaining a facility to permit triple-zero calls to be monitored, and if appropriate, be joined by persons other than the call taker.

Response and action
Agreed and implementation is complete with ongoing implications
Responsible agency: Queensland Police Service

The Brisbane Police Communications Centre and other major communication centres, including Rockhampton Police Communications Centre, currently have the capacity for a supervisor/third party to monitor (and join) triple-zero calls in 'real time', for quality assurance purposes and ensuring an appropriate emergency service response is initiated in a timely manner.

In addition, the Queensland Police Service introduced a new computer aided despatch system to all major communications centres statewide including Rockhampton Police Communications Centre in 2012-13. In the future, this will have the added functionality of storing all recorded triple-zero calls in the relevant computer aided dispatch job record.

Recommendation 10

That the Queensland Police Service revise its communication procedures between the District Duty Officer (DDO) and the Communications Coordinator ('Comco') to ensure each know the status of the job, including the areas being patrolled and the areas to be patrolled and requiring the Comco to consult with the DDO before re-allocating resources from an incident managed by the DDO to another job.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

It is already an established practice in many areas of the state for communication coordinators to liaise with district duty officers in regards to the status and prioritisation of job taskings.

However, to ensure a consistent statewide approach, the Queensland Police Service reviewed its *Operational procedures manual* and identified possible amendments to ensure liaison occurs between district duty officers and communication coordinators. In particular, communication coordinators will be required to consult with the relevant District Duty Officer prior to re-allocating crews to other job tasks wherever possible.

Amendments were published to the Queensland Police Service *Operational procedures manual* in July 2013, section 17.5.3. states the duty officer or officer in charge of the police communications centre should advise the relevant district officer, patrol group inspector or regional duty officer regarding a search for a missing person, and that officer advised will assume overall command of the search and rescue operation.

Recommendation 11

That the Queensland Police Service increase the frequency of the broadcasts of BOLFs [be on lookout for alerts] in searches for missing persons who are classed as 'known vulnerability' such that broadcasts are sufficient in the circumstances to inform the greatest possible number of officers of the information.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service proposes to amend its policy relating to missing persons contained in s.12.5.2 of the Queensland Police Service *Operational procedures manual.* Among other requirements, the shift supervisor/district duty officer is to ensure dissemination of information has been arranged including police radio broadcasts of be on the lookout for alerts (BOLFs) and media releases, and where the missing person occurrence involves a known vulnerability, ensure the frequency of police radio broadcasts of BOLF is increased to such that they are sufficient in the circumstances to inform the greatest possible number of officers of the information. A 'known vulnerability' includes a child.

The Queensland Police Service *Operational procedures manual*, section 12 was revised and the amended version was published in July 2013. It required the officer receiving the report of a missing person (amongst other matters) to enter a missing person report into the Queensland Police Service QPRIME system,and additionally to assign a 'be on the look out' task to be sent to relevant police stations in areas the missing person is likely to go to. The district duty officer, shift supervisor or patrol group inspector is to be advised of the occurrence of a missing person to enable a review of the occurrence and ensure appropriate action is taken. The local search and rescue mission coordinator is to be advised where the missing person is of 'known vulnerability.

Section 12.4.2 of the *Operational procedures manual* requires the district duty officer, patrol group inspector or regional duty officer to advise the OIC of the local CIB where the missing person is of 'known vulnerability'. Additionally, in such cases consideration must be given to urgent release of information to the public through the media or other appropriate means.

Recommendation 12

That the Department [of Communities, Child Safety and Disability Services] consider developing an audit tool for examining policies and procedures, internal communication, communication with the department and staff training of a start up organisation which could be used by the CTMS in the initial phases of the commencement of a residential facility (e.g. monthly site visits to conduct an audit by CTMS until the review of the licence application is undertaken by the independent assessor).

Response and action
Agreed and implementation is complete
Responsible agency: Department of Communities, Child Safety and Disability Services

In February 2013 the Department of Communities, Child Safety and Disability Services (the department) introduced the *Human services quality framework*.

Organisations providing care services must undergo an external audit against the *Human services quality standards* and achieve certification under the *Human services quality framework* by a Joint Accreditation System of Australia and New Zealand (JAS-ANZ) accredited certification body prior to applying for a licence. This allows the department to ensure that the policies and procedures in place in the organisation meet legislative and departmental requirements.

Under the newly introduced organisation level licensing, new services which are provided by an existing licensed organisation, can be added to a licence. This involves an inspection using the department's monitoring tool and can be undertaken once a service has commenced. As the *Human services quality framework* consists of a three year audit cycle which includes a certification audit and a mid-term maintenance audit at 18 months, new services added to a licence will undergo regular departmental inspections until the next scheduled *Human services quality framework* audit. This process will ensure new services are effectively incorporated into the department's monitoring regime and added to the scope of Human Services Quality Framework audits.

The need for any additional audit tools in the initial phases of the commencement of a residential care facility will be considered in light of these changes.

Inquest into the death of Anthony Mark Perry

In the early hours of 23 March 2010, Anthony Perry died in the Rockhampton watch-house, five hours after he had been taken into custody. Mr Perry died accidentally as a result of respiratory depression caused by self administered alcohol and drugs.

The then-State Coroner, Michael Barnes, delivered his findings on 31 May 2012.

Recommendation 1 - mixed alcohol and drug intoxication

A high proportion of watch-house prisoners are affected by alcohol, prescription drugs or a combination of those substances. Determining whether a prisoner who appears intoxicated may also be affected by a drug other than alcohol is difficult but important because combining drugs may make them more dangerous. To assist officers in this regard I recommend the Health Questionnaire be reviewed with a view to including separate questions about the ingestion of each of those substances and the inclusion in Appendix 16.12 of the Operational procedures manual of a list of clues or signs that indicated drugs other than alcohol might be responsible for the symptoms a prisoner is displaying.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Police Service

The Queensland Police Service State Watch-house Coordinator conducted an extensive review of watch-house policies and related police QPRIME computer system requirements in consultation with the Director, Clinical Forensic Medicine Unit, Queensland Health, and Executive Manager (Clinical Standards and Quality), Queensland Ambulance Service.

As part of this review, the risk management (health) questions for the initial assessment of persons entering into watch-house custody were revised and re-written. The changes include separate questions regarding alcohol and drug use.

In addition to asking separate health questions, the charging officer must record five observations and conduct voluntary tests for blood alcohol concentration (breath) and blood sugar levels.

If based on this assessment, the officer forms a 'reasonable suspicion' with regards to the prisoner's health status, the officer is to seek a professional healthcare assessment.

Where a professional healthcare provider has deemed a person fit to be held in custody but has recommended close observation, the person is to be monitored and assessed in accordance with a modified Glasgow Coma Scale every 30 minutes for the first four hours after the initial assessment.

The changes to the risk management (health) area in QPRIME also include full details of care plans, timings of when healthcare professionals where notified, and a visual guide to injuries.

The Director, Clinical Medicine Unit, has discussed the new screening and assessment measures with the former State Coroner who is satisfied the changes will address the recommendation.

The Queensland Police Service QPRIME changes took effect in June 2013 and will be reflected in Chapter 16 of the Queensland Police Service Operational procedures manual.

Recommendation 2 - replacement of the Closed-circuit television (CCTV)

In view of the important role CCTV plays in monitoring prisoners and investigating incidents that inevitably occur in watch-houses, more up to date and reliable equipment than that presently in use in the Rockhampton watch-house is highly desirable. Accordingly, I recommend the Queensland Police Service give priority to its replacement.

Response and action
Agreed and implementation is under consideration
Responsible agency: Queensland Police Service

On 6 February 2007 the previous Government announced a commitment to fund the upgrade of closed circuit television (CCTV) equipment in police stations and watch-houses in Queensland Deed of Grant in Trust (DOGIT) communities. It was further announced that the Commissioner of Police would conduct an audit of surveillance facilities in all 24-hour watch-houses to determine scope and costs with upgrading these facilities from analogue to digital MPEG-4 technology. The audit identified 45 24-hour watch-houses that required upgrading.

A Digital Video Recorder CCTV system is currently installed in the Rockhampton Watch-house. The upgrade of the system at Rockhampton is number 29 on the statewide priority list of the CCTV upgrade program and dependent upon future budget allocations, it is anticipated that the upgrade will be completed in 2015-16.

Recommendation 3 - advising family members

It seems the Queensland Police Service's policies relating to how the relatives of a person who dies in custody are advised of the death may not have been complied with in this case. Because those concerns were raised for the first time at the inquest the responses or explanations of the officers involved could not be sought. Accordingly, I recommend an appropriate officer within the Central Region ensure that all officers stationed in Rockhampton are reminded of the importance of these policies.

Inquest into the death of Anthony Mark Perry

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

On 14 June 2012 the District Officer of Rockhampton Police District disseminated an email throughout the district reminding officers of their obligations under section 16.24.3 of Commissioner's Circular 9/2009: 'Additional responsibilities of officers investigating deaths in police custody'. This section provides that investigating officers as part of their investigation into a death in police custody are to immediately arrange for the next of kin, previously nominated by the deceased, to be notified.

Inquest into the death of Antony Way, Tania Simpson, Kyla Rogers and Paul Rogers

On the evening of 15 May 2011, Tania Simpson and Antony Way were killed by Ms Simpson's estranged partner, Paul Rogers, at Ms Simpson's home on the Gold Coast. Mr Rogers then abducted he and Ms Simpson's five year old daughter, Kyla, eventually taking her to Piora in northern New South Wales, where Mr Rogers asphyxiated Kyla before taking his own life.

The then-State Coroner, Michael Barnes, delivered his findings on 21 June 2012.

Recommendation 1

Having regard to the number and proportion of homicides associated with domestic and family violence and the limitations of current policing an intervention models to prevent them, I recommend the Departments of Communities, Justice and Attorney-General and Police continue to fund the Domestic and Family Violence Death Review Unit so that intensive, expert scrutiny of all aspects of these deaths can better inform the responses of the relevant agencies.

Response and action
Agreed and implementation is complete
Responsible agencies: Joint response by the Department of Justice and Attorney-General (lead), the Department of Communities, Child Safety and Disability Services and the Queensland Police Service

In 2011 the Office of the State Coroner established the Domestic and Family Violence Death Review Unit on a trial basis. The unit was to examine domestic and family violence related deaths from a systemic perspective and identify opportunities to prevent these deaths.

In October 2012, an interdepartmental review of the Domestic and Family Violence Death Review Unit was undertaken by the Departments of Communities, Child Safety and Disability Services and Justice and Attorney-General and the Queensland Police Service. Based on the results of the review and in alignment with the Coroner's recommendation the Departments of Communities, Child Safety and Disability Services and Justice and Attorney-General agreed to permanently establish a death review process within the Office of the State Coroner by jointly funding a Principal Researcher and Coordinator Domestic and Family Violence Death Review position. The position was established permanently in January 2013. The Queensland Police Service has also agreed to provide a resource to the Office of the State Coroner to support the death review process.

The Department of Communities, Child Safety and Disability Services has negotiated with the Centre for Domestic and Family Violence Research based at Central Queensland University to provide expert advice and information to support the death review process. This is reflected in the new service agreement with the Centre for Domestic and Family Violence Research which commenced on 1 May 2013. A formal agreement between the Centre for Domestic and Family

Violence Research and the Office of the State Coroner will be reviewed within 12 months of its commencement to consider the effectiveness of the arrangement.

Recommendation 2

I recommend that officers of the Queensland Police Service Domestic and Family Violence Unit liaise with the officers of the Office of the State Coroner Domestic and Family Violence Death Review Unit to review the categorisation of some of the risk factors contained in the protective risk assessment framework and that they apply the assessment tool to the circumstances of the domestic and family fatalities reviewed by the Domestic and Family Violence Death Review Unit to ascertain whether it is likely to have prompted first response officers to have effectively intervened.

Response and action
Agreed and implementation is complete
Responsible agencies: Department of Justice and Attorney-General (lead) and the Queensland Police Service

The Queensland Police Service Domestic and Family Violence Unit liaised with the Office of the State Coroner Domestic and Family Violence Death Review Unit in regards to the Queensland Police Service's domestic violence protective assessment framework ('the framework') and the proposition of revising and or re-ordering the factors within the framework. The framework was released concurrently with the commencement of the new domestic violence legislation on 17 September 2012.

As a result of these discussions, the following outcomes were agreed:

- Officers are being trained to apply a 'structured professional judgement' to risk assessment; meaning although officers are to use the framework in conducting a protective assessment, it is still the officer's judgement of risk arising from a number of risk factors, including stalking. This approach allows for the officer to consider the level of risk involved and any other circumstances they believe are relevant, identifying the person in most need of protection and taking appropriate action.

- It is acknowledged that stalking was found to be a highly significant risk factor for predicting future risk for the victim. Stalking is identified as a risk factor in the framework and is considered by police when assessing immediate and future risk for victims. Ongoing consideration will be given to this risk factor and how the Queensland Police Service can better educate and inform officers in identifying and predicting future risk to victims.

- It is anticipated in the future the framework will be enhanced and modified in light of new research by relevant experts and mental health professionals, further inquests, feedback from front line officers and formal evaluation mechanisms to ensure the framework remains evidence based and reflective of good practice.

- The Domestic and Family Violence Unit approved the use of the framework to examine cases of domestic and family violence homicide by the Domestic and Family Violence Death Review Unit. The Domestic and Family Violence Death Review Unit use the framework to examine their caseload including retrospective analysis of past cases. The Domestic and Family Violence Unit are committed to regular meetings on a monthly basis with the Domestic and Family Violence Death Review Unit to discuss outcomes of reviews.

Recommendation 3

I recommend the officers of the Office of the State Coroner Domestic and Family Violence Death Review Unit liaise with the Department of Communities to consider whether the evidence presented to this inquest should inform public awareness campaigns about the risks posed by non-violent domestic and family violence.

Response and action
Agreed and implementation is complete
Responsible agencies: Department of Justice and Attorney-General (lead) and the Department of Communities, Child Safety and Disability Services

The evidence presented at the inquest was considered in the development of a new three-year Queensland Government domestic and family violence prevention campaign entitled 'Make the call'. The Department of Communities, Child Safety and Disability Services consulted with the Domestic and Family Violence Death Review Unit about the nature of the awareness raising campaign launched in April 2013 in support of domestic and family violence prevention month in May 2013.

The new social marketing campaign targets friends, family and colleagues of victims of domestic and family violence and is designed to increase awareness around non-physical forms of domestic violence such as controlling behaviours and stalking and to highlight the often high risk nature of these behaviours. The campaign encourages the target audience to seek advice about appropriate intervention to help prevent serious injury and death resulting from domestic and family violence.

The campaign commenced in April 2013 and its performance will be measured via a number of indicators over the period 2013-2015.

Inquest into the death of Jack Wallace MacNicol

Jack MacNicol died on 15 December 2007 in the Townsville Hospital after suffering serious head injuries in a motorbike accident two days earlier. Jack had been mustering cattle on a motorbike at his family's property, 20 kilometres south of Collinsville but was not wearing a helmet at the time of the accident.

Coroner Kevin Priestly delivered his findings on 29 June 2012.

Recommendation and comments, page 9

At the time of this hearing Workplace Health and Safety Queensland have published a draft for comment of amendments to the *Rural Plant Code of Practice 2004* ... The draft acknowledges the various uses made of motorbikes in that setting including mustering and imposes a requirement that an approved helmet be worn ...

While I acknowledge that Workplace Health and Safety Queensland had embarked on major programs for raising awareness about the need to wear helmets on motorbikes in the rural sector, I was concerned about the number of reported deaths associated with the failure to wear a helmet. The advisory nature of the requirement for young rural workers to wear helmets did not seem to be well appreciated in the sector. Ultimately, it is for Workplace Health and Safety Queensland (now Fair and Safe Work Queensland) to take a leadership position as regulator to determine whether it is advisable to wear helmets and regulate accordingly...

I have reviewed the proposed amendments to the *Rural Plant Code of Practice 2004* and having regard to the circumstances of this tragedy, the regulatory confusion afterwards in attempting to enforce a particular view, I have no hesitation in recommending promulgation of those amendments.

By way of comment pursuant to section 46 of the *Coroners Act 2003*, I recommend the introduction into law of the proposed amendments to the *Rural Plant Code of Practice 2004* requiring the wearing of helmets on motorbikes.

Response and action
Agreed and implementation is partially complete
Responsible agency: Department of Justice and Attorney-General

The proposed amendments to the *Queensland rural plant code of practice* were not progressed pending the development of the proposed *National model code of practice on managing risks of plant in rural workplaces*. The *National model code of practice* was endorsed in late 2012 by Safe Work Australia and requires duty holders to consider

appropriate protective equipment such as helmets when using farm vehicles such as motor bikes.

The Queensland Government's decision on the proposed model code of practice will be informed by consultation with key Queensland stakeholders to ensure we fully understand the impact on business if these codes are to be given effect in Queensland.

Inquest into the death of Ian Robinson, Natarsha Charlesworth, Georgina Hatzidimitriadis, Sang Won Park and Seongeun Choi

An inquest was held to investigate the adequacy of the regulatory framework in establishing minimum safety standards for commercial white water rafting operators. This inquest follows four other inquests held in 2010 which investigated the deaths of five people who have died between 2007 and 2009 whilst white water rafting on rivers in far north Queensland. On each occasion, the deceased became entrapped under the water and drowned after falling from their boat into the rapids.

