The Queensland Government's response to coronial recommendations 2010

Queensland Government

Preface

The *Queensland Government's Response to Coronial Recommendations 2010* is a whole-of-government report responding to coronial recommendations and comments directed towards Government during 2010. It also includes updated responses to recommendations that remained under consideration in the *Queensland Government's Response to Coronial Recommendations 2009.* It is the third in a series of annual reports 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 directed to Queensland Government entities by coroners.

While nothing will compensate for the loss of a loved one, it is hoped that the families and friends of the individuals profiled in this report will receive a measure of comfort from knowing that the 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 still in the process of being implemented. However, the few recommendations in this report that are still under consideration by Government will be further responded to in next year's report.

As the report is a consolidation of responses that have been authored by the relevant Government agency, any questions regarding the specifics of 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 calling (07) 3008 8763.

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Inquest into the death of Casey Andrew Frizzel

Mr Casey Andrew Frizzel died on 10 January 2007 at a housing construction site in Cannonvale from heart damage resulting from heatstroke.

Coroner Ronald Muirhead delivered the findings on 19 February 2010.

Recommendation 2

That all building sites (whether residential or industrial) be required to post an "Emergency Information Sheet" (in a conspicuous format such as a poster) at a designated position on site, such as an electrical junction box, as well as such other places that make it readily visible and available, containing:

- emergency telephone numbers
- exact site location details, including street cross references and directions as well as longitudinal coordinates
- basic first aid instructions (such as those required to be placed at public swimming pools).

The requirement for an "Emergency Information Sheet" be regulated and monitored by the Department of Workplace Health and Safety.

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

Workplace Health and Safety Queensland is currently participating in the national harmonisation of work health and safety laws, which will see nationally harmonised laws adopted on 1 January 2012. The commitment to national harmonisation by Workplace Health and Safety Queensland is derived from the Inter-Governmental Agreement for Regulatory and Operations Reform in Occupational Health and Safety, which was agreed by the Coalition of Australian Governments on 3 July 2008.

This agreement prevents States and Territories from unilaterally adopting workplace health and safety legislation and codes of practice outside of the national harmonisation arena.

National harmonisation seeks to ensure that businesses operating across borders are subject to the same work health and safety standards.

It is considered that the objectives of the Coroner's recommendations will be accommodated by currently proposed national model work health and safety legislation and codes of practice, which require the preparation of an emergency plan for each workplace. This plan must cover (amongst other things) an effective response to an emergency including notification of emergency services and provision of medical treatment and assistance.

The emergency plan must be tested and relevant workers must be provided with information, training and instruction on the implementation of this plan.

Recommendation 3

That all building sites be required to display posters at designated positions (as outlined in recommendation 2 above) warning employees of the signs and symptoms of heatstroke and include guidelines as to the prevention, treatment and management of heatstroke.

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

Workplace Health and Safety Queensland is currently participating in the national harmonisation of work health and safety laws, which will see nationally harmonised laws adopted on 1 January 2012. The commitment to national harmonisation by Workplace Health and Safety Queensland is derived from the Inter-Governmental Agreement for Regulatory and Operations Reform in Occupational Health and Safety, which was agreed by the Coalition of Australian Governments on 3 July 2008.

This agreement prevents States and Territories from unilaterally adopting workplace health and safety legislation and codes of practice outside of the national harmonisation arena.

National harmonisation seeks to ensure that businesses operating across borders are subject to the same work health and safety standards.

It is considered that the objectives of the Coroner's recommendations will be accommodated by currently proposed national model work health and safety legislation and codes of practice, which will introduce a raft of provisions dealing with the management of risks associated with exposure to extremes of heat. These include:

- the need to ensure workers exposed to extremes of heat (or cold) are able to carry out work without risk to health and safety
- a requirement for the elimination or minimisation of exposure to risk
- the need for corrective action and immediate assistance to workers experiencing symptoms of heat stress.

Recommendation 4

That the Department of Workplace Health and Safety give consideration to implementing and monitoring a requirement that all building sites have at least one person who has obtained a prescribed level of first aid training. Such first aid training is to include education about the signs and symptoms of heatstroke (as well as prevention

and treatment of heat related illnesses) and resuscitation and/or cardio pulmonary resuscitation (CPR).

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

Workplace Health and Safety Queensland is currently participating in the national harmonisation of work health and safety laws, which will see nationally harmonised laws adopted on 1 January 2012. The commitment to national harmonisation by Workplace Health and Safety Queensland is derived from the Inter-Governmental Agreement for Regulatory and Operations Reform in Occupational Health and Safety, which was agreed by the Coalition of Australian Governments on 3 July 2008.

This agreement prevents States and Territories from unilaterally adopting workplace health and safety legislation and codes of practice outside of the national harmonisation arena.

National harmonisation seeks to ensure that businesses operating across borders are subject to the same work health and safety standards.

It is considered that the objectives of the Coroner's recommendations will be accommodated by currently proposed national model work health and safety legislation and codes of practice, which will introduce specific provisions regarding access to trained first aid officers. These draft provisions require that an adequate number of workers be trained to administer first aid or that workers have access to an adequate number of other persons (that is, non-workers) who have been trained to administer first aid in the workplace. There is also a proposed requirement to ensure the provision of first aid equipment so that each worker has access to the equipment, and to ensure the provision of facilities for the administering of first aid.

The existing *Queensland First Aid Code of Practice 2004* provides that workers at workplaces should have access to a person with at least the Australian Qualifications and Training Framework qualification of 'Apply First Aid', which includes training on heat and cold induced illness.

A national model code of practice is proposed for development. Due to the number of codes of practice to be developed and the timeframe in which this is to be done, a staged approach has been adopted. The first aid code of practice has been identified for development in stage two. It is anticipated that this code of practice will be made available around March or April 2012.

The existing *Queensland First Aid Code of Practice 2004* will continue to have effect until such time as a national code is adopted.

Recommendation 5

All employees should receive basic first aid training as part of their induction process to be assessed and monitored by the Department of Workplace Health and Safety.

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

Requiring all employees to receive basic first aid training would be impractical and impose a significant regulatory and cost burden on employers. This issue may be given further consideration during the development of the national code of practice for first aid, which will allow industry consultation on the proposal.

Recommendation 6(a)

In relation to a Memorandum of Understanding that is currently being negotiated between the Coronial Support Unit (of the Queensland Police Service) and the Department of Workplace Health and Safety, I recommend as follows:-

a) That such Memorandum of Understanding contain provisions regarding effective scene preservation in the case of a death in a workplace.

Response and action
Agreed and completed
Responsible agency: Queensland Police Service

The Memorandum of Understanding (MOU), incorporating the provisions recommended by the Coroner, has been signed and approved by the Deputy Commissioner (Specialist Operations), within the Queensland Police Service.

Response and action
Agreed and completed
Responsible agency: Department of Justice and Attorney-General

Provisions regarding effective scene preservation have been incorporated into the Memorandum of Understanding (MOU) between Workplace Health and Safety Queensland and the Queensland Police Service. The provisions align with protocols that have been established within Workplace Health and Safety Queensland to ensure adequate advice is provided to obligation holders about scene preservation following a fatality at a workplace.

The MOU between the Department of Justice and Attorney-General and the Queensland Police Service has been agreed and obtained final sign off in August 2011.

Recommendation 6(b)

b) That the Department of Workplace Health and Safety develop information resources for employers and contractors regarding

the importance of scene preservation to prevent scenes being disturbed by workers prior to the completion of an investigation.

Response and action
Agreed and partially completed
Responsible agency: Department of Justice and Attorney-General

Advice regarding scene preservation is an element of the work being done nationally to achieve consistent triaging of incident notifications and workplace health and safety complaints. The value of developing nationally consistent information products on this issue is being considered as part of the implementation of the national incident notification and complaint triaging model.

A *Framework for a common approach to work health and safety regulator event triaging* has been developed, which addresses the triaging of incident notifications and requests for regulator response to work health and safety issues. This framework has been endorsed by the Heads of Workplace Health and Safety Authorities (HWSA) and it is anticipated that it will commence on 1 January 2012.

Recommendation 7

That Queensland Ambulance Service give consideration to implementing an orientation policy for officers new to a particular area whereby such officers are required to familiarise themselves with their district (including but not limited to local landmarks and local reference points) at the commencement of their employment. This may also include the preparation and update of a local directory showing relevant local landmarks and reference points which is kept on site.