Coroner Kevin Priestly delivered his findings on 29 June 2012.

Recommendation 1

I recommend that a Code of Practice be developed for commercial white water rafting operations under the *Safety in Recreational Water Activities Act 2011*. The Code of Practice be developed in consultation with the operators but as a minimum, it require the development of safe operational procedures specific to each set of rapids by conducting formal risk assessments identifying all hazards, selecting control measures appropriate to the unique attributes of each set of rapids that mitigates the risk to a defined acceptable level; and then periodically review the control measures for their effectiveness. The hazards, risks and workings of the control measures should be shown as an overlay on current maps of the rapids, as well as in text. Explanatory notes about relevant strategies should accompany the maps. Safety critical strategies should be highlighted. These documented procedures should be incorporated into training and auditing programs.

Response and action
Agreed in part and implementation is partially complete
Responsible agency: Department of Justice and Attorney-General

Based on consultation with the white water rafting industry groups in late 2011, it was agreed to progress this recommendation by amending the *Queensland activity adventure standard* as opposed to developing a separate code of practice.

The development of a code of practice was not supported by industry. In addition, the development of a code of practice does not meet the Government's red tape reduction strategy. There are no significant issues with not having a code of practice.

Guidance material (like the *Queensland adventure activity standards*) helps duty holders comply with the law by allowing duty holders wider discretion to choose the options that best suit their circumstances. Guidance material contributes to the overall state of knowledge regarding hazards, risks and controls and may also be tendered as evidence in court proceedings.

Workplace Health and Safety Queensland is working with Sport and Recreation Queensland (Department of National Parks, Recreation, Sport and Racing) to amend the *Queensland adventure activity standard* for river rafting.

A revised draft of the Queensland activity adventure standard was considered by the industry group in late April 2013 and an extension of time was requested by the white water rafting operators until mid August 2013 for further consideration.

Inquest into the death of Patient A

On 6 December 2009, a 49 year old man with a mental illness (referred to as Patient A in the inquest findings) hung himself at his home in Yandina after a deterioration of his illness. Patient A had been treated by the Adult Mental Health Community Assessment and Treatment Team in the weeks leading up to his death.

Brisbane Coroner John Lock delivered his findings on 5 July 2012.

Concluding comment, page 20

I comment that wherever possible, root cause analysis processes should be conducted such that relevant members of a treating team, if they wish to participate, are provided an opportunity to be interviewed and are provided with feedback as to the outcome of the root cause analysis.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

Queensland Health's Patient Safety Unit has taken a number of steps to reinforce the interviewing of staff as best practice in undertaking root cause analyses. The Patient Safety Unit has:

- Invited patient safety officers, managers of clinical governance/patient safety and executive directors of medical services from across the state to participate in a teleconference in July 2012 to clarify that all relevant staff should be identified and interviewed as part of a best practice root cause analysis (as described in training and support tools).

- Updated the root cause analysis report template in September 2012 to include a requirement to document numbers of staff identified and interviewed as part of a root cause analysis.

- Advised hospital and health service chief executives in January 2013 of the number of concerns raised by coroners during 2012 about the quality of root cause analyses and recommended each service review their local policies and practices in relation to conducting root cause analyses and other forms of incident analysis.

Inquest into the death of Angus William Keith Ferguson

On 6 March 2011, Angus Ferguson died from injuries he sustained when he crashed his motorcycle on Duporth Avenue in Maroochydore. Mr Ferguson was 18 years old. The State Coroner found that immediately prior to the crash, Mr Ferguson was probably attempting to evade a police vehicle that was attempting to intercept him for a traffic violation.

The then-State Coroner, Michael Barnes, delivered his findings on 22 August 2012.

Concluding comment, pages 11-12

The inquest heard several aspects of the communication between police officers and Mr Ferguson's parents were less than optimal.

I have considered whether changes should be made to Queensland Police Service policy to better delineate the role of a family liaison officer. I am wary though of being too prescriptive in describing or setting requirements for a role that must be adapted in every case to the enormously varying factors that are involved in the manner of a death and the ways in which the deceased's loved ones may wish to interact with the Queensland Police Service.

I trust the Queensland Police Service will re-focus on the need to effectively communicate with bereaved families without the need for me to make a formal recommendation.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service acknowledges the Coroner's comment regarding 'regrettable problems' with matters of family liaison by an officer from North Coast Region in the early stages of the investigation.

The Ethical Standards Command has been made aware of the Coroner's comment and the relevant provisions of Queensland Police Service policy contained in Commissioner's Circular 19/2009 relating to the investigation of deaths in police custody.

In particular, section 16.24.3 requires the investigating officer to liaise with the family of the deceased and provide such information as sought by the family and/or lawyers representing the family about the progress of the investigation and the preparation of the brief for the inquest. Under these arrangements, senior investigating officers from the Ethical Standards Command are primarily responsible for liaison with family members.

The Queensland Police Service considers that current policy is sufficient and does not require amendment.

Inquest into the death of Adam Cartledge

Adam Cartledge died on 5 October 2010 in his cell at the Arthur Gorrie Correctional Centre in Wacol where he was being held on remand. The State Coroner found that Mr Cartledge intentionally hanged himself.

The then-State Coroner, Michael Barnes, delivered his findings on 29 August 2012.

Concluding comment, page 13

As mentioned earlier, there are still 380 cells in use at the Arthur Gorrie Correctional Centre with exposed hanging points. This is contrary to the recommendations of the Royal Commission into Aboriginal Deaths in Custody, made 20 years ago and to numerous recommendations made by coroners.

The prison operators and Queensland Corrective Services say this is unavoidable: that all safer cells that have been built more recently are full and that the system could not function adequately without the unsafe cells being utilised. Queensland Corrective Services also says that many millions of dollars have been spent and will continue to be spent incrementally addressing the issue.

I acknowledge that progress has been made and that the proportion of unsafe cells has decreased. Of course, I readily accept that there is on-going competition for public funds and that it is the role of governments to balance those competing needs. Conversely, it is the role of coroners to point out the consequences of these decisions when they result in reportable deaths. Accordingly, I observe that preventable fatalities will continue to occur in Queensland correctional centres while prisoners continue to be housed in cells with readily accessible hanging points.

There is no recommendation to reduce this risk that I could make that has not been already made.

Response and action
Agreed and implementation is partially complete
Responsible agency: Department of Justice and Attorney-General (the machinery of government arrangements in November 2013 saw Queensland Corrective Services transition from the Department of Community Safety to the Department of Justice and Attorney-General)

Queensland Corrective Services is committed to a policy of replacing unsafe cells with suicide resistant facilities, and is progressively reducing the number of hanging points in Queensland correctional centres with the construction of new and refurbished correctional centres.

Funding of $19.5 million is provided in 2013-14 to continue the $33 million cell upgrade program to modify cells in the Arthur Gorrie Correctional Centre. Work commenced on site in January 2013 with completion expected in the 2014 calendar year.

Suicide reduction measures are in place in 90% of all secure cells.

The first stage of the Arthur Gorrie Correctional Centre cell upgrade program will provide a further 112 suicide resistant cells increasing the total percentage to 93% in the 2014 calendar year.

Following completion of stage one at the Arthur Gorrie Correctional Centre, 268 cells at the Arthur Gorrie Correctional Centre and 138 cells at Townsville Correctional Centre will remain to be modified.

Inquest into the death of Isabella Wren Diefenbach

Isabella Diefenbach, a seven week old baby, died on 29 May 2010 from head injuries after falling from her father's arms earlier that day as he stood on the verandah of their rented home. Mr Diefenbach lost his balance and subsequently lost hold of Isabella when his foot fell through a decking board on the verandah that had become significantly decayed.

Coroner Annette Hennessy delivered her findings on 19 September 2012.

Recommendation 1

That the Office of Fair Trading and relevant residential rental industry stakeholders (including the REIQ) review the current property management training program with a view to incorporating a component that provides property managers with an appropriate level of guidance about how to conduct a satisfactory inspection of decks, verandahs and stairs for property management purposes. This review should be undertaken with advice and input from entities including the Building Services Authority and Timber Queensland Ltd.

The review should also consider a revision of the training about what constitutes an emergency repair, with a view to identifying potential structural compromise due to the effects of wood rot and termite activity as clearly falling into this category of repair.

Response and action
Agreed in part and implementation is partially complete
Responsible agency: Joint response between the Department of Justice and Attorney-General (lead) and the Department of Housing and Public Works

The Government agrees that consideration be given to reviewing the current property management training program with a view to incorporating a component that provides property managers with an appropriate level of guidance about how to conduct a satisfactory inspection of decks, verandahs and stairs for property management purposes.

Under the *Property Agents and Motor Dealers Act 2000* property managers must complete certain training units to be issued a licence as a real estate agent, or registered as a salesperson. However, the Department of Justice and Attorney-General does not have any direct involvement in developing, reviewing, or approving the training units.

The national Construction and Property Services Industry Skills Council develops, manages and distributes nationally recognised training packages and associated training and assessment materials. The council represents the workforce training and skills development needs of the construction and property services industries.

Accordingly, the Attorney-General and Minister for Justice has written to the Construction and Property Services Industry Skills Council referring to the coronial findings and recommendations and asking that it consider incorporating into any

property management training package a component that provides property managers with an appropriate level of guidance about how to conduct a satisfactory inspection of decks, verandahs and stairs for property management purposes.

The Attorney-General has asked that the Construction and Property Services Industry Skills Council undertake its review with advice and input from the Building Services Authority and Timber Queensland Limited. The Attorney-General has also written to the Minister for Housing and Public Works asking for assistance from the Building Services Authority to be made available to the national Construction and Property Services Industry Skills Council when input is needed.

Additionally, many real estate agents undertake voluntary continuing professional development training.

Accordingly, the Department of Justice and Attorney-General has consulted with the Real Estate Institute of Queensland to request that it consider incorporating the relevant components into its continuing professional development courses for property management.

In relation to public sector housing, at state level, the Department of Housing and Public Works is a significant lessor with approximately 55,000 social housing properties. The Department of Housing and Public Works provides detailed property management training for staff.

In light of the recommendation, the Department of Housing and Public Works will review its property management training to ensure it provides property managers with an appropriate level of guidance about how to conduct a satisfactory inspection of decks, verandahs and stairs for property management purposes.

Recommendation 2

That the Office of Fair Trading and relevant residential rental industry stakeholders conduct an awareness campaign across the industry about the agreed minimum standards of inspection of decks, verandah and stairs for property management purposes and the need to actively consider potential structural compromise due to the effects of wood rot and termite activity as an emergency repair issue.

Response and action
Agreed and implementation is partially complete
Responsible agency: Joint response between the Department of Justice and Attorney-General (lead) and the Department of Housing and Public Works

The Government supports an education/awareness campaign for residential rental industry stakeholders. The aim is two-fold. Firstly, the education/awareness campaign aims to reinforce the importance of regularly and properly maintaining residential rental properties. Secondly, the education/awareness campaign aims to increase awareness

of tenants, property managers and owners about the importance of checking and maintaining decks, verandahs and stairs as a means of ensuring the safety of tenants. This will highlight what are routine and emergency repairs and the importance of considering wood rot and termite damage as a potential emergency repair issue.

A shared education/awareness campaign will be led by the Office of Fair Trading with input from the Residential Tenancies Authority, Building Codes Queensland and the Building Services Authority.

The awareness campaign will comprise the following key activities:

- updated web content on websites of the Office of Fair Trading, Building Services Authority, Residential Tenancies Authority and Building Codes Queensland
- updated web content on Queensland Government franchise sites (www.qld.gov.au, www.business.qld.gov.au)
- organisation of internal and external newsletter articles including *Smart business bulletin* and *Inside trading* for the Office of Fair Trading
- media releases
- social media messages
- editorial for submissions to external industry and consumer stakeholder newsletters.

The Residential Tenancies Authority has a number of existing information and education resources available on its website that promote lessor obligations for rental properties.

Currently, under the *Residential Tenancies and Rooming Accommodation Act 2008,* at the start of a tenancy lessors must ensure that they are not in breach of a law dealing with issues about health or safety of persons using or entering the premises. During a tenancy the *Residential Tenancies and Rooming Accommodation Act 2008* requires that the lessors must ensure that any law dealing with issues about the health or safety of persons using or entering the premises is complied with.

The Office of Fair Trading is developing the strategy/action plan, allocating responsibilities and determining deadlines. The Building Services Authority, Residential Tenancies Authority and Building Codes Queensland will continue to consult with the Office of Fair Trading during the development and implementation of the education/ awareness campaign.

Recommendation 3

That the department responsible for administering the *Building Act 1975* review the guideline Department of Local Government and Planning (DLGP) Use, Inspection and Maintenance of decks, balconies and windows (Sept 2010) with a view to incorporating guidance about the inspection

of decking boards for signs of deterioration that may compromise their structural integrity. This review should be informed with advice and input from entities including the Building Services Authority and Timber Queensland Ltd.

Further, that the reviewed guideline be brought to the attention of the building and real estate industries, local government authorities and, through them, landlords.

Response and action
Agreed and implementation is partially complete
Responsible agency: Department of Housing and Public Works

Building Codes Queensland commenced a review of the guideline *Department of Local Government and Planning use, inspection and maintenance of decks*, balconies and windows (September 2010) (guideline) and has also carried out initial meetings with the Building Services Authority and Timber Queensland Ltd. Both of these bodies provided technical guidance on suitable inspection practices for timber decking boards.

Building Codes Queensland intends to incorporate new information in the updated guideline on 'Decking board inspections' under Chapter 4 'Inspecting decks and balconies'. Building Codes Queensland will also update the guideline to align with recent building code changes.

The final draft guideline will be provided to the Building Industry Consultative Group for comment.

Building Codes Queensland will alert industry to the release of the updated published guideline via a building newsflash available to Building Codes Queensland subscribers. Building Codes Queensland will also notify peak bodies, such as the Australian Institute of Building Surveyors, Royal Institution of Chartered Surveyors, Master Builders Association, Housing Industry Association and Real Estate Institute of Queensland of the new published guideline, so that they may notify their members.

Further, Building Codes Queensland will seek the assistance of the Local Government Association of Queensland and Department of Local Government, Community Recovery and Resilience to announce the new guideline to local government via their regular circulars.

Recommendation 4

That the Department responsible for administering the *Property Agents and Motor Dealers Act 2000* and the *Residential Tenancies and Rooming Accommodation Act 2008* amend the relevant legislation to introduce a system of mandatory inspections by an independent licensed builder of the structural integrity of a residential rental property with a deck,

verandah or balcony that is greater than 10 years old immediately prior to the property being placed on the rental market and thereafter at a minimum three year interval during its continued use as a rental property.

Response and action
Under consideration
Responsible agency: Joint response between the Department of Housing and Public Works (lead) and the Department of Justice and Attorney-General

The *Property Agents and Motor Dealers Act 2000* is an occupational licensing Act and focuses on the conduct of licensees (including real estate agents) when dealing with their clients. The *Property Agents and Motor Dealers Act 2000* does not regulate tenancy or rental property matters and not all rental properties are managed by real estate agents. Furthermore, it does not govern the conduct of owners of tenanted residential property. The *Property Agents and Motor Dealers Act 2000* is therefore not considered to be the appropriate Act within which to make any of the recommended changes.

If amendments were to be considered by the Residential Tenancies Authority the appropriate Act would be the *Residential Tenancies and Rooming Accommodation Act 2008*. The Residential Tenancies Authority is responsible for administering the *Residential Tenancies and Rooming Accommodation Act 2008*.

The Government notes that currently, the *Residential Tenancies and Rooming Accommodation Act 2008* requires that at the start of the tenancy, the lessor must ensure:

- the premises and inclusions are clean
- the premises are fit for the tenant to live in
- the premises and inclusions are in good repair
- the lessor is not in breach of a law dealing with issues about the health or safety of persons using or entering the premises.

That Act also requires while the tenancy continues, the lessor:

- must maintain the premises in a way that the premises remain fit for tenant to live in
- must maintain the premises and inclusions in good repair
- must ensure any law dealing with issues about the health or safety of persons using or entering the premises is complied with
- if the premises include a common area – must keep the area clean.

Further, while mandatory inspections may provide prospective tenants with information about the property, this would be similar to the existing inspection process under the *Residential Tenancies and Rooming Accommodation Act 2008* which requires an entry

condition report to be completed by the landlord/agent and checked by the tenant at the start of every tenancy.

It is considered that introducing another layer of mandatory inspection requirements specifically for rental premises would be an additional regulatory burden for the sector and duplicate existing provisions.

An important consideration is balancing the interests of landlords and additional costs with the likely benefit of mandatory inspections.

Anticipated issues if the recommended mandatory inspections were required by legislation include:

- significant cost of inspections
- enforceability of inspections – both how to monitor and encourage compliance as well as to ensure any repairs or maintenance are carried out
- poor access to inspectors, particularly in regional and remote areas
- identifying age of properties as opposed to age of add-on decks, etc
- defining requirements (for example verandahs may be less than half a metre off the ground and pose little or no risk)
- attaining certifications – if defects were identified during inspections, it is not clear whether they could still be rented or whether they would have to be withdrawn from the market
- impact on the rental market in terms of properties available for rent, particularly in regional areas
- lessors and agents have indicated that costs of inspections would be passed on to tenants through increased rents.