Response and action
Agreed and completed
Responsible agency: Department of Community Safety

All seven regions of the Queensland Ambulance Service have a localised Introduction and Orientation Strategy which is delivered to new staff. The strategies have been reviewed again as a result of receiving this recommendation and the Director of Operations (Regional Liaison) of the Queensland Ambulance Service is satisfied that the orientation of officers includes rural street numbering and local land marks.

The orientation of officers includes local communications centre familiarisation and knowledge of local complexities. All seven regional orientation documents include generic orientation themes along with content addressing the uniqueness of each specific area.

Recommendation 8

That in cases where the cause of death cannot be established at an autopsy, then the coroner should consult with the pathologist

performing the autopsy to ascertain if it may be of assistance to obtain a family medical history.

Response and action
Agreed and partially completed
Responsible agency: Joint response between Department of Justice and Attorney-General (lead) and Queensland Health

The Chief Forensic Pathologist, based at Queensland Health Forensic and Scientific Services (FSS), fully supports the recommendation and advises that coroners do generally consult with pathologists (and vice versa), not only about the need to obtain a family history, but about many other matters to do with the conduct of autopsies, the acquisition of additional information (notably under section 22 of the *Coroners Act 2003* - "Extra medical evidence for autopsy"), the interpretation of autopsy findings and test results, and the need to seek additional expert opinions.

Furthermore, coronial counsellors and coronial nurses are available at FSS to assist coroners (and pathologists) to obtain family histories and other medical information from families and a variety of other sources.

Under s14 of the *Coroners Act 2003* the State Coroner may issue guidelines to coroners about the performance of their functions under the Act. While the current guidelines in relation to autopsies are adequate they are currently being reviewed by the State Coroner.

It is expected that the revised guidelines will be issued by the end of 2011.

Inquest into the death of Brett Thomas Johnstone

Mr Johnstone died on 2 October 2007 in Yeerongpilly from a gunshot wound to the chest whilst attempting to evade arrest. The police officer who fired the shot was struck by the deceased's vehicle as he tried to apprehend him. This caused the officer to fear for his safety and consequently fire two shots, one of which hit Mr Johnstone in the chest.

The State Coroner delivered the findings on 10 March 2010.

Recommendation 1

The only policy issue raised by the circumstances of this case concerned an apparent anomaly in the Queensland Police Service Operational Procedures Manuals (OPMs) that prohibits an officer from firing at a motor vehicle. It was suggested this might be inconsistent with an officer's right to self defence. I was assured this is currently being reviewed. In those circumstances there is no need for me to make any comment in relation to the issue other than to urge those undertaking the review to ensure any changes do not undermine the very sound policy reasons for prohibiting officers firing at vehicles in circumstances where others could be placed in grave danger as a result.

Response and action
Agreed and completed
Responsible agency: Queensland Police Service

The Queensland Police Service provides detailed policies and procedures (in Chapter 14 of the Queensland Police Service Operational Procedures Manual) in relation to an officer's right to self defence and defence of others in relation to the use of firearms in circumstances where a motor vehicle is being used to endanger life. These policies and procedures outline circumstances that must be considered by an officer prior to using lethal force to ensure undue risk is not added to those under threat and the public at large.

Inquest into the death of Sridhar Shekar

Dr Shekar died on 28 April 2008 at the Broadwater in Labrador as the result of multiple injuries sustained after the jet ski he and his wife were riding collided with a boat.

Coroner Hutton delivered his findings on 11 March 2010.

Recommendation 1

That all PWC hire and drive operations be inspected and audited on a regular basis, including at least one yearly covert audit. That full records and documentation be maintained of all interaction between Maritime Safety Queensland officers and PWC hire and drive operations. That a quality assurance program for all hire and drive operations be developed.

Response and action
Agreed in part and completed
Responsible agency: Department of Transport and Main Roads

In 2010, Maritime Safety Queensland conducted statewide audits of Hire and Drive personal watercraft (PWC) businesses. The audits examined the sufficiency of existing safety management procedures and practices.

Maritime Safety Queensland compliance programs include periodic monitoring of personal watercraft hire and drive operations, including audits at least once in every 12 months. Maritime Safety Queensland maintains documentation of audits and inspections. The audits examine the sufficiency of existing safety management procedures and practices. The audit of all Hire and Drive PWC operators now operating apply Quality Assurance methodology. Ongoing annual audits of every PWC provider every 12 months of operation will continue to use Quality Assurance methods to assess safety operating in Hire and Drive PWC providers.