It is also noted that the recommended change may not prevent the unfortunate situation encountered in this inquest where the tenant had reported wood rot in a rental property to a real estate agent but repairs were not made.

Having regard to the above, the proposed recommendation may not achieve sufficient benefits for tenants given the costs involved. However, the *Residential Tenancies and Rooming Accommodation Act 2008* is still under review, so further consideration will be given to this recommendation. It should be noted that amendments are being considered to the *Residential Tenancies and Rooming Accommodation Act 2008* to allow tenants to more effectively enforce Queensland Civil and Administrative Tribunal orders about repairs. This potential amendment would impose a penalty for each day that a lessor fails to comply with a Tribunal order to repair a property.

Recommendation 5

That the Departments responsible for administering the *Property Agents and Motor Dealers Act 2000* and the R*esidential Tenancies and Rooming Accommodation Act 2008* amend the relevant legislation to:

(a) require the lessor or the lessor's agent to maintain a register of all maintenance or repairs requested by a tenant or identified by the agent during a tenancy and the lessor's instructions in respect of each maintenance or repair item

(b) enable a prospective or current tenant, on request to the lessor or lessor's agent, to inspect and take a copy of any of the following documents relating to a residential rental property that they propose to rent or are currently renting:

(i) a mandatory inspection report, as proposed above

(ii) any building, pest or termite inspection report commissioned by or on behalf of the lessor

(iii) any building pest or termite inspection report commissioned by another person in the possession of the lessor or the lessor's agent i.e. pre-purchase inspection reports provided to the lessor or the lessor's agent

(iv) a prior entry or exit condition report

(v) a routine inspection report

(vi) the maintenance register for a previous or current tenancy.

Response and action
Not agreed and not being implemented
Responsible agency: Joint response between the Department of Housing and Public Works (lead) and the Department of Justice and Attorney-General

The Government does not support the recommended legislative amendments for the following reasons:

Recommendation (a):

Requiring this information to be recorded in a register by way of prescriptive legislative requirements would significantly increase costs and red-tape for agents and would outweigh any demonstrable benefits and is therefore not supported.

The *Residential Tenancies and Rooming Accommodation Act 2008* makes provision for emergency and routine repairs and sets out a process for the tenant to formally lodge a written request for repairs with the lessor/agent. This is generally through the tenant issuing the lessor/agent with a 'Notice to Remedy Breach', requiring action to occur within seven days. The lessor/agent can respond to this notice or dispute it. In addition, the *Residential Tenancies and Rooming Accommodation Act 2008* allows lessors/agents to conduct inspections of properties as regularly as every three months where repair and maintenance issues can be identified. It would be an unnecessary regulatory burden to further legislate for general business processes around records keeping.

It is noted that many landlords use real estate agents to manage rental properties. Section 34 of the *Property Agents and Motor Dealers (Real Estate Agency Practice Code of Conduct) Regulation 2001* already requires a real estate agent managing a rental property to promptly respond to and, subject to the client's instructions, attend to all requests by a customer for maintenance of, or repairs to, the property. Additionally, the Real Estate Institute of Queensland's standards of business practice require members to manage a client's property with due regard to the health and safety of tenants and visitors. Further, the landlord has the opportunity to clearly specify their requirements of the agent in the Appointment of agent – letting and property management form. This form can specify what repairs and maintenance on the property the agent may be authorised to supervise and carry out on the property and how an agent will perform their property management services.

Having regard to the above, the recommendation is not supported on the grounds of duplication of existing processes, increased regulatory burden and increased costs.

Recommendation (b):

With respect to recommendation (b) which would allow a tenant to ask the lessor for certain documentation, the Government notes that the *Residential Tenancies and Rooming Accommodation Act 2008* already requires/allows the following:

- entry and exit condition reports for the property completed by both the tenant and lessor/agent
- lessors to maintain the property to ensure it is fit to live in, in good repair and complies with health and safety laws
- tenants to formally lodge requests for repairs and a dispute resolution process (including an application to the Queensland Civil and Administrative Tribunal for an order about repairs) to follow if the lessor/agent does not attend to repairs
- ability for tenants to arrange for emergency repairs.

The proposed recommendation is not supported on the grounds of it not being cost-effective for the residential rental sector, particularly given:

- the cost of implementation, compliance and regulatory burden outweighs any potential benefits

- current remedies exist for tenants, including tribunal orders
- it was not supported by lessors when consulted during the recent review of the *Residential Tenancies and Rooming Accommodation Act 2008*.

While the proposed recommendation would assist in terms of tenants being aware of building issues, it would not achieve the outcome of ensuring the property was fixed or maintained. The proposed amendment to impose a penalty for each day that a lessor fails to comply with a Tribunal order to repair a property (mentioned in the response to recommendation four above) is considered to have greater, more practical benefit for tenants.

Recommendation 6

That the Department (responsible for administering the *Property Agents and Motor Dealers Act 2000*) amend the *Property Agents and Motor Dealers (Real Estate Agency Practice Code of Conduct) Regulation 2011* to deal specifically with the letting agent's responsibilities in relation to reading building, pest or termite inspection reports commissioned on behalf of the lessor and communicating the inspection outcomes and recommendations to the lessor for further written instructions, if required, particularly having regard to the circumstances of Isabella's death.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Justice and Attorney-General

The Government does not support the recommended legislative changes.

Property owners (landlords) are responsible for the upkeep of their rental properties. Agents act only on the owner's instructions and therefore it is the owner's responsibility to commission, read and interpret property inspection reports and instruct their agent to do a specific action in response.

If a landlord requires and agent to undertake additional responsibilities, the appropriate place to document this is the Appointment of agent – letting and property management form that is agreed between the landlord and agent. This form states how an agent will perform the services, including whether, and to what extent, the agent is authorised to supervise and carry out repairs and maintenance on property etc.

Recommendation 7

That the Office of Fair Trading, the Real Estate Institute of Queensland, the Residential Tenancies Authority and relevant industry stakeholders continue their efforts to reinforce the importance of regularly and properly maintaining residential rental properties. This requires commitment from:

a) tenants to promptly report and document emerging maintenance and repair issues

b) letting agents to comply with their obligation to promptly report those issues to, and seek instructions from, the lessor

c) lessors to diligently consider those issues and respond promptly and appropriately to them, preferably with the assistance of licensed contractors.

Response and action
Agreed and implementation is partially complete
Responsible agency: Joint response between the Department of Justice and Attorney-General (lead) and the Department of Housing and Public Works

The Government supports ongoing information and education with relevant stakeholders to reinforce the importance of regularly and properly maintaining residential rental properties.

In addition to existing information avenues, an education/awareness campaign will also be developed and led by the Office of Fair Trading in conjunction with Residential Tenancies Authority, Building Codes Queensland and Building Services Authority in response to this inquiry. The aim is to increase awareness regarding existing responsibilities for:

- tenants to promptly report and document emerging maintenance and repair issues
- letting agents to comply with their obligation to promptly report those issues to, and seek instructions from, the lessor
- lessors to diligently consider those issues and respond promptly and appropriately to them, preferably with the assistance of licensed contractors.

The education/awareness campaign will also expand on present education materials in response to recommendation two to draw attention to tenants, property managers and owners the importance of checking and maintaining decks, verandahs and stairs as a means of ensuring the safety of tenants.

The Residential Tenancies Authority already provides a number of support services to lessors and tenants to encourage compliance with their obligations, including:

- responding to telephone enquiries
- education and information material (publications, on-line resources and workshops)
- dispute resolution services to help the parties come to an agreement.

Building Codes Queensland has an existing guideline *Deck, balcony and window safety* for the use, inspection and maintenance of decks, balconies and windows. This guideline may be of assistance to industry and stakeholders for ongoing education.

The Department of Housing and Public Works is committed to advising public housing tenants of their rights and obligations under the *Residential Tenancies and Rooming Accommodation Act 2008*.

All new public housing tenants, when commencing their tenancy are provided with a welcome to your home kit which provides tenants with general information affecting their tenancy including maintenance, which details what their responsibilities are and provides examples of typical maintenance priorities and response times and the process of reporting maintenance issues.

The Office of Fair Trading communications team will lead the awareness campaign. Building Services Authority, Residential Tenancies Authority and Building Codes Queensland agreed to review and provide feedback on the plan. The Office of Fair Trading is developing the strategy/action plan, allocating responsibilities and determining deadlines.

The Building Services Authority, Residential Tenancies Authority and Building Codes Queensland will continue to consult with the Office of Fair Trading during the development and implementation of the education/awareness campaign. Building Codes Queensland will update the guideline in consultation with Building Services Authority and Timber Queensland Ltd.

Recommendation 8

That consideration be given by the Office of Fair Trading to implementing a requirement that real estate agents become members of a peak body or association which is charged with the responsibility of providing guidelines, a uniform code of practice and the provision of continuing professional development to its members, including the issues raised as a result of this tragedy.

Response and action
Agreed and implementation is complete
Responsible agency: Department of Justice and Attorney-General

The proposal for mandatory membership to an industry association has been considered by the Office of Fair Trading and is not supported as it would create a significant addition of regulatory red tape and cost on industry and government.

In effect, all licensees in Queensland would be legislatively required to comply with both the *Property Agents and Motor Dealers Act 2000* (which the government would continue to enforce) and the industry association's standards, such as the Real Estate Institute of Queensland's *Standards of business practice* (which industry would enforce).

This proposal will significantly increase costs on industry and will remove any free will to choose whether or not to be a member of an industry association. Increased costs not only relate to mandatory membership costs to an industry association, but also any audit and compliance costs borne by the industry association as a result of its co-regulatory role are generally passed on to members.

Recommendation 10

That the department responsible for administering the *Property Agents and Motor Dealers Act 2000* and the *Residential Tenancies and Rooming Accommodation Act 2008* amend the relevant legislation to require real estate agencies to adopt a clear and uniform system of recording complaints received by the real estate agent from the tenant, passing those complaints on in the same terms to the landlord and making it clear that instructions are being sought by a certain date that approval is either given for those repairs and conducted or that the landlord will attend to those issues within a specified period; and that feedback be provided to the tenant as to the result of the complaint.

Response and action
Under consideration
Responsible agency: Joint response between the Department of Housing and Public Works (lead) and the Department of Justice and Attorney-General

Some landlords use real estate agents to manage rental properties and section 43 of the *Property Agents and Motor Dealers Act (Real Estate Agency Practice Code of Conduct) Regulation 2001* requires a real estate agent who is a principal licensee to have a reasonable, simple and easy to use procedure in place for handling complaints by clients or customers of the agent.

However, as the *Property Agents and Motor Dealers Act 2000* does not regulate tenancy or rental property matters, or govern the conduct of owners of tenanted residential property, the *Property Agents and Motor Dealers Act 2000* is not considered to be the appropriate Act within which to make any of the recommended changes.

If amendments were to be considered by the Residential Tenancies Authority the appropriate Act would be the *Residential Tenancies and Rooming Accommodation Act 2008*.

The *Residential Tenancies and Rooming Accommodation Act 2008* already provides a way for tenants to lodge requests for repairs and maintenance through the Notice to Remedy Breach and dispute resolution request processes. These processes use approved forms which provide appropriate documentation and set timeframes within which action must occur. Failure to address the breach can result in the tenant seeking orders for repairs through the Queensland Civil and Administrative Tribunal, or potentially ending their tenancy agreement.

Accordingly, this recommendation is largely addressed within the *Residential Tenancies and Rooming Accommodation Act 2008*. However the *Residential Tenancies and Rooming Accommodation Act 2008* is still under review and further consideration will be given to this recommendation.

Recommendation 11

That the departments responsible for administering the *Property Agents and Motor Dealers Act 2000* and the *Residential Tenancies and Rooming Accommodation Act 2008* amend the relevant legislation to require tenanted properties to be subject to a mandatory building and pest inspection before a property is rented and at subsequent regular intervals.

Response and action
Under consideration
Responsible agency: Joint response between the Department of Housing and Public Works (lead) and the Department of Justice and Attorney-General

As the *Property Agents and Motor Dealers Act 2000* does not regulate tenancy or rental property matters, or govern the conduct of owners of tenanted residential property, the *Property Agents and Motor Dealers Act 2000* is not considered to be the appropriate Act within which to make any of the recommended changes.

If amendments were to be considered by the Residential Tenancies Authority the appropriate Act would be the *Residential Tenancies and Rooming Accommodation Act 2008*.

A preliminary assessment of recommendation 11 has highlighted the following concerns if it was progressed:

- Increased costs and regulatory burden to the sector.
- There are insufficient resources to ensure coverage throughout Queensland, particularly in regional and rural areas with restricted access to building and pest inspectors.
- The average length of a tenancy is 12 months, with some tenancies of up to 6 months. Costs of potentially annual inspections would invariably be passed on to tenants which would increase the cost of housing. In social housing, costs will have to be borne by the registered provider, adversely impacting viability. Initial indicative cost estimates would be about $500 per inspection of a property
- It is considered that the proposed amendments may not achieve the intended outcome. Requirements for additional inspections and reports will not necessarily result in action to repair or maintain. An amendment to the Act, to impose a penalty for each day that landlords fail to comply with tribunal orders about repairs and maintenance of rental properties, is being considered.

The recommendation was canvassed during the recent review of the *Residential Tenancies and Rooming Accommodation Act 2008*. It was supported by tenant advocates and the Real Estate Institute of Queensland. However it was not generally supported by property owners because of increased regulatory burdens, higher costs associated with maintaining rental properties and concerns about tenants accessing building reports.

It is also noted that such a mandatory requirement would have a flow-on effect to tenants as mandatory building and pest inspection costs could be expected to be passed on to tenants and increase rental prices.

The *Residential Tenancies and Rooming Accommodation Act 2008* under section 185 requires lessors to comply with any law dealing with issues about the health and safety of persons using or entering the premises. Landlords and agents generally inspect rental premises every three months. The details and requirements for residential premises are contained in the relevant legislation or standards (for example requirements contained in building codes and local laws, and laws about swimming pool inspections), not in tenancy law.

The *Residential Tenancies and Rooming Accommodation Act 2008* is still under review and further consideration will be given to this recommendation.

Inquest into the death of Troy Jason Howse

In the late evening of 28 March 2010, Troy Howse died from significant head injuries sustained when the vehicle in which he was travelling rolled over on Old Byfield Road in Cobraball, near Yeppoon in Queensland.

Coroner Annette Hennessy delivered her findings on 20 September 2012.

Recommendation 1

Queensland Health ensure it has appropriate guidelines dealing with a request under section 80 of the *Transport Operations Road Use Management Act 1995* for a blood sample request and should ensure that all requests are documented.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

Queensland Health supports the appropriate documentation of requests under section 80 of the *Transport Operations (Road Use Management) Act 1995*, including the refusal and grounds for refusal of any such requests, and notes that various guidelines are already in place in hospitals across the state for dealing with, and documenting, such requests. This is now a function of local hospital and health services established under the *Hospital and Health Boards Act 2011*.

Queensland Health issued a communiqué to hospital and health service chief executives outlining the circumstances of this case, recommending that they review local policies and procedures for dealing with requests for blood samples under section 80 of the *Transport Operations (Road Use Management) Act 1995* accordingly, including ensuring that all requests are appropriately documented. Any action will be at the discretion of each hospital and health service.

Inquest into the death of Mia Davies

On 15 April 2010, Mia Davies, a newborn infant, died of peripartum hypoxia, as a result of being deprived of oxygen at some point during her mother's labour.

Coroner John Lock delivered his findings on 28 September 2012.

Recommendation 1

The [Royal Brisbane and Women's] Hospital considers the suggestions made at the mortality and morbidity meeting in order to ensure as many of the suggestions for improvement can be implemented.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Health

A number of suggestions from the Royal Brisbane and Women's Hospital mortality and morbidity meeting have been implemented by the metro north hospital and health service district and others are partially completed, they include:

- The registrar training calendar has been amended to include Royal Australian and New Zealand College of Obstetricians and Gynaecologist training days.
- Human error and patient safety training is available for all staff and is a requirement for the Safety and Quality Officer.
- The statewide pregnancy health record, the management plan and a suite of intra-partum tools are used by clinicians to document and refer to in an emergency.
- A detailed phone communication handover between outgoing and incoming consultants occurs when the incoming Visiting Medical Officer is off campus.
- Midwifery team leaders (as required) update the clinical staff throughout the shift; for example changes in acuity, increased activity and escalation requirements to the consultants.
- Documentation audits are undertaken and results are fed back to the maternity advisory group meetings.
- A representative for the women's and newborn services attends the Royal Brisbane and Women's Hospital clinical handover committee.
- The option of sending an equivocal cardiotocography (CTG) to the after hours consultant on call and where necessary is being explored.
- The provision of senior medical staff backed up by a second on-call consultant for obstetrics
- The recruitment and appointment of additional obstetric staff specialists is under review due to current workforce design.

In regard to increased obstetric consultant involvement, the women's and newborn services is consulting on a proposal for earlier consultant start times to allow for multidisciplinary ward rounds.

Recommendation 2

Given Mrs Davies met the criteria for being defined as a "high risk" patient I agree with Ms Marten's submissions and recommend the [Royal Brisbane and Women's] Hospital adopt a policy, procedure and practice that at the changeover of shifts between consultants (i.e. at 8:15 and 16:30) that a consultant (either the outgoing or incoming) personally review all high risk patients to satisfy themselves of the ongoing management plan and that the management of the patient is appropriate.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

A number of improvements to the clinical handover process have been implemented by the metro north hospital and health service to review high risk patients in the women's and newborn services at the Royal Brisbane and Women's Hospital.

Consultants, registrars and midwifery staff received a memo requiring them to be present at a twice daily clinical handover and use a concise template for this process, followed by documentation in the patient's management plan of the day.

The clinical handover process has been reiterated in the *Obstetric and gynaecology medical staff handbook* (2013) and is discussed at the registrar orientation program.

Ongoing review and improvements are achieved through regular monthly consultant meetings.

Recommendation 3

The [Royal Brisbane and Women's] Hospital ('the Hospital') now has a policy that any clinician asked to review a cardiotocography (CTG) should note their interpretation of the trace on the trace itself and in the medical records and also note the actions to be taken. Given I have now heard evidence in two recent cases involving Queensland Health facilities, which suggests this practice has not universally been adopted, I agree with Ms Martens' submission and recommend the Hospital should conduct an audit to ensure that this is occurring satisfactorily.

Response and action
Agreed in part and implementation is complete
Responsible agency: Queensland Health

All desktop computers in the women's and newborn services have a specific icon that provides direct access to the *Queensland maternity and neonatal clinical guideline* on intrapartum fetal surveillance.

Brief notation of the action taken after interpretation of cardiotocography (CTG) is made on the CTG trace. Although the recommendation suggests noting the clinician's interpretation on the CTG trace, there is insufficient space on the CTG trace itself for further details and therefore a more detailed interpretation and management plan is made on a standardised CTG sticker in the patient's progress notes.

Quarterly CTG audits are conducted and presented to the maternity advisory group meetings.

Inquest into the death of Jennifer Ann Boon

Jennifer Boon died shortly after midnight on 12 July 2009 from multiple injuries, including significant head injuries, sustained after she was accidentally hit by a chartered bus she had alighted from.

Coroner Stephanie Tonkin delivered her findings on 10 October 2012.

Recommendation 1

I recommend that the Department of Transport and Main Roads, through its Operator Accreditation process conducted pursuant to the *Transport Operations (Passenger Transport) Act 1994*, ensure and enforce that all drivers of passenger vehicles complete any and all necessary reversing to allow a driver to continue with the journey prior to allowing any passengers to alight at a particular stop, and further that no driver of a passenger vehicle reverse that vehicle without first ensuring unrestricted or adequate visibility to the rear of the vehicle, through the use of a person assisting, getting out of the bus and performing a visual inspection, a camera or other appropriate means.

Response and action
Agreed in part and implementation is partially complete
Responsible agency: Department of Transport and Main Roads

The operator accreditation process is not the appropriate mechanism for enforcement of driver responsibilities.

Ensuring that all reversing manoeuvres are completed before allowing a passenger to alight would mean that in some circumstances, the passenger then has to cross a road which may expose them to a greater risk.

The use of another passenger getting out of the bus to assist with the reversing process exposes that person to risk (especially if they have been consuming alcohol, as they were in this instance). The use of an employee of the bus company is not a financially viable option and such a person would not be available on journeys where the driver was not expecting to reverse the bus (as in this instance).

The Department of Transport and Main Roads (the department) considers an amendment to the *Transport Operations (Passenger Transport) Standards 2011* in a way that is sympathetic to the Coroner's recommendations is the best option.

The department is progressing an amendment to the *Transport Operations (Passenger Transport) Standard 2011* to mandate that drivers of buses (over a certain size) take all reasonable action to avoid having to reverse the vehicle after dropping off passengers and to take reasonable action to ensure any pathway is clear of pedestrians before reversing.

Operator accreditation audits will be used to ensure that drivers are aware of this responsibility.

Recommendation 2

I recommend that all companies operating in Queensland give serious consideration to the installation of reversing cameras on all passenger vehicles capable of being fitted with such equipment.

That the Department of Transport and Main Roads communicate this recommendation to all Accredited Operators (as a recommendation, rather than a requirement) through the use of the Operator Accreditation system or other means more suited to such communication.

Response and action
Agreed and implementation is complete
Responsible agency: Department of Transport and Main Roads

The Department of Transport and Main Roads wrote to all 1700 holders of bus operator accreditation in May 2013 highlighting the benefits of reversing cameras and recommending the installation and use of reversing cameras where such equipment can be fitted.

Recommendation 3

I recommend that the Department of Transport and Main Roads give consideration to the need for an appropriate public education campaign, designed to educate the public on the dangers of large passenger vehicles, and the need to act in a safe and prudent manner (including being conscious of the risk of being distracted by the use of a mobile phone) when in close proximity to such vehicles, and to give consideration to any visibility issues that might be presented to both the driver in seeing any passengers and the passengers in seeing around the vehicle. It is recommended that such an education campaign is to be designed and implemented at the discretion of the department, after due and appropriate consideration to any available data on such safety issues.

Response and action
Agreed in part and implementation is partially complete
Responsible agency: Department of Transport and Main Roads

The Department of Transport and Main Roads appointed a new supplier (BCM Partnership) in June 2013 to develop a new and innovative approach to improve community road safety. The focus is to strengthen, influence and refocus the community

on the significance of road safety and how individuals can play a role in reducing the road toll.

A 'social change' strategy is currently being developed and, following trials in pilot communities, will be finalised in 2014. This strategy will prioritise road safety issues and focus campaign work on those that pose the greatest risks and involvement in crash statistics. The department notes the importance of safety around larger vehicles including buses and other heavy vehicles, and will consider the timing and priority of educational activities to address this risk against other high risk road safety issues over the coming years. In the meantime, the department will also look at the possibility of no/lower cost awareness raising strategies, including social media and articles in electronic newsletters.

Inquest into the death of Joshua Jai Plumb

Joshua Plumb, a seven year old boy with epilepsy and spastic quadriplegia, died unexpectedly at the Ipswich Hospital on 16 December 2010 after nurses found him to have become entrapped in the railings of his hospital bed.

Deputy State Coroner Christine Clements delivered her findings on 18 October 2012.

Comment 1, pages 19-20

Nurse training might usefully be reviewed in light of this coronial inquest around particular issues namely to highlight:

a) the responsibility of the person in the team leader nurse role on each shift to continually consider the need for additional staffing during the shift and to communicate such a need assertively when necessary

b) the responsibility of the person in the appropriate nurse role to actively enquire, assess and respond to a unit's capacity to deliver adequate nursing services throughout a shift

c) emphasis on training nursing staff to assess the risk and prioritise competing demands for attention from patients to maximise patient safety

d) review of the Team nursing model to ensure emphasis on the requirement for the creation of a documented plan to assist in identifying necessary tasks and aid communication between the team to ensure these tasks are dealt with in a timely manner.

Response and action
Agreed in part and implementation is complete
Responsible agency: Queensland Health

Nurses are educated in universities and are assessed against both theoretical and practical learning outcomes. Those learning outcomes are set nationally through Australian Nursing and Midwifery Council for all universities to comply with and the issues raised by the Coroner are covered within the course to become a registered nurse.

There are also system-wide quality measures in place across all health facilities for nurses to utilise a decision-making framework regarding what nursing resources are required based on the clinical needs of clients.

The events leading to this inquest appear to highlight the capacity for failures in the application of clinical judgment to reduce the effectiveness of the education and quality systems that are already in place, rather than any broader system-wide failure.

Queensland Health agrees that nursing care plans are an essential element of good nursing practice and should be utilised to guide care requirements for each client and identify who is accountable for care. Nurses are assigned patients and activities within a nursing team to ensure all care is completed under the supervision and accountability of the registered nurse.

Queensland Health's Chief Nursing and Midwifery Officer wrote to all hospital and health services outlining the Coroner's findings and concerns raised in this case and:

(a) suggested quality and safety nurses at health facilities provide ongoing in-service training as necessary for nurses in determining nursing resources and skill-mix required for their patients, with particular attention on communicating escalation of requests should more staffing be emergently required

(b) highlighted the key leadership role of executive directors of nursing across hospital and health services in ensuring safety and quality mechanisms such as documented care plans are appropriately in place and in use to instil accountability of all nurses in actively assessing, managing and resolving clinical risk issues.

Comment 2, page 22

The work of Ipswich Hospital together with Patient Safety Queensland's work referred to in this inquest is to be commended. It is hoped Patient Safety Queensland will continue to be sufficiently funded and resourced to continue and complete this review and other vital work to review and improve patient safety. I note this is required statewide and it is particularly significant given the advent of independent hospital districts. There is a risk that isolated incidents which threaten patient safety may not be identified and addressed at the statewide level unless the work of Patient Safety Queensland is allowed to continue at a meaningful level.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

The Patient Safety Unit continues as a key unit within the Health Service and Clinical Innovation Division of Queensland Health. The Patient Safety Unit is continuing to undertake important statewide work in the areas of:

- Supporting local hospital and health boards to meet *National safety and quality health service standards*, including developing tools for statewide adoption such as early warning observation charts.

- Supporting best practice incident analysis and sharing lessons learned locally across the state.

- Investigating and issuing patient safety alerts and advisory notices to inform local hospital and health Ssrvices about patient safety and quality issues and recommended solutions.

- Facilitating the Queensland bedside audit and emergency department patient experience survey.

- Developing and maintaining patient safety information systems.

Comment 3, page 23

Educational follow up by the Office of the State Coroner for investigating police will be arranged to ensure a greater knowledge and cooperation between Queensland Police and the Office of the State Coroner to assist them in investigating matters for and on behalf of a coroner.

Response and action
Agreed and implementation is complete
Responsible agency: Department of Justice and Attorney-General

The investigation of reportable sudden deaths on behalf of a coroner is a key policing function. To this end, the Queensland Police Service provides training and other resources to all sworn members. This includes face to face lectures and presentations, by both training staff and the Coronial Support Unit, at recruit training, detective training, Officer in Charge conferences and Criminal Investigation Branch/Child Protection and Investigation Unit conferences throughout Queensland. This is evidenced by recent face to face training provided in all police regions as a result of the new coronial reporting structures.

Other training includes online learning products and workbooks within the competency acquisition program.

The Coronial Support Unit also maintains a comprehensive intranet presence which provides significant information and resources available to operational police. In February 2013 these training packages and resources were reviewed and updated with the latest information.

Comment 4, page 23

It would appear essential that Queensland Health now completes the root cause analysis process or otherwise completes the review of bed and bed bumper related safety issues, particularly in the context of children, and children with disabilities.

Completion of the root cause analysis or other investigative process should then disseminate results across Queensland Health to ensure improvement of patient safety statewide.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Health

West Moreton hospital and health service completed the root cause analysis. Queensland Health's Patient Safety Unit will now work further with the west Moreton hospital and health service and other stakeholders to develop statewide guidance about use of bed bumpers if required in conjunction with appropriate staff supervision to manage patient safety in selected patients, particularly in the context of children, and children with disabilities.

Comment 5, pages 23-24

While it is noted the use of bed bumpers at Ipswich Hospital immediately ceased, the inquest did not establish whether this had occurred state-wide. At the least, the evidence on this inquest suggests if bed bumpers are used they must be firmly secured not just to the top of the bed rail but also to the base of the bed/mattress and to each end of the bed to eliminate the risk of the mat being forced between the rails either vertically or horizontally. A consideration of the 'breathability' of the bumper material could also be undertaken. The better course appears to be removal statewide of their use. In some cases this will necessarily require the increase of nursing resources to [provide] 'specialling' [for a] patient to safeguard against the risk of perceived harm when a patient moves within a bed and comes into contact with bed rails.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Health

There are a range of options for improved safety in association with the use of bed bumpers and further consideration of options and stakeholder consultation is required before acting to require the mandatory removal of all bed bumpers statewide. As a preliminary step, the Patient Safety Unit issued a patient safety notice to all hospital and health services outlining the circumstances of this case, the Coroner's concerns in relation to the use of bed bumpers and highlighting known areas of risk when considering bed safety. The patient safety notice recommended local risk assessment and appropriate action.

Following the outcome of the root cause analysis being undertaken by west Moreton health service, Queensland Health's Patient Safety Unit will review the information obtained and any recommendations from the root cause analysis, and conduct further research and stakeholder consultation before determining any further statewide action to be taken.

Inquest into the death of Joshua Jai Plumb

Concluding comments, page 23

Standards for care of children with special needs should apply across the state. While it is acknowledged changes have been implemented in Ipswich Hospital to increase staffing levels to provide 'specialling' by a designated nurse for disabled children, reviewing the regime of observations and to consider the appropriate bed for each child, the evidence at the inquest could not establish this was a Queensland Health-wide safety improvement.

Response and action
Under consideration
Responsible agency: Queensland Health

This issue was referred to the statewide Child and Youth Clinical Network for review and advice to Queensland Health.

Queensland Health will provide a response regarding consideration of this recommendation in next year's report, 'The Queensland Government's response to coronial recommendations 2013'.

Inquest into the death of Preston Paudel

Preston Paudel, a newborn infant, died at the Mater Mothers Hospital on 13 October 2009 of global hypoxic-ischaemic encephalopathy. Preston had been deprived of oxygen during his birth at the Toowoomba Hospital two days earlier.

Brisbane Coroner John Lock delivered his findings on 25 October 2012.

Comment 1, page 31- root cause analysis process and recommendations arising from said process

Despite what I consider to be concerns about the root cause analysis process, the root cause analysis did identify areas for improvement and adopted changes that were necessary and appropriate. The recommendations were supported by the independent experts. It is recommended the Hospital (Toowoomba Hospital) continues to implement and monitor the success of the recommendations of the root cause analysis, particularly the K2MS training and the completion of the cardiotocography (CTG) sticker.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

Compliance with use of the cardiotocography (CTG) sticker and associated procedure is monitored through the aiming for excellence program at Toowoomba Hospital. This audit tool has now been implemented across the Rural Health and Aged Care division. Audit results have demonstrated continued high usage of the CTG stickers in the maternity ward at Toowoomba Hospital.

K2MS training is a computer-based fetal monitoring training system developed by the company 'K2 Medical Systems' and staff access is funded by the Darling Downs hospital and health service. K2MS training is available to staff online with the Midwifery Nurse Educator assuming the role of administrator for this program.

Comment 2, page 31- hourly cardiotocography (CTG) reviews

There was some conflicting evidence at the inquest about who is to conduct the hourly reviews of the CTG. Given this, the [Toowoomba Base] Hospital should clarify this position with all staff.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

A memo clarifying responsibilities for hourly reviews of cardiotocography (CTG) was sent to consultants, registrars and residents of the Toowoomba Hospital by the Director Obstetrics and Gynaecology on 7 December 2012. Work has also begun to develop a hospital and health service-wide procedure.

A procedure is now in place and published on the Queensland Health intranet that details the processes of CTG recording and documentation and in addition covers hourly rounding, including midwife and registrar review.

Comment 3, page 31- hourly completion of the cardiotocography (CTG) sticker

There was evidence that it is sometimes difficult for the hourly review of the CTG sticker to be completed. It would be appropriate for the [Toowoomba] Hospital to continue to audit this process to ensure the procedure is complied with.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

This inquest triggered the initiation of a suite of maternity audit tools that are now part of the aiming for excellence program across the hospital and health service, including an audit of cardiotocography (CTG) stickers. The audits are conducted monthly across the hospital and health service in all maternity facilities and are reported on at all levels of the organisation. The CTG audits cover the completion of documentation and specifically identify whether the CTG interpretation sticker has been placed in the medical record, whether the documentation is legible, that an assessment is completed, with a management plan, that the woman is aware of her plan, and that the team leader and medical officer have done alternate reviews of the CTG.

Recommendation 1

The cardiotocography (CTG) assessment sticker adopted by Toowoomba Hospital appears to be a comprehensive tool to provide an interpretation of the CTG. Given the issue of a CTG interpretation has arisen in other inquests, I agree with Ms Marten's submission and make a recommendation that Queensland Health consider the implementation of this sticker at all hospitals throughout the state.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Health

The department's Patient Safety Unit has undertaken initial assessment and targeted consultation and received feedback about the potential interaction of the cardiotocography (CTG) sticker with the existing statewide Intrapartum record that was released in 2011. In addition, the Patient Safety Unit will ascertain the feasibility of a statewide intra-uterine foetal early warning and response system tool.

The Patient Safety Unit will conduct an initial review of the Darling Downs hospital and health service's experience of the compliance and patient safety impact since implementing the CTG sticker and then consult with clinical and human factors experts to determine the appropriateness of implementing the CTG sticker. The Patient Safety Unit will identify if there are any existing tools that are more appropriate, or review the feasibility of a statewide intra-uterine foetal early warning and response system that meets requirements of relevant national standards and human factors design.

Comment 4, page 32- assertiveness training

There was also evidence that some staff had not completed graded assertiveness training. The [Toowoomba] Hospital should continue to review this aspect to ensure all staff receive or attend the appropriate training.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

Assertiveness training is included in the Practical Obstetric Multi-Professional Training (PROMPT), which is designed for multi-disciplinary staff. PROMPT is held three to four times per year and it is mandatory for staff to complete this training every two years.

The Darling Downs hospital and health service will continue to monitor relevant staff attendance at these training courses as part of the requirements for safe and appropriately supported clinical service delivery set out in the clinical services capability framework.