Maritime Safety Queensland has developed a model Hire and Drive Business Safety Management Plan to assist operators. It has also developed and applied a system of auditing operators using comprehensive checklists and reporting mechanisms in accordance with quality management processes.

During September 2011, Marine Safety Queensland executed its PWC Hire and Drive Providers Compliance and Auditing Operational Plan 2011-2012, which included covert and overt audits. As at September 2011, nearly all providers have been audited and enforcement action instigated where necessary. Maritime Safety Queensland will perform audits, including covert audits, of Hire and Drive PWC providers at least once every 12 months.

Full records and documentation are maintained of all interaction between Maritime Safety Queensland officers and PWC Hire and Drive operations.

On 26 November 2010, Maritime Safety Queensland released the *Hire and Drive Personal Watercraft Consultation Paper* in order to:

- seek the views of PWC Hire and Drive providers and people with an interest in this marine sector, on how to improve the safety of hire and drive riders

- present initiatives that could be adopted to improve hire and drive personal watercraft rider safety in Queensland including regulatory responses to the Coroner's findings.

Public comment on the Consultation Paper closed on 4 February 2011. Maritime Safety Queensland is evaluating the submissions and will develop appropriate strategies to improve Hire and Drive PWC rider safety in Queensland, including regulatory responses to the Coroner's findings.

Recommendation 2

That legislation be developed requiring all persons who use a PWC in Queensland be licensed.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Transport and Main Roads

Consideration was given to this recommendation; however, it was determined not to be practicable or beneficial due to:

- the reasonable safety record of the Hire and Drive personal watercraft (PWC) sector
- the dubious merit of interstate and international licences as an indicator of the skills of infrequent riders
- the commercial and social impact, including on the Queensland tourism sector
- comparatively, the estimated fatal and serious injury rate for unlicensed Hire and Drive PWC operations (1.14 per 100,000 hours of operation) is significantly lower than the rate for licensed recreational PWC operations (2.06 per 100,000 hours of operation), determined using hospitalisation data.

Maritime Safety Queensland has consulted with stakeholders on mandatory licensing of all Hire and Drive PWC operators.

The *Hire and Drive Personal Watercraft Consultation* released in November 2010 proposed alternative regulatory responses including imposing conditions on the registration of Hire and Drive PWC. The following measures have been implemented for all new and existing Hire and Drive PWC in Queensland:

- Hire and Drive PWC must be fitted with a device to govern maximum speed to 30 knots by 1 May 2013 and operated at a maximum speed of 30 knots or lesser limit specified by gazetted speed limit.
- the registration condition of each craft now requires providers to assess the skills and abilities of each rider to operate a Hire and Drive PWC in accordance with an approved

competency standard and record the competency of each rider on an approved competency assessment sheet.

- the registration condition of each craft requires providers' safety management plans to comply with the more comprehensive requirements of the new Leisure Craft section of the National Standard for Commercial Vessels.

Maritime Safety Queensland will assess ongoing compliance with and the effectiveness of these changes through the annual audit program.

Recommendation 3

That legislation is put in place requiring all PWC users to wear appropriately designed helmets for PWC.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Transport and Main Roads

Maritime Safety Queensland has not been able to identify any country that presently mandates the use of helmets by personal watercraft (PWC) riders.

Anecdotally, many PWC operators are opposed to wearing helmets, mainly based on the need for optimum peripheral vision and hearing to maintain situational awareness and the risk of injury from what is colloquially known as 'the bucketing effect'.

International research indicates the likelihood of serious neck or spinal injury from impact with the water is significantly increased for riders with helmets even at normal operating speeds. Helmets have the potential to exacerbate non-head injuries or cause additional injuries such as neck and spinal injuries where the injury involves the head hitting the water. The international research indicates that upper neck twisting force increased 160% at 30 miles per hour for a rider wearing a full face helmet compared to a bare head.

Unless the potential for head injury due to collision or blunt trauma is significant (like in racing), Maritime Safety Queensland does not recommend mandating the wearing of helmets on personal watercraft.

Recommendation 4

That Maritime Safety Queensland develops guidelines for all enforcement agencies to assess compliance with the Transport Operations (Marine Safety - Hire and Drive Ships) Standard 2007 and facilitate the sharing of information between enforcement agencies.