Recommendation 2

It is further recommended that the [Toowoomba] Hospital implements a policy that the four hourly reviews of high risk patients be conducted by the registrars or consultants.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

A memo clarifying that high risk patients must be reviewed every four hours by the Registrar On Call for the labour ward was sent to consultants, registrars and residents of the Toowoomba Hospital by the Director, Obstetrics and Gynaecology on 7 December 2012. A hospital and health service-wide procedure is now in place and published on the Queensland Health intranet that details the processes of cardiotocography recording and documentation and in addition covers hourly rounding, including midwife and registrar review.

Comment 5, page 32- contemporaneous completion of documentation

There was evidence that the volume of documentation is difficult to complete. By way of comment it is suggested that the [Toowoomba] Hospital consider ways to ensure midwives have an opportunity to complete the required documentation contemporaneously.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

The Darling Downs hospital and health service recognises the busy and complex environment in which clinical staff work and the many competing demands on their time. Monthly documentation audits of the Toowoomba Hospital maternity ward through the aiming for excellence program in 2012 show compliance is consistently over 85% and often well above 90%. Despite these excellent results, the hospital and health service continues to identify opportunities for further improvement and the hospital and health service's clinical standards committee recently commenced a review of the *Nursing and midwifery clinical document manual*.

Comment 6, page 32- team leader workloads

There was some evidence that team leaders, whilst now carrying a lighter patient load, still have some difficulty completing their duties. It is suggested the [Toowoomba] Hospital consider conducting an audit of the team leader's activities on shift to ensure they have adequate time to supervise staff and complete the CTG sticker reviews.

Response and action
Agreed in part and implementation is complete
Responsible agency: Queensland Health

The Darling Downs hospital and health service agrees with the need to monitor workloads of team leaders but does not agree that an audit of activities on shift is the most appropriate way to approach such monitoring. This is because audits are by their nature reactive and retrospective, not allowing action to be taken at the time an issue is detected.

However, the Darling Downs hospital and health service has met the intent of the Coroner's recommendation with the development of the following initiatives:

- A range of work instructions have been developed to better define roles and responsibilities for team leaders and these work instructions are reviewed every two years.
- A process is in place for staff to document and report issues about excessive workload on shift and those issues are reviewed by management for further action.

The hospital and health service will continue to monitor the workload of individual team leaders through routine performance appraisal and development reviews and through the review of excessive workload reports from staff.

Recommendation 3

I repeat my recommendation made at previous inquests that wherever possible, root cause analysis processes should be conducted such that the relevant members of a treating team, if they wish to participate, are provided an opportunity to be interviewed and are provided with feedback as to the outcome of the root cause analysis.

This should include, where possible, staff no longer at the Hospital.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

Queensland Health's Patient Safety Unit undertook a number of steps to re-enforce the interviewing of staff as best practice in undertaking root cause analyses. The Patient Safety Unit:

a) Invited patient safety officers, managers of clinical governance/patient safety and executive directors of medical services from across the state to participate in a teleconference in July 2012 to clarify that all relevant staff should be identified and interviewed as part of a best practice root cause analysis (as described in training and support tools).

b) Updated the root cause analysis report template in September 2012 to include a requirement to document numbers of staff identified and interviewed as part of a root cause analysis.

c) Advised hospital and health service chief executives in January 2013 of the number of concerns raised by coroners during 2012 about the quality of root cause analyses and recommended each service review their local policies and practices in relation to conducting root cause analyses and other forms of incident analysis.

All staff within the Darling Downs hospital and health service involved in a serious adverse event are offered the opportunity to be interviewed by the root cause analysis team. All reasonable efforts are made to ensure staff that may have left the hospital are afforded the opportunity to be involved.

The updated root cause analysis report template was implemented across the health service. Further, a new process has been implemented to ensure that at the conclusion of each root cause analysis the Health Service Chief Executive is provided with a specific authorisation form to release summaries or copies of root cause analysis reports to managers of staff involved in the adverse event to enable feedback.

Inquest into the death of James Leon Short

On 6 August 2010, James Short died at the Gold Coast Hospital from injuries he sustained after being accidentally run over by a reversing dog trailer at his place of work earlier that day.

South-eastern Coroner, James McDougall, delivered his findings on 1 November 2012.

Recommendation 1

I recommend that Workplace Health and Safety, in consultation with the Department [of Transport and Main Roads] consults with the relevant industry manufacturers/representatives - and/or national bodies - to conduct an analysis of whether the use of the smart alarm is a cost effective solution that would be effective on work sites.

Response and action
Agreed and implementation is partially complete
Responsible agency: Joint response between the Department of Justice and Attorney-General (lead) and the Department of Transport and Main Roads

The Department of Justice and Attorney-General and the Department of Transport and Main Roads worked together to explore ways of addressing this recommendation.

The Department of Transport and Main Roads supports voluntary codes of practice by an industry sector to improve workplace health and safety, provided the codes do not conflict with transport laws.

The Transport and Storage Industry Sector Standing Committee (convened by Workplace Health and Safety Queensland) has published guidelines for working around trucks. It contains practical and straight-forward information on how risks associated with reversing trucks or plant can be managed. The controls detailed within these guidelines include, but are not limited to: removing or reducing the need to reverse; providing clearly marked reversing areas; excluding non-essential personnel from parking areas; using reverse alarms and reversing flashing lights if the workplace noise is too loud; ensuring drivers have another person to direct them while reversing and that this person wears highly visible clothing. There are similar guidelines in other Australian jurisdictions.

Representatives from each of the departments met in March 2013. Following this meeting, representatives from Workplace Health and Safety Queensland, Department of Transport and Main Roads, the Commercial Vehicle Industry Association of Australia and the Truck Industry Council Limited met in April 2013. The meeting discussed whether the use of smart alarms is a cost effective solution that would be effective on worksites. It was agreed that additional information was required in relation to available products, industry participation level and the cost impacts. Both the Commercial Vehicle Industry Association of Queensland and the Truck Industry Council agreed to provide further information and the Truck Industry Council has agreed to conduct a survey of the trailer

manufacturers in Queensland. Once that further information is provided to Workplace Health and Safety Queensland, an analysis of whether the use of the smart alarm is a cost effective solution on work sites will be carried out.

Workplace Health and Safety Queensland agreed to draft an analysis report on cost effectiveness of smart alarms and to circulate it for comments from departmental representatives. The Department of Transport and Main Roads has provided several papers and product catalogues to Workplace Health and Safety Queensland to assist in the analysis.

Once the analysis of smart alarms is complete, the data will be considered and appropriate outcomes determined and implemented as required.

Recommendation 2

There are adequate helpful sources of information regarding safe work practices and preventing potential injuries and damage that have been published by Workplace Health and Safety. A quick perusal of the Queensland Trucking Association's website shows that industry relevant information is provided to members, however, neither the *Transport and Storage Industry Sector Standing Committee Guidelines* nor the Code [*Plant Code of Practice]* are available.

I recommend that Workplace Health and Safety liaise with relevant industry organisations, associations and unions to encourage them to publish these documents so that members are able to readily access them.

Response and action
Agreed and implementation is partially complete
Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland are engaging with identified associations and unions to encourage the publication and distribution of the Transport and Storage Industry Sector Standing Committee Guidelines *Guidelines for working around trucks. Loading and unloading* and the *Plant Code of Practice 2005*, both of which are available on the Workplace Health and Safety Queensland website.

In addition, Workplace Health and Safety Queensland raised awareness within relevant transport industry sectors through meetings throughout 2013.

Inquest into the death of Antonio Carmelo Galeano

Antonio Galeano died on 12 June 2009 in the custody of police while restrained after a protracted struggle and multiple applications of a Taser device.

Deputy State Coroner Christine Clements delivered her findings on 14 November 2012.

Recommendation 1- forensic pathology

I commence with a comment arising from the difficulty in determining excited delirium as a cause of death. The inquest heard evidence there is a neurological tissue test known as a positive mash test available in the United States of America. Inquiry should be made to see if such a test is commonly accepted by forensic pathologists to be determinative or probative of a diagnosis of excited delirium, and if so, I suggest resources be made available to enable the test to be performed where it is considered there is prima facie evidence of reasonable possibility of excited delirium. Investigating police, coroners and forensic police would be assisted by advice from forensic pathologists on this matter.

Response and action
Not agreed and not being implemented
Responsible agency: Queensland Health

Queensland Health understands that excited delirium syndrome and its relationship to deaths during arrests is an extremely difficult and complex topic. Further research and consultation has revealed that forensic pathologists currently view the mash test as experimental and not yet commonly accepted to be determinative or probative of a diagnosis of excited delirium. This of course could change with further scientific work in the future. Much of the work in this field is being done in the United States and is the subject of extensive discussion amongst experts there, especially the National Association of Medical Examiners.

As the opinion of forensic pathologists is that the mash test is currently experimental, it would be premature for Queensland Health to routinely make resources available for the test at this time.

Recommendation 2- variation in Queensland Police time records

The Queensland Police Service should review the evidence on variation of timekeeping within their organisation, audit the various systems and consider standardisation and monitoring in accordance with a recognised international time keeping standard.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Police Service

The Queensland Police Service Information and Communications Technology Command examined various Information and Communication Technology (ICT) systems and devices used by the Queensland Police Service. In early 2013 the Queensland Police Service ICT strategy and investment section established a working group comprised of business and legal stakeholders within the Queensland Police Service and other public safety agencies to determine the:

- required level of variance for time synchronisation
- set of devices that require time synchronisation
- level of urgency (which dictates the implementation approach)
- ongoing auditing approach and required recording keeping.

It is anticipated the Queensland Police Service Information Steering Committee will consider the recommendations of the ICT strategy and investment working.

Recommendation 3- strategies for minimising mortality rate of persons displaying symptoms of excited delirium syndrome

A review should be conducted by the Queensland Ambulance Service and the Queensland Police Service to ensure that joint protocols and training of officers fully deal with the cooperation required to deal with and treat severely disturbed individuals involved in anti-social behaviour showing apparent agitation. This review should ensure:

(i) the first response should be focused on safely providing urgent medical attention as a first priority.

(ii) police are trained and aware of the need to involve QAS officers as early as possible in dealing with such individuals.

(ii) medical input should inform the police approach how best to achieve a rapid take down without escalation of the struggle.

(iv) adequate numbers of responding trained officers should be resourced in accordance with medical advice.

(v) training should address the need to transport restrained individuals to hospital as quickly as possible after restraint is achieved.

Response and action
Under consideration
Responsible agency: Queensland Police Service (lead) and Queensland Health (the machinery of government administrative arrangements in November 2013 saw the Queensland Ambulance Service transition from the Department of Community Safety to Queensland Health)

The Queensland Police Service and Queensland Ambulance Service agreed to conduct an extensive review of the joint emergency response and management of severely agitated patients including those displaying symptoms of excited delirium.

The review will encompass the current Memorandum of Understanding between both the Queensland Police Service and the Queensland Ambulance Service in relation to mental health incidents, training conducted by both departments and associated policies.

Recommendation 4- the thresholds for Taser use and multiple use

I support including the words 'imminent risk' (of serious harm to a person) to the threshold test for application of Taser. This would help to emphasize and guide police officers not to resort to Taser deployment unless the situation demands that course.

Response and action
Not agreed and not being implemented
Responsible agency: Queensland Police Service

The Queensland Police Service Taser Project Board, established in 2011, reviewed the Coroner's recommendation and determined that the current threshold of 'Risk of serious injury' in existing Taser policy will remain.

Use of a conducted energy weapon (Taser) is considered an appropriate use of force option for a police officer called upon to resolve many situations involving risk of serious injury to themselves or other persons. The decision to deploy a Taser is made after conducting an appropriate threat assessment and will depend on a variety of factors including the mental and physical state of the offender, whether he or she is armed or could arm themselves, and environmental factors such as the type of place where the incident is occurring or whether it is night-time or daytime.

In many situations, the risk to an officer will be imminent or extremely likely. Examples include where there is a short distance or reactionary gap between the officer and offender, or where an officer is confronted with a person with a firearm.

However, there will be situations where the risk to an officer would although remain high, arguably not be imminent because there is larger distance or reactionary gap between the officer and the offender, or where the offender is not armed with a potentially lethal weapon.

In all situations, it would be reasonable for the officer to present the Taser to the offender

in self defence as a pre-emptive or preventative action to gain offender compliance and control of the situation.

Data from use of force reports available statewide indicates that in the majority of cases, the presentation of a Taser has successfully resolved a situation without the need to discharge it. For the period 01/01/13 to 28/02/13 there were 214 Taser deployments. Of those, 160 (75%) were presentation only. As there was no further escalation it may be assumed that in these instances presentation of the Taser only was sufficient to promote offender compliance.

Existing Taser policy provides that 'use of a Taser' means:

- drawing the Taser out of the holster, or
- presentation of the Taser, or
- deployment of the Taser

in the performance of the officer's duties.

Thus amending the threshold to 'imminent risk' (of serious harm) would unnecessarily limit or prevent officers from drawing their Taser out of their holster or presenting the Taser to successfully resolve a potentially dangerous situation without injury.

Recommendation 5- repeated or prolonged use of Taser

The policy in circular 15/2009 says that repeated or prolonged (greater than five seconds) use of the Taser should not occur unless exceptional circumstances exist.

This is clearly an improvement over the policy that existed on 12 June 2009 which did little more than require that, where a deployment is ineffective, the officer should reassess the situation and consider all other options. It is clear that the officers, Myles and Cross, received little guidance from that aspect of the policy.

In his oral evidence Inspector Hutchings pointed out that the panel to whose work he had contributed had recommended that the criterion for prolonged or repeated use should involve both the existence of exceptional and justifiable circumstances. He remained of the view that the reference to 'justifiable' would be appropriate.

I support the inclusion of the word 'justifiable' to the word exceptional to establish the context in which an officer can consider prolonged or repeated use of the Taser.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service Taser Project Board concurred with the Coroner's recommendation for the inclusion of the word 'justifiable' to the word exceptional to establish the context in which an officer can consider prolonged or repeated use of the Taser. This is in line with current Queensland Police Service policy with respect to the Situational Use of Force Model 2009 which provides that all 'use of force' applications must be:

- authorised
- justified
- reasonable/proportionate/appropriate
- legally defensible
- tactically sound and effective.

The amendment was incorporated into the revised Taser policy in July 2013.

Recommendation 6- review of multiple or prolonged Taser deployments

I support there being a requirement by the Queensland Police Service as part of the [Operational procedures manual] to review and audit every occasion when a Taser is deployed on multiple [occasions] or for a prolonged period (longer then five seconds). This should occur within a short timeframe and involve a debrief, and re-training if required. This is important given the evidence before the inquest about this deployment as well as evidence of other deployments in the field where an officer was unaware of multiple applications or holding the device 'on' past the five second setting.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service Taser Project Board supports the recommendation of reviewing every occasion when a Taser is deployed on multiple occasions or for a prolonged period. This process is currently being implemented through Significant Event Review Panels (SERPs) with Ethical Standards Command oversight.

SERPS are established in every district within the Queensland Police Service to examine significant event review matters with a view to:

- identifying good and/or inappropriate practices
- identifying issues, causal factors and potential trends in behaviour and practice
- recommending action to address the cause of inappropriate practice or reduce its effect, and

promoting good practice and a culture of continual improvement.

In addition, the revised Taser policy requires supervisors or district duty officers to include the use of the Taser as part of any debrief conducted in accordance with section 1.4.8 of the Queensland Police Service *Operational procedures manual*. The new policy also requires that where the use of a Taser is a critical incident as defined in Queensland Police Service human resources policies, supervisors/officers in charge or their delegate are to notify their local human services officer.

Recommendation 7- safeguards by way of technological advance

I support the Queensland Police Service investigating options to acquire safer and more technologically advanced weapons including:

- Consideration of the X2 model Taser or other alternative Conducted Electricity Weapons. The aim should be a device which is engineered to prevent the trigger/switch being held 'on' for longer than five seconds without a specific conscious re-activation of the switch/trigger.
- Consideration of upgrade of the Taser or other Conducted Electricity Weapon which incorporate a camera which is activated on deployment.
- Consideration of other camera recording devices to be used by officers in accordance with particular guidelines.
- In the context of evidence that some officers supply and wear their own audible recording devices, consideration of this practice and review of whether the Queensland Police Service should supply standard devices to all officers and the guidelines for their use.

Response and action
Agreed and implementation is under consideration
Responsible agency: Queensland Police Service
The Queensland Police Service conducted a review and evaluation with respect to the X2 Taser, Taser cams and body worn video, including audio recording devices. The outcome of these reviews is currently under consideration by the Senior Executive of the Queensland Police Service.

Recommendation 8- mental Health, the effect of Illicit drugs and police intervention strategies

I recommend a review of the [Operational procedures manual] informed by the comments in this inquest and the evidence of Acting Senior Sergeant Hayden. The aim should be to cross reference and incorporate the various sections dealing with operational use of force, psychotic episodes and acute psycho-stimulant-induced episodes and excited delirium.

All of these policies need to be reviewed and informed by input from the Mental Health Intervention Project. Education should aim to ensure an understanding that drug induced psychosis is a form of mental illness and should be dealt with in the same way as any other incident involving other forms of mental illness.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service reviewed the previous Taser policy contained in section 14.23 of Commissioner's Circular 16/2009 and made amendments in line with the Coroner's comments. The revised Taser policy contains cross referencing to relevant sections of Queensland Police Service policy dealing with psychotic episodes, acute psycho-stimulant induced episodes and debriefing of officers.

Recommendation 9- mental health, the effect of illicit drugs and police intervention strategies

I reiterate my earlier commentary that it would be wise to incorporate a review of Queensland Police Service personal safety equipment with respect to administering first aid and/or cardiopulmonary resuscitation by the Queensland Ambulance Service. Police officers are entitled to be safe in their work and they need to be assured their equipment and the expectations required of them do not place their health at risk.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service reviewed personal protective equipment (PPE) currently supplied to police officers for use in the performance of their duties in line with the Coroner's recommendations. Current Queensland Police Service Human Resource Policy is that PPE (pocket masks) are to be placed in all operational police vehicles and they must be properly and regularly maintained in accordance with manufacturer's instructions.

The review found that only two police regions supplied all police vehicles with pocket masks in accordance with Queensland Police Service policy and a number of regions provided alternative PPE which was not compliant with the policy.

As a result of the review, the Queensland Police Service Safety and Wellbeing Branch engaged the services of an external consultant, Queensland Risk Management, to assess and report on the effectiveness and appropriateness of current PPE provided for cardiopulmonary resuscitation (CPR) to police. The independent review will also consider alternative PPE options available on the market against Australian Standard 4259.

In addition, 1000 pocket masks were purchased and distributed to police regions for placement in police vehicles. The distribution for the remaining masks is on-going.

The Queensland Police Service is also revising its First Aid Training Policy to increase the numbers of members trained in senior first aid and CPR after they leave the Police Academy. This training will include the safe use of Queensland Police Service supplied PPE.

Once the reviews are completed, the Queensland Police Service will facilitate a safety awareness campaign to educate all members on the protection afforded by PPE and first aid equipment supplied in the workplace.

Recommendation 10- the role of police communications

There is an opportunity for these key personnel to better assist front line police by guiding them and supporting them to a greater extent. This can include contemporaneous advice informed by online checks with [Operational procedures manual] requirements. Processes could be evolved for the Communications Centre to alert ambulance or other health services at the earliest opportunity when it is identified a person with a known history places them at elevated health risk.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

Since the death of Mr Galeano in 2009, the Queensland Police Service rolled out a new Queensland Police Service computer aided despatch system (QCAD) in seven major communication centres throughout the state including North Coast Region (Maroochydore), South Eastern Region (Beenleigh), Brisbane, Cairns, Townsville, Rockhampton and Toowoomba. The QCAD system has an enhanced ability for operators to assist operational officers by a direct interface with the Queensland Police Service QPRIME computer system. Using a tool called Intelliview, CAD operators can view cautions, flags, occurrences and associations in relation to locations, people and vehicles.

QCAD also has call taker advice prompts. Each incident type (activity code) utilised by the Queensland Police Service is associated with a specific call taker advice. In the case of a mentally ill person incident type, in addition to being linked to the mentally ill person call taker advice a set of relevant questions are also appended to the Incident. The prompts and questions assist to ensure an operator actions relevant procedures to support frontline staff in resolving an incident, for example, requesting information from Queensland Health and the attendance of the Queensland Ambulance Service to a mental health incident in accordance with the Queensland Police Service *Operational procedures manual*.

In March 2013, the Queensland Police Service released an electronic copy of the *First response handbook* which can be downloaded onto smart phones and personal digital devices. This will allow police officers to have timely access to key legislation and first response policy and procedures while at incident scenes.

Recommendation 11- advising the police service and family of discharges from hospital

It was submitted Queensland Health and the Queensland Police Service should examine and consult to consider whether notifications to the police can be made under the Memorandum of Understanding and the *Health Services Act 1991* when a patient is discharged from hospital in particular circumstances or when particular risks are identified in the context of mental health. This may require legislative or administrative changes to enable these notifications to local police.

I simply refer the matter for consideration. I note it involves complex balancing of an individual's right to privacy weighed against possible risk to public safety.

Response and action
Agreed and implementation is complete
Responsible agency: Joint response between Queensland Health (lead) and the Queensland Police Service

Queensland Health and the Queensland Police Service consider existing legislative and administrative mechanisms for sharing information with the local police and/or family members about patient discharges adequately address situations where particular risks are identified in the context of mental health.

In the view of both departments, the sharing of confidential information in situations of possible risk to public safety is appropriately balanced with an individual's right to privacy. This balance is reflected in the provisions of current legislation and through the Mental Health Collaboration Memorandum of Understanding in mental health crisis situations and through the Information Exchange Memorandum of Understanding regarding prosecution of criminal offences, as agreed between Queensland Health and the Queensland Police Service.

Relevant exceptions to the duty of non-disclosure of patient identifying confidential information are available under current legislation. Existing Memoranda of Understanding for the release of information to the Queensland Police Service are justifiable exceptions to the duty of non-disclosure where there is an alleged criminal offence or a mental health crisis situation.

Any proposed amendments to legislation must comply as far as possible with fundamental legislative principles and have sufficient regard to the rights and liberties of individuals, including the right to privacy and confidentiality. A strong public interest argument would be required to support more extensive exceptions to the duty of non-disclosure of patients' confidential information than exist under current legislation. The possibility that a mental health crisis might occur at some point in the future would not appear to be a sufficient public interest justification to abrogate such personal rights.

Queensland Health and the Queensland Police Service will continue to work collaboratively, particularly in the context of mental health, but do not propose to seek any further legislative or administrative changes for sharing of information at this time.

Recommendations 12-17- investigation of deaths in police custody

Recommendation 12- scenes of crime and innovation

I consider that the Queensland Police Service should review its in service training of forensic scientific officers to ensure that, as new technology comes on line, officers are kept abreast of its implications for their work. This comment is made due to the forensic officers being unaware of the existence of minute confetti like markers known as AFIDs which are dispersed at the point of deployment of the Taser. Further technical and expert resources should be identifiable and readily available to forensic officers to ensure they remain best equipped to perform their work.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service Forensic Services Branch undertakes training of scenes of crime officers in new techniques and technology of relevance to their duties every two years. In 2012, all scenes of crime officers were trained in the possible evidence that is available post-T125 Taser deployment.

Recommendation 13- scenes of crime and innovation

With respect to the issue of the forensic investigation required in a death in custody scenario, it is important that forensics are properly directed and briefed and remain open to all possible scenarios. A refocusing

of forensic evidence gathering for death in custody investigations is required. Items relating to resuscitation efforts, police equipment and accoutrements all need to be considered which is different from the usual investigation focus.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service agrees with the Coroner in relation to the importance of forensic investigations including examination of the resuscitation actions undertaken by police. In response, the existing investigation checklist has been amended to ensure Internal Investigations Branch on call officers provide direction at the time of initial regional advice for the purposes of scene preservation and investigation integrity. The checklist requires the issue of resuscitation actions undertaken by police to be examined during the course of any investigation.

Recommendation 14- treat the death in custody like a homicide

I suggest changing the approach and rigour with which these situations are investigated may properly involve some seminars involving officers from various ranks and various areas of expertise. Such a process could identify the needs of effective investigation of deaths in custody so that the appropriate attitude, in the future, may be supplemented by clear thinking as to the special needs of such investigations. It needs to be appreciated that public confidence in the Queensland Police Service, the legitimate interest of the deceased person and their family, and the opportunity to fully exonerate the police all depend on a rigorous, transparent and professional investigation. The results of such a process may then be effectively fed back to officers through the development of an expanded policy and improved training processes.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service recognises the investigative deficiencies identified by the Coroner during the inquest. As a consequence of the incident, the Queensland Police Service Ethical Standards Command amended its standard operating procedures and implemented investigation checklists to ensure the deficiencies were addressed. This includes the need for added transparency, a requirement for officers to be separated and clear instruction given to officers not to discuss the incident.

The Ethical Standards Command is responsible for the overall management of all investigations into deaths in police custody or deaths as a result of policing operations

in Queensland as either the lead investigative body or the over-viewing body, in consultation with the State Coroner and the Crime and Misconduct Commission. All members of the Internal Investigations Branch within Ethical Standards Command receive orientation training which addresses in depth investigations of this nature. The role of the Senior Investigation Officer, Internal Investigations Branch, has full responsibility for all incident investigation decisions including direction of expert assistance (crime scene management, forensic examination, evidence collection and analysis), interviewing and reporting.

The Queensland Police Service is satisfied the current procedures are sufficient to ensure that any death in custody or death as a result of policing operations is investigated and managed with the utmost transparency, as if it was a homicide.

Recommendation 15- the role of the ethical standards command

It is appropriate for the Queensland Police Service to review the changed Standard Operating Procedures to ensure that all the difficulties identified in the evidence in this inquest are addressed. This should be an ongoing responsibility of a senior level officer.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

As identified by the Coroner, the Queensland Police Service Ethical Standards Command implemented a number of changes to procedures in dealing with deaths in police custody or deaths as a result of policing operations.

A further review of the Ethical Standards Command Standard Operating Procedures was undertaken and the Queensland Police Service is satisfied the existing procedures address the difficulties identified in the inquest particularly the issue of communication.

Further, the Ethical Standards Command has developed a two stage formal engagement process to delineate the roles and responsibilities of all stakeholders from the first advice of the relevant death. The stakeholders include the State Coroner, the police region within which the death has occurred, Ethical Standards Command and the Crime and Misconduct Commission.

The Queensland Police Service will continue to engage with stakeholders on an ongoing basis to ensure that both local and Queensland Police Service-wide policies and procedures are improved wherever possible.

Recommendation 16- leadership

The inquest has identified a number of areas where leadership at various levels that one might reasonably expect was not forthcoming. At all times, it is necessary to convey to officers under one's supervision that the

highest standards of conduct are required.

The opportunity now arises for the Queensland Police Service to reflect and discuss the topic of leadership. There is significant pressure brought to bear when a serious incident suddenly demands active leadership, especially when thrust back into a front line role.

Recommendation 17- communication

Police officers operate as a team often engaged in stressful tasks and environments. For these reasons, effective communication is one of the most important resources available to officers.

The evidence has revealed various failures in effective communication between police officers throughout the hierarchy. At times of stress and operational crisis, communication is critical but appears to falter.

Again, an opportunity to reflect and discuss how best to address this challenge should be availed.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service acknowledges a failure of leadership and communication in the early stages of the police investigation into the death of Mr Galeano but does not consider this is a systemic issue or that it adversely influenced the outcome of the investigation.

As indicated during the inquest, as a result of key learnings from the investigation, the Internal Investigations Branch, Ethical Standards Command, developed a standard operating procedure to guide the Ethical Standards Command response to death in custody investigations and formalised the role of Senior Investigating Officer to ensure an effective and unambiguous coordination of the investigative response especially in remote locations.

More broadly, the Queensland Police Service recognises sound leadership and communication as pivotal to providing an effective and transparent policing response to serious incidents within the community. This commitment is evidenced by the diverse ongoing professional development and education provided to various officer levels by Education and Training Command.
The Incident Command Development Unit delivers training to supervisors in the command and control of high risk and unplanned emergencies. The Incident Command course is a two week residential course for senior sergeants and is a pre-requisite for commissioned rank. In July 2013 Incident Command training was made mandatory for officers undertaking the key frontline leadership role of district duty officer.

The Investigations and Intelligence Training Unit delivers training to investigators (Criminal Investigation Branch and Child Protection Investigation Unit) and intelligence officers, including leading and supervising teams of officers, making decisions in stressful circumstances, briefing senior managers and generating and presenting options to decision makers.

The Leadership Development Unit aims to develop strategic leadership skills and understanding through the application of strategic management. It is designed principally for the continuing professional development of senior sergeants who are future commissioned officers and senior managers within the Queensland Police Service.

The Supervisor Development Unit delivers a range of programs aimed at developing operational supervision and leadership skills from constable to sergeant.

Recommendation 18- review of adequacy of QPS first aid masks

I consider this [the adequacy of Queensland Police Service first aid masks] is enough of an issue on the available evidence to entitle the comment that the Queensland Police Service urgently review the standard and health and safety quality of the masks supplied to their officers. This should be done in conjunction with the Queensland Ambulance Service. If it is determined the Queensland Police Service masks are deficient, they should be upgraded to an appropriate standard to ensure Queensland Police Service officers are not at risk when using them. If the current masks are of a suitable standard then the Queensland Police Service should still address its members to inform and reassure them that their equipment does comply with necessary health and safety standards.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service reviewed personal protective equipment (PPE) currently supplied to members for use in the performance of their duties in line with the Coroner's recommendations. Current Queensland Police Service Human Resource Policy is that PPE (pocket masks) are to be placed in all operational police vehicles and they must be properly and regularly maintained in accordance with the manufacturer's instructions.

The review found that only two police regions supplied all police vehicles with pocket masks in accordance with Queensland Police Service policy and a number of regions provided alternative PPE which was not compliant with the policy.
As a result of the review, the Queensland Police Service Safety and Wellbeing Branch engaged the services of an external consultant, Queensland Risk Management, to assess and report on the effectiveness and appropriateness of current PPE provided for cardiopulmonary resuscitation (CPR) to police. The independent review will also consider alternative PPE options available on the market against Australian Standard 4259.

In addition, 1000 pocket masks were purchased and distributed to police regions for placement in police vehicles. The distribution for the remaining masks is on-going.

The Queensland Police Service is also revising its First Aid Training Policy to increase the numbers of members trained in senior first aid and CPR after they leave the Academy. This training will include the safe use of Queensland Police Service supplied PPE.

Once the reviews are completed, the Queensland Police Service will facilitate a safety awareness campaign to educate all members on the protection afforded by PPE and first aid equipment supplied in the workplace.

Inquest into the death of Elizabeth Joan Cardwell, Isabella Rose Cardwell and Gregory Ryan Sanderson

On 6 December 2011, Elizabeth Cardwell, her infant daughter Isabella and her partner Gregory Sanderson died when the car they were travelling in crashed into a tree on the side of Neurum Road near Winya. Mr Sanderson was driving at the time of the accident and lost control of the car as he tried to negotiate a sharp bend in the road at excessive speed.

Brisbane Coroner John Lock delivered his findings on 19 November 2012.

Recommendation 1

It is recommended that the State Government, through the Department of Transport and Main Roads, consider contributing towards and/or conducting public awareness campaigns on the importance of the correct selection, use or installation of child restraints.

Response and action
Agreed and implementation is complete
Responsible agency: Department of Transport and Main Roads

The Department of Transport and Main Roads' (the department) website includes a question and answer factsheet in relation to child restraints. One such question in this factsheet is: 'Can I use a second hand child restraint?' Previously, this section did not make reference to the manufacturer's instruction manual. On 16 October 2012, Counsel Assisting the Coroner wrote to the department asking what the department's view would be on including in the factsheet words to the effect of: 'The manufacturer's instruction booklet should be passed on with the child restraint to the new owner. If the child restraint does not come with the relevant instruction booklet, it is recommended that you obtain a copy of it directly from the manufacturer'.

The department replied on 24 October 2012 that it had no objection to the suggestion and it would proactively amend the factsheet to include words to this effect. An amended fact sheet was published on the department's website in early November 2012. The factsheet now includes the following warning:

'If you are using a second hand child restraint it is recommended that you obtain a copy of the manufacturer's instructions for that device. If the person providing the restraint does not have the instructions, they may be available on the internet, or direct from the manufacturer. The instructions should be referred to before the restraint is used as they contain important information about the safe use of the restraint'.

Inquest into the death of Julie Anne Bramble

Ms Bramble died on 1 April 2011 at her home in Bundaberg from septicaemia, which developed from an untreated infection.

Coroner Annette Hennessy delivered her findings on 6 December 2012.

Concluding comments, page 18

Both Dr Hall and Dr Hayllar were supportive of information being conveyed to the public about seeking medical assistance when withdrawing from alcohol and/or drugs and the public being reminded to be aware when others might need medical assistance and to seek medical assistance irrespective of their views.

I intend to provide the Chief Health Officer with a copy of these findings in order to determine whether a statement might be able to be issued to further inform the public on the issues identified in the previous paragraph.

Response and action
Not agreed and not being implemented
Responsible agency: Queensland Health

Information regarding the importance of seeking medical attention when a person is undergoing detoxification or withdrawal is publicly available on the Australian Drug Foundation website at http://www.druginfo.adf.org.au/treatment-options/withdrawal#where.

Information is provided on symptoms that may be experienced when withdrawing, safety precautions, preparations for withdrawal and timeframes.

Evidence has shown that a mass saturation campaign, such as public statements, is not the most appropriate mechanism in the management of alcohol and other drugs issues, including withdrawal. Specialist alcohol and other drugs services consider it is more appropriate and beneficial to provide targeted information and assistance to people planning detoxification or withdrawal on a case-by-case basis.

The Queensland Alcohol and Drug Information Service on 1800 177 833, is a free 24 hour telephone service which provides additional support and information regarding detoxification or withdrawal. Callers to this service who are going through withdrawal are encouraged to discuss their detoxification plan with their doctor and/or with an alcohol and other drug treatment service for advice on which setting would be best for their particular needs.

Queensland Health's Mental Health Alcohol and Other Drugs Branch will continue to partner with other drug and alcohol sectors at both a national and state level to promote the accessibility of information regarding detoxification or withdrawal and the support that may be required for people during this time.

Inquest into the death of Judith McNaught

On 6 June 2012, Mrs McNaught died from septic shock following post-operative complications, after a laproscopic cholecystectomy at the Rockhampton Hospital five days earlier.

Coroner Annette Hennessy delivered her findings on 6 December 2012.