Response and action
Agreed and completed
Responsible agency: Department of Transport and Main Roads

Inquest into the death of Sridhar Shekar

Since the incident that gave rise to the Coroner's recommendations, Maritime Safety Queensland established an Enforcement Guideline in 2008 that identifies the enforcement action to be taken in any given situation and, as far as possible, provides guidance on the types of behaviour that will result in prosecution or other enforcement action.

The Enforcement Guideline aims to ensure industry members and the wider boating community understand their obligations by clearly defining the types of behaviour that demonstrate compliance with marine safety legislation. This aims to prevent the types of unintentional breaches that occur when people are unaware of, or do not clearly understand their obligations. The Enforcement Guideline also ensures that public resources are allocated and utilised in an effective and efficient manner by identifying what the most appropriate enforcement action is in any given situation.

Inquest into the death of Roy Barnes

Mr Barnes died on 12 February 2008 at the Gold Coast Hospital as the result of a blood vessel in his brain rupturing four days prior. In the days prior to his hospitalisation, Mr Barnes was being held in custody at the Southport watch house.

State Coroner Barnes delivered these findings on 17 March 2010.

Recommendation 1

I recommend that the position of the 'dead man switch' in the Southport watch house be reviewed to ensure its placement is most conducive to compliance with the obligation to inspect prisoners.

Response and action
Agreed and completed
Responsible agency: Queensland Police Service

The position of the 'dead man switch' (prisoner inspection alarm console) at the Southport watch house was reviewed. It has been relocated from the charge counter to the corridor providing access to the prisoner cell modules.

Recommendation 2

In conjunction with the review of the regime for managing drug withdrawal in watch house prisoners, I recommend the nursing needs of the Brisbane and Southport watch houses be reviewed and that the review take into account the police time that could be saved by not having to escort prisoners to hospital for assessment.

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

The nursing needs at Brisbane and Southport watch houses were reviewed in consultation with the Clinical Forensic Medicine Unit, Queensland Health. The arrangements for nursing services at Brisbane watch house were considered adequate.

The review at Southport watch house recommended that nursing services be upgraded to provide for a permanent nursing presence on an 8 hour per day, 7 days per week basis.

Funding for nurses in watch houses is provided by Queensland Health and the matter is under discussion between Queensland Health and the Queensland Police Service. The Standing Offer Agreement between the Queensland Police Service and Blue Care expires on 21 December 2011. A costed plan for ongoing funding of nurses in watch houses will be determined by 30 November 2011.

Recommendation 3

I recommend that Queensland Health collaborate with the Queensland Police Service to develop guidelines to assist doctors to manage prisoners suffering from heroin withdrawal. In view of the large and growing number of prisoners at risk and the significant uncertainty concerning the suitability of the guidelines currently being used, this should be done as a matter of urgency.

Response and action
Agreed and completed
Responsible agency: Queensland Police Service

The review of Queensland Health guidelines to manage prisoners in watch houses suffering heroin withdrawal was incorporated into the agenda for the State watch house Manager's Workshop as a matter of discussion with the Director of the Clinical Forensic Medicine Unit within Queensland Health.

Queensland Health is working on trialling new guidelines and protocols for treating prisoners in watch houses.

Response and action
Agreed and partially completed
Responsible agency: Queensland Health

Queensland Health has formally reviewed procedures for the treatment of opioid dependent prisoners in watch houses. This included obtaining a report from an independent expert.

As a result, a trial has been initiated in Brisbane and Southport whereby opioid dependent prisoners will be treated with codeine phosphate in a way analogous to the United Kingdoms's dihydrocodeine program. The trial will be for 12 months with a formal review at three months. A decision will be made following this review. Once the trial has been shown to be effective and a formal protocol designed, the program will be rolled out to all other watch houses. This involves no cost to Queensland Health or the Queensland Police Service.

Recommendation 4

In view of the serious doubts raised by Dr Hallyar as to the advisability of refraining from administering medication to watch house prisoners for 24 hours after a doctor has prescribed it (the “24 hour rule”), I recommend that the practice be reviewed.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health has formally reviewed procedures for the treatment of opioid dependent prisoners in watch houses. This included obtaining a report from an independent expert.

As a result, a trial has been initiated in Brisbane and Southport whereby opioid dependent prisoners will be treated with codeine phosphate in a way analogous to the United Kingdom's dihydrocodeine program. The trial will be for 12 months with a formal review at three months. A decision will be made following this review. Once the trial has been shown to be effective and a formal protocol