Recommendation 1

That the Rockhampton Hospital seriously consider the allocation of resources for dedicated discharge planners in its major acute wards, with additional resources allocated for nursing care in those wards to replace the nurses performing discharge planning duties where possible.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

The central Queensland hospital and health service considered the resourcing of discharge planning as recommended by the coroner and does not consider an additional or specific allocation of resources is required.

The core scope of practice for registered nurses includes the ongoing clinical care and assessment of all patients. This includes discharge planning which commences at admission, and continues throughout the patient's stay rather than being provided as a stand-alone function by a separate nurse.

Additional support is available to all units across Rockhampton Hospital for complex discharge planning requirements. This is provided by the Patient Flow Unit under the newly created position of Nursing Director, Patient Flow. The unit is run by a Nurse Manager with support from a clinical nurse and an enrolled nurse. These staff provide a facility–wide resource to supplement the discharge planning function of all registered nurses.

Recommendation 2

That the Rockhampton Hospital seriously consider whether the patient outlier system is necessary and appropriate for acute and post-surgical patients at all, particularly having reference to the expert opinion on the issue in this inquest.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

Rockhampton Hospital management agrees the ideal circumstance would see all patients managed in the 'home' ward of their treating doctor. Unfortunately this is only possible on days when there are staffed and available beds in the home ward.

In addition, the clinical condition of patients and other considerations such as the desirability not to mix cases where there is a risk of cross-infection not to mix 'clean' and 'dirty' cases, not to mix genders, not having older patients in the same room as younger ones, increases the difficulty of achieving this goal.

Further, in some circumstances it can be clinically inappropriate to move patients – even to return them to a 'home ward' – as this further interrupts continuity of care and may increase rather than decrease risks of adverse incidents.

Rockhampton Hospital management reluctantly accepts that the need to outlier patients will continue.

Recommendation 3

That in the event that it is considered that patient outlier is necessary and appropriate for acute and post-surgical patients, the Rockhampton Hospital conduct a complete review of the patient outlier system using input from key frontline personnel to ensure that if the practice needs to continue that all precautions are taken to ensure patient safety, including:

- patient reviews before transfer
- appropriate and complete handover of patients to receiving wards
- detailed nursing care plan for the patient
- consultation with treating doctors before the transfer as well as the supervisor of the sending and receiving wards before the transfer is effected
- regular reviews of the patient and the appropriateness of their remaining in the receiving ward.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

The outlier section of the Rockhampton Hospital Admission/Transfer/Outliers/Discharge Procedure was reviewed and updated in accordance with this recommendation. Each of the key elements recommended by the Coroner has been considered. The updated procedure was published in May 2013 and disseminated to staff via the central Queensland hospital and health service newsletter.

Recommendation 4

That those conducting root cause analyses at Rockhampton Hospital ensure that all relevant care providers be interviewed in the investigation. It is clearly desirable that the nurses and doctors who are involved in an adverse incident be given the opportunity to give information to an investigating root cause analysis team which is protected by statutory privilege so that the health care team can speak freely. Such participation can only assist in the early identification of issues which may need to be addressed to prevent tragedies from occurring in the future. It is noted that previous coronial comment on this issue has been made.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Health

Queensland Health's Patient Safety Unit has taken a number of steps to reinforce the interviewing of staff as best practice in undertaking root cause analyses. The Patient Safety Unit:

- invited patient safety officers, managers of clinical governance/patient safety and executive directors of medical services from across the state to participate in a teleconference in July 2012 to clarify that all relevant staff should be identified and interviewed as part of a best practice root cause analysis (as described in training and support tools)

- updated the root cause analysis report template in September 2012 to include a requirement to document numbers of staff identified and interviewed as part of a root cause analysis

- advised hospital and health service chief executives in January 2013 of the number of concerns raised by coroners during 2012 about the quality of root cause analyses and recommended each service review their local policies and practices in relation to conducting root cause analyses and other forms of incident analysis.

Within the central Queensland hospital and health service all staff involved in a serious adverse event are offered the opportunity to be interviewed by the root cause analysis team and the updated root cause analysis report template has been implemented across the health service.

Inquest into the death of Michael David Ley

On 7 June 2011, Michael David Ley died at the Townsville Hospital from global hypoxic ischemic brain injury and aspiration pneumonitis which was precipitated by severe alcohol intoxication. Three days earlier, Mr Ley was taken to the Townsville watch-house while severely intoxicated and it was there he suffered the respiratory arrest which caused his death.

The then-State Coroner, Michael Barnes, delivered his findings on 12 December 2012.

Comment, pages 13 – 14

Sergeant Lord's management of Mr Ley on the night in question is to me inexplicable. He had before him a man who was clearly, deeply unconscious, who could not be roused, who could not answer the questions designed to assist [or] determine whether a medical assessment was needed. Rather than taking the obvious step of calling an ambulance, he subverted that process by falsely recording that Mr Ley had refused to answer all of the questions when only the first few were asked and not answered because the prisoner was incapable of doing so.

Despite it being suggested to him by two junior members that hospital might be a better option, Sergeant Lord was content to watch Mr Ley be carried to a cell.

His actions were completely contrary to the various procedures I have outlined above and that have been repeatedly emphasised in recent years as a result of other deaths in custody.

I acknowledge that Sergeant Lord encouraged the watch-house staff to keep an eye on Mr Ley and they did so. However they were not in a position to monitor his condition as would have occurred in a hospital had Sergeant Lord complied with the relevant policies and procedures.

Accordingly I consider I am obliged to refer the relevant information to the Queensland Police Service for consideration of disciplinary action.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service Internal Investigation Branch completed an investigation into the incident and recommended disciplinary action against Sergeant Lord with regard to duty failures. The matter was referred for consideration by a prescribed officer at the level of Deputy Commissioner.

Inquest into the death of Herbert John Mitchell

On 18 April 2011, Herbert John Mitchell died at the Townsville Hospital from global hypoxic brain injury after suffering a cardiac and respiratory arrest whilst in custody at the Townsville watch-house the previous day.

The then-State Coroner, Michael Barnes, delivered his findings on 14 December 2012.

Concluding comments, page 13

Further, as the evidence in these inquests has canvassed, the Service is continuing to develop new policies with expert assistance. I therefore consider it would be inappropriate for me to make prescriptive, detailed recommendations that might cut across the work that is being done. I will instead limit myself to some observations of principle and articulation of particular problems that the evidence has exposed, confident that those responsible for the on-going work will give due consideration to the matters raised.

Consideration of how best to address health issues in watch-houses should involve health care providers, especially when changes in Queensland Police Service policy are bound to impact upon them. Accordingly, it would seem appropriate that the Queensland Ambulance Service and Queensland Health hospitals be active participants in the development of new watch-house policies.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Police Service

The Queensland Police Service State Watch-house Coordinator; the Director, Clinical Forensic Medicine Unit, Queensland Health and the Executive Manager (Clinical Standards and Quality), Queensland Ambulance Service commenced meetings on a regular basis to discuss prisoner health management in Queensland Police Service watch-houses generally, and to address relevant comments by the Coroner.

The State Watch-house Coordinator coordinated an extensive review of Queensland Police Service watch-house policies and related custody components of the police QPRIME computer system in consultation with the Queensland Ambulance Service and Queensland Health. In particular, the review focussed on sections 16.9 (relating to lodging a prisoner at a watch-house) and 16.13 (relating to health of prisoners and persons in custody) of the Queensland Police Service *Operational procedures manual*.

As a result, the Queensland Police Service implemented significant changes to the management of prisoner health, including:

- Changing the health assessment model from a diagnostic approach to 'degree of suspicion' approach based on prisoner responses, observations, and blood sugar and alcohol levels.

- A written copy of all available medical information known to police is to be provided to the professional health care provider assessing a person in custody.

- Professional Health Care Provider (including the Queensland Ambulance Service) to provide written advice to police as to the person's medical condition and whether they are fit to stay in custody.

- New medical observations of a person deemed fit to be in police custody based on a modified Glasgow Coma Scale to be given every thirty minutes for the first four hours after assessment.

- Significant upgrades to the Queensland Police Service QPRIME computer system based on a best practice model sourced from Metropolitan Police in the United Kingdom.

The Queensland Police Service QPRIME changes were released in June 2013 with the procedural changes to be reflected in amendments to the Queensland Police Service Operational procedures manual.

Comment 2, page 13

The policies of the respective agencies should be complementary. For example, currently the [Queensland Police Service] Operational procedures manual requires police to obtain a written report of treatment provided by Queensland Ambulance Service officers but Queensland Ambulance Service policies don't require one to be given.

Response and action
Agreed and implementation is partially complete
Responsible agency: Joint response between the Queensland Police Service (lead) and Queensland Health (the machinery of government administrative arrangements in November 2013 saw the Queensland Ambulance Service transition from the Department of Community Safety to Queensland Health)

Meetings between the Queensland Police Service, Queensland Ambulance Service and Queensland Health occurred in January, March, May and October 2013 to discuss the implementation of the recommendation.

A joint agency review of pertinent policies was conducted and found no other anomalies other than that identified by the Coroner.

The Queensland Ambulance Service has developed a policy in liaison with the Queensland Police Service, a senior Queensland Health Emergency Physician and Queensland Health Forensic Medical Officer, which is specific to the treatment and transportation of patients at the watch-house. This policy includes provisions for printing of an electronic ambulance report form on-site to be provided to police at watch-houses. The form contains a summary of the treatment provided by Queensland Ambulance

Service officers. In circumstances that an electronic ambulance report form is unable to be provided, Queensland Ambulance Service officers will complete a prisoner observation recommendation form.

The prisoner observation recommendation form is in final review with the Queensland Police Service. It is anticipated the form will be implemented with a staged rollout of purpose printers at specific watch house locations. The new policy requiring Queensland Ambulance Service officers to provide police with an ambulance report form or prisoner observation recommendation form on-site will be released to coincide with the form implementation date.

Comment 3, page 14

Queensland Ambulance Service policies should be developed to cater for the specific needs of watch-house prisoner patients. For example, the presumption that busy watch-house staff can give the same level of monitoring to an intoxicated prisoner as can be expected of a family member caring for a drunk relative at home seems unrealistic.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Health (the machinery of government administrative arrangements in November 2013 saw the Queensland Ambulance Service transition from the Department of Community Safety to Queensland Health)

The Queensland Ambulance Service developed a draft policy in liaison with the Queensland Police Service, a senior Queensland Health Emergency Physician and Queensland Health Forensic Medical Officer, which is specific to the treatment and transportation of patients at the watch-house. This policy takes into account the understanding that a watch-house is not a facility for medical supervision. The policy considers aspects of limited medical supervision, the requirement for transport to hospital, and other issues relating to the specific needs of watch-house patient prisoners.

The draft policy (Clinical practice guideline – patients in police custody) was tabled for review at the May 2013 meeting between the Queensland Police Service, Queensland Ambulance Service and Queensland Health officers.

The Guideline will be released and implemented to coincide with implementation by the Queensland Police Service of the prisoner observation recommendation form and statewide education within the Queensland Ambulance Service. This Guideline will be targeted during these sessions.

Any follow-up training or clarification that might be required will be managed at a local level by Queensland Ambulance Service clinical support officers.

The Guideline will be provided to the Queensland Police Service following release of the *Clinical practice manual* to assist the police in identification of high risk individuals who may require the attendance of paramedics.

Comment 4, page 14

If health care providers come to a watch-house to assess a prisoner it is essential they are made aware of all relevant information known to police. This should be provided in written form to avoid miscommunication and to be available for audit purposes. It would include any information about trauma suffered by the prisoner before coming into custody, blood alcohol levels, history of drug taking, whether he had deteriorated since coming into custody etc.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Police Service

Changes to the Queensland Police Service QPRIME computer system were released in June 2013. These include separate drug and alcohol questions as part of Risk Assessment (Health) Questions and a Prisoner Detention Log which details all long-term information about a prisoner such as illnesses or a history of violence.

A printout of the risk assessment (health) questions, detention log and any other available information will be provided to the healthcare provider to impart a true picture of the patient's medical history.

Comment 5, page 14

Similarly, when health care providers make an assessment they should communicate that in writing to police if the prisoner is to remain in their custody. Any expectations of how the prisoner's health care needs should be managed in the watch-house need to be clearly spelled out for the same reasons. Police can then make an informed decision as to whether they are likely to be able to provide that level of care.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Police Service

Changes to Queensland Police Service watch-house procedures include that a responsible officer with a person in custody who has received a professional healthcare assessment, whether in a watch-house or not, is to request a written statement from the professional healthcare provider indicating the person's medical condition and whether the person is fit to be held in police custody.

The changes to watch-house procedures will be reflected in amendments to the Queensland Police Service Operational procedures manual.

Both the Queensland Ambulance Service and the Director, Clinical Forensic Medicine Unit, Queensland Health, agreed to ensure that Queensland Ambulance Service members and Government medical officers provide such a written statement to police, and amend their policies accordingly.

A trial of Bluetooth printers at all major watch-houses to allow Queensland Ambulance Service members to simply print patient notes from their electronic note-taking devices is also being undertaken.

Additionally, a Queensland Ambulance Service/Queensland Health/Queensland Police Service approved health care professional assessment form has been designed for use by professional healthcare providers.

Comment 6, page 14

Mechanisms for monitoring a prisoner's condition need to effectively distinguish between sleeping and unconsciousness and should enable an officer to ascertain whether a prisoner's level of consciousness is deteriorating or symptoms requiring immediate treatment are escalating.

Comment 7, page 14

The stipulation of observable, clearly defined symptoms or, in appropriate cases, numerical values as a basis for the obtaining of medical attention are more likely to lead to consistent outcomes than expecting officers to respond to poorly understood medical terms and subjective assessments. For example, "unable to be roused by calling, shaking or sternum rub" is less likely to be misinterpreted than "unconscious".

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Police Service

A new screening/assessment tool which is a modified version of the Glasgow Coma Scale, commonly used in hospitals, has been introduced to assess persons in custody after they have been cleared to be held in custody by police. This uncomplicated series of observations will readily determine, in a clear and straightforward manner, if the person is fit to remain in custody. A person in custody must able to:

- open their eyes
- respond verbally to questions
- move their limbs with purpose.

If a person in custody fails to achieve all three above benchmarks, a professional health care provider must be called to further assess the person.

The changes to watch-house procedures will be reflected in amendments to the Queensland Police Service Operational procedures manual.

Comment 8, page 14

Electronic record keeping should facilitate compliance with policies. For example, a forcing function that allows an officer to record when a prisoner is unable to answer questions and then requires him or her to indicate what response has been activated to deal with that medical problem is better than encouraging officers to input the closest inaccurate answer from a limited pick list.

Response and action
Agreed in part and implementation is partially complete
Responsible agency: Queensland Police Service

Due to issues within the Queensland Police Service QPRIME computer system the Queensland Police Service is unable to 'force' a set list of choices onto officers. However, the intent of the Coroner's suggestion has instead been met through ensuring appropriate notations in the detention log.

Comment 9, page 14

The proliferation of checklists dealing with similar issues and the contemporaneous circulation of different versions can contribute to uncertainty. Perhaps a more simplified decision tree using the methodology employed in the clinical pathways used by nurses could be adapted and developed.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Police Service

The Queensland Police Service implemented significant changes to the management of prisoner health, including changing the decision tree for health assessment from a diagnostic approach to 'degree of suspicion' approach based on prisoner responses, observations, and blood sugar and alcohol levels. If an officer has a reasonable suspicion that the person in custody may be suffering from a medical condition, the officer is compelled to then seek a professional healthcare assessment.

This new model was developed in consultation with the Director, Clinical Forensic Medicine Unit and the State Coroner.

Comment 10, page 14

If all officers are to be responsible for ensuring the health condition of their prisoners is appropriately assessed and monitored, it is inevitable on occasions that more junior officers will need to challenge decisions or inaction by their superiors. Overcoming an authority gradient is difficult in a hierarchical, disciplined organisation but the alternative is based on the false premise that rank, wisdom and insight completely coincide. Junior officers should be provided with the means to by-pass obstacles when safety is at risk without fearing retribution.

Response and action
Agreed and implementation is partially complete
Responsible agency: Queensland Police Service

Amendments to the Queensland Police Service *Operational procedures manual* proposed as part of the review by the Queensland Police Service State Watch-house Coordinator, will specify that the responsibility for contacting a professional healthcare provider (when the requisite reasonable suspicion exists) cannot be abrogated regardless of rank. Further, the amendments will include a statement of intent that the officer will not be liable for criticism or disciplinary action from senior officers where they have contacted a professional healthcare provider without seeking permission from their supervisor.

Comment 11, page 15

Mechanisms for assessing the level of compliance with policies are essential. Some of the evidence in these cases suggests aberrant behaviour is not uncommon and that luck has limited poor outcomes.

Response and action
Agreed and implementation is complete
Responsible agency: Queensland Police Service

At the present time, regional duty officers (commissioned officers) are required to inspect watch-houses, watch-house records and persons in custody, in their area of responsibility. To strengthen the current governance regime, the Queensland Police Service State Watch-house Coordinator will facilitate yearly watch-house inspection courses for commissioned officers tasked with supervising watch-houses. This will include regional duty officers and the provision of a risk management 'toolkit' to assist these officers to fulfil their inspection duties

Further, the State Watch-house Coordinator will conduct a series of rolling audits on watch-houses around the State as part of their core duties.

Recommendations profiled in the Queensland Government's response to coronial recommendations 2011

The following recommendations appeared in the *Queensland Government's response to coronial recommendations 2011*. At the time, the Government was considering either whether to implement the Coroners' recommendations or how implementation should progress. Further information is now available and the relevant agencies provided the following responses.

Inquest into the death of Malcolm Mackenzie, Graham Brown, and Robert Wilson

A joint inquest was held after Senior Constable Malcolm Mackenzie, Graham Brown and Robert Wilson died in two separate car accidents in which driver fatigue was suspected to be a contributing factor. Senior Constable Mackenzie and Mr Brown died on 24 October 2005 on the Yeppoon-Rockhampton Road, approximately 10 kilometres west of Yeppoon. Mr Wilson died on 1 February 2007 on the Dysart-Middlemount Road in Central Queensland. In both accidents, one of the drivers was commuting home after a shift at a mine located in the Bowen Basin when their respective vehicles crossed into the opposite lane and collided with an oncoming car.

Coroner Annette Hennessy delivered her findings on 23 February 2011.

Recommendation 9 – fatigue detection and fatigued related driving offences

That ongoing consideration be given by Queensland Police Service to:

a) creating specific powers for police to stop drivers suspected of being fatigued;

b) the development of a fatigue-specific driving offence; and, in the meantime

c) the utilisation of additional investigative techniques to establish fatigue until such time as appropriate fatigue detection methodology is available.

Response and action
Agreed in part and implementation is complete
Responsible agency: Joint response between the Queensland Police Service (lead) and the Department of Transport and Main Roads

The Queensland Police Service and the Department of Transport and Main Roads agree that fatigue is a major risk for light vehicle drivers and a significant contributing element in crashes.

The *Transport Operations (Road Use Management) Act 1995* (administered by the Department of Transport and Main Roads) allows drivers to be stopped and prosecuted for fatigue-specific driving offences. However it only applies to drivers of heavy commercial vehicles and not to drivers of private vehicles.

The *Police Powers and Responsibilities Act 2000* allows officers to stop a private vehicle, investigate and collect evidence of offences and prohibit persons driving, if an officer reasonably believes a person has or is likely to commit a dangerous driving offence under the *Transport Operations (Road Use Management) Act 1995*, the associated Regulations or other relevant road use regulations.

While a police officer can stop a driver whom they reasonably believe is behaving dangerously, the ability to accurately detect, and later prove successfully in a prosecution, that the driver was affected by fatigue is difficult.

Both agencies consider it would be impractical to implement and enforce a new fatigue-specific driving offence for light vehicles at this time. The most significant barrier is the lack of a valid, unobtrusive, objective and reliable technology for the roadside detection of fatigue. As a result, the offence would need to be determined on the opinion of a police officer based on information provided by the driver, and inconsistencies would likely be experienced. Given the complexities of research on the effects of fatigue on different people in various circumstances, the Queensland Police Service believe a medical expert would be required to make this determination.

In comparison, detection of drivers of heavy commercial vehicles is uncomplicated due to the regulated nature of that industry ensuring that there is evidence of driving times, usually in the form of log books. This is something that would obviously be harder to enforce for drivers of private vehicles.

For these reasons the Queensland Police Service and the Department of Transport and Main Roads do not support (a) the creation of new powers for police to stop drivers suspected of being fatigued, or (b) the development of a fatigue-specific driving offence.

In relation to the part (c) of the Coroner's recommendation, the Queensland Police Service does agree that an enhancement of investigation techniques will help establish whether fatigue contributed to the cause of a traffic crash and the recording of statistical information to inform policy and legislation development at state and national levels.

On 25 March 2013 changes were made to the Queensland Police Service QPRIME computer system by way of new data crash fields designed to improve the collection of fatigue related information.

With the assistance of the Queensland Police Service Forensic Crash Unit, Brisbane information in relation to questioning drivers suspected of being fatigued was incorporated into the Competency Acquisition Program (CAP) booklet 'Traffic Crash Investigation QCP003, Fifth Edition, released in July 2012. This CAP Booklet is available for all police officers and is considered by the Queensland Police Service to be an important training tool.

The Forensic Crash Unit training syllabus' 'Basic Course' was amended to include information on identifying and questioning drivers in relation to fatigue driving. However, apart from questioning, and in the absence of a standardised definition of fatigue, the Queensland Police Service does not intend to provide specialist training to police officers in relation to identifying physical symptoms of fatigued drivers.

Additionally, the Queensland Police Service *First response handbook*, 9th Edition, published in March 2013, includes questions in relation to fatigue to assist first response officers investigating traffic crashes. The *First response handbook* is also used for the training of recruits under the PROVE program.

The Department of Transport and Main Roads monitors in-vehicle technology developments, for example, technology that monitors steering wheel movements, lateral position, head nodding, visual and auditory reaction time and physiological states. These devices have not yet been proven.

Inquest into the death of Malcolm Mackenzie, Graham Brown, and Robert Wilson

The Queensland Government remains committed to investigating all reasonable measures to improve driver safety, including implementing road-based fatigue counter-measures. For example, these currently include audible edge line marking, wider shoulder seals, provision of rest areas and the installation of harm minimisation (barriers, clear zones). As new technology becomes available, the Queensland Police Service and the Department of Transport and Main Roads will continue to monitor and investigate advancements in fatigue detection with a view to implementing those technologies if found appropriate.

Inquest into the death of a 15 month old child referred to as 'C'

On 1 November 2005, a 15-month-old child, known as C, died at the Royal Children's Hospital from the combined effects of complications from burns and tears to his mesenteric artery. C was scalded after being immersed in hot water in his family home but it is unknown as to what caused his internal injuries.

Coroner John Lock delivered his findings on 24 June 2011.

Recommendation 2

The Queensland Government ensure all Queensland Housing stock it has responsibility for comply with *AS 4032[1] 2-2005* and *AS 3500[1] 4.1 1997* such that hot water tempering valves are installed in all premises notwithstanding that the hot water systems were installed prior to 30 April 1998.

Response and action
Agreed in part and implementation is partially complete
Responsible agency: Department of Housing and Public Works

The Department of Housing and Public Works has a policy for its social housing properties which complies with the *Plumbing and Drainage Act 2003* and relevant standards. Since the commencement of the *Standard Plumbing and Drainage Regulation 2003*, hot water tempering valves have been installed for all personal hygiene outlets in all newly constructed social housing stock.

However, the present regulatory requirements do not include tempering the kitchen and laundry outlets, or the undertaking of a blanket retrofit for hot water temperature control mechanisms.

Generally, in other existing housing stock, where hot water systems have required replacement since 2003, hot water tempering valves have also been installed as part of the replacement, tempering water to all personal hygiene outlets within the property.

The Department of Housing and Public Works has finalised its strategy for the most economical and effective means to install hot water temperature control valves to the remainder of the portfolio.

The Department of Housing and Public Works is finalising amendments to the maintenance policies for social housing residences, so as to install tempering devices at the hot water unit to temper all hot water outlets. The proposed amended procedure is that the tempering devices will be installed when hot water units need replacement within the general maintenance program, in lieu of a retrospective program. This course of action will be less disruptive to tenants and enable cost effective delivery.

Directives to implement the amended procedure are currently being distributed and practices are being implemented by service providers.

Inquest into the death of Saxon Phillip Bird

Mr Bird died on 19 March 2010 from drowning after being knocked unconscious when he was struck in the head by a surf ski whilst competing at the Australian Surf Life Saving Championships at Kurrawa Beach.

The then-State Coroner, Michael Barnes, delivered his findings on 2 August 2011.

Recommendation 3

I recommend that the Queensland Police Service contingent at large surf life saving events include at least one officer with advanced marine search and rescue training that will equip the officer to plan and coordinate the emergency response should a competitor or official go missing in the water.

Response and action
Agreed in part and implementation is complete
Responsible agency: Queensland Police Service

The Queensland Police Service requested clarification from the State Coroner on the term 'large surf life saving' and were provided with the definition as 'being one where it is big enough for the Queensland Police Service to believe it needs to have a presence'.

The Water Police State Coordinator and the State Training Search and Rescue Mission Coordinator (SARMC) within the Queensland Police Service agree that members with state or national search and rescue training are a limited resource and current on-call arrangements provide greater efficiencies in ensuring search and rescue resources are positioned to provide an effective response to the whole community, as opposed to positioning resources in one location to deal with a potential situation at a surf life saving carnival.

The success of a search and rescue response, regardless of the attendance of a SARMC, would have a limited effect given that a drowning, particularly in white water, can occur within a very short time-frame.

The Queensland Police Service supports the provision of at least one water police officer trained to Assistant SARMC or SARMC level (of which there are 70 such officers available across the state) at the state and national Surf Life Saving Titles (each held once a year), and with a Regional SARMC, if not attending the event, to be on-call at all times during the event.

The Queensland Police Service as part of the planning process for these events meets with Surf Life Saving Australia and ensures that both risk management and contingency plans are implemented within the operational planning document.

Inquest into the death of an unnamed prisoner

In the early hours of 3 September 2008, a prisoner was found to have died from self-inflicted asphyxiation in his cell at the Arthur Gorrie Correctional Centre. The prisoner cannot be named as to do so would breach legislation.

The then-State Coroner, Michael Barnes, delivered his findings on 14 October 2011.

Recommendation 2

It will rarely be appropriate for an accused person who is the respondent to a domestic violence order and who is in custody to have contact with the victim of his/her alleged crimes or the aggrieved person named in the Domestic Violence Order. Queensland Corrective Services policies should require all correctional centres to have in place procedures to ensure this only occurs after a fully informed and considered decision to allow it is made and such contact as is permitted is not contrary to the terms of the Domestic Violence Order. I recommend Queensland Corrective Services review its policies to ensure this occurs.

Response and action
Under consideration
Responsible agency: Department of Justice and Attorney-General (the machinery of government arrangements in November 2013 saw Queensland Corrective Services transition from the Department of Community Safety to the Department of Justice and Attorney-General)

Queensland Corrective Services reviewed its policies and advice was sought from the Commissioner, Queensland Police Service. In addition, this matter was considered as part of the legislative review of the *Corrective Services Act 2006*.

Potential actions to enable implementation of this recommendation have been referred to the Commissioner, Queensland Corrective Services, for consideration.

Inquest into the death of Gregory McLellan, Yang Sun, Shengqi Chen and Dominic Chen

On 1 September 2007, Gregory McLellan, his wife Yang Sun, their friend Shengqi Chen and his twelve-year-old son Dominic Chen died after the boat they were all travelling in collided with and was run over by another boat, the Four Winns, in Moreton Bay. Mr McLellan and Mr Chen both succumbed quickly to the multiple injuries they suffered while Ms Sun and Dominic Chen both drowned. Wei Chen (Mr Chen's wife and Dominic's mother) was the only survivor from their boat.

Deputy State Coroner Christine Clements delivered her findings on 25 November 2011.

Comment 2 – licence changes

Wei Chen passionately submitted the age of eligibility for operation of a boat as large as the Four Winns should be increased. The McLellan family joined in this submission. I consider the recent changes of boat licensing which require a higher standard of boat skill operation for new licence holders of large recreational boats will improve the safe operation of these craft. I consider the best approach is to require demonstrated higher levels of skill, rather than a rule about minimum age requirements...

I note the licensing regime for driving a motor vehicle which provides a sequence of licences with various restrictions being lifted over time... Motor bike riders likewise must commence at a lower capacity machine before progressing over time to a higher capacity bike...

I would therefore suggest that Maritime Safety Queensland consider a similar scheme. This should require a demonstration of prescribed skills for particular classes of vessels, but also a progression of licensing at minimum intervals of time to enable the applicant to gain experience and maturity in developing those skills over time. The effect of such a scheme would necessarily increase the age at which a person could apply for a licence for a higher powered vessel. I do not consider the coroner is best equipped to suggest time intervals between applying for types of licences or the range of vessel capacity.

Response and action
Not being implemented
Responsible agency: Department of Transport and Main Roads

In 2007 Maritime Safety Queensland developed a proposal to introduce an advanced recreational boat licence for larger vessels. At this stage it has been decided not to proceed with the proposal. An analysis of marine incident statistics for the last decade and the costs of developing, implementing and administering the proposed licence demonstrated that its introduction could not be justified when alternative strategies to achieve improved safety in the operation of larger vessels were available.

Inquest into the death of Graham Robert Tait

Mr Tait died on the evening of 21 March 2007 from electrocution after coming into contact with live low voltage powerlines that had fallen to the ground in a vacant lot behind his home in Narragon Beach.

Coroner Brassington delivered her findings on 9 December 2011.

Recommendation 1, page 36, paragraph 137

Accordingly, with a view to minimising the significant safety risks posed by live fallen LV conductors, I recommend that the Office of Fair and Safe Work Queensland progress legislative amendments to mandate the reporting to the ESO of all incidents in which LV conductors fall to the ground and remain energised.

Response and action
Agreed in part and implementation is partially complete
Responsible agency: Department of Justice and Attorney-General

Consideration was given to a new requirement for electricity distribution entities to report annually on incidents in which low voltage conductors fall to the ground and remain energised (except in instances of mass failures such as cyclones etc). This proposal was included in the Regulatory Assessment Statement for the review of the *Electrical Safety Regulation*.

The incident notification requirements in the *Work Health and Safety Act 2011* would require notification of all incidents in which low voltage conductors fall to the ground and remain energised.

The government does not consider that the recommended legislative amendment is necessary. Section 38 of the *Work Health and Safety Act 2011* establishes a duty to notify the regulator (in this case the Electrical Safety Office) of all notifiable incidents (defined to include a dangerous situation) immediately after becoming aware of the notifiable incident. Failure to comply carries a maximum penalty of 100 penalty units (currently $11,000).

As a result, it is not proposed to implement a regulatory change on this matter but instead to emphasise with electricity distribution entities their duty to notify under the *Work Health and Safety Act 2011* which includes a duty to notify the regulator (in this case the Electrical Safety Office) of all notifiable incidents (defined to include a dangerous situation). Situations involving low voltage conductors falling to the ground and remaining energised is a dangerous incident and as such is a notifiable event.

Inquest into the death of Tracey Lee Inglis

Ms Inglis died on 17 or 18 September 2010 in her cell at the Townsville Women's Correctional Centre from blood loss resulting from self-inflicted wounds. Ms Inglis had a history of depression and suicidal ideation, which was exacerbated by chronic pain she suffered as the result of other physical injuries.

The then-State Coroner, Michael Barnes, delivered his findings on 9 December 2011.

Recommendation 1

To maximise the likelihood of the Initial Risk and Needs Analysis (IRNA) form gathering reliable information, prisoners should be explicitly asked whether they identify with any ethnic group and if so, whether they would like a person from that ethnic group to be present during the assessment. Similarly, prisoners should always be offered the option of having the assessment undertaken by a counsellor of either gender. I recommend QCS consider mandating such policies be implemented in all correctional centres.

Response and action
Agreed in part and implementation is complete
Responsible agency: Department of Justice and Attorney-General (the machinery of government arrangements in November 2013 saw Queensland Corrective Services transition from the Department of Community Safety to the Department of Justice and Attorney-General)

Queensland Corrective Services is reviewing the operational practice guideline to ensure the appropriate identification, referral and management of vulnerable groups.

Queensland Corrective Services' officers ask prisoners their ethnicity at the first point of contact at admission (for example nationality, whether they are Aboriginal and/or Torres Strait Islander). This information is immediately entered into the Integrated Offender Management System (IOMS) and is readily available for Immediate Risk Needs Assessment (IRNA) assessing officers.

In October 2012, Queensland Corrective Services completed an examination of available research, including consultation with internal and external stakeholders (including multicultural language service providers), regarding gender matching for assessments and whether doing so supports disclosure of personal information by prisoners in a correctional environment. The literature provided inconclusive evidence of the importance of gender matching. On 29 October 2012, the Queensland Corrective Services' Board of Management determined that given the inconclusive evidence and the current professional staff demographic profile (i.e. typically Caucasian female), an alternative approach to enhancing disclosure would be more appropriate. It was determined that improving the quality of the assessment and the skills of the assessors would more effectively and feasibly encourage disclosure.

Subsequently, a comprehensive IRNA training package was developed and implemented in May 2013. The training package includes guidance for staff in terms of engaging with

vulnerable population groups such as Aboriginal and/or Torres Strait Islander prisoners and culturally and linguistically diverse prisoners. The training package was distributed to all correctional centres for use as an essential training mechanism for all staff who conduct IRNA assessments and is mandatory for all assessing staff prior to undertaking IRNA with prisoners. During 2013, Queensland Corrective Services delivered further IRNA training to offender management staff at correctional centres statewide.

Queensland Corrective Services will implement online training for offender development staff including a module on the IRNA, to ensure the sustainability of mandatory training.

Additionally, the IRNA operational practice instruction has been amended to provide further guidance regarding the identification and referral of vulnerable prisoners. While not directly asking prisoners if they would like someone from their ethnic group present, the practice instruction directs staff to access cultural support where appropriate for prisoners and where this would not delay the initial reception process. The revised operational practice instruction was published on the Queensland Corrective Services intranet in March 2013.

The IRNA online training package, including a video mock interview and other interactive activities, was developed and built into the offender development training framework. Appropriate approval of the framework will be gained prior to the delivery to relevant staff.

The matter was reviewed by the Queensland Corrective Services Incident Oversight Committee on 20 June 2013 and the Committee determined to endorse the completion of this recommendation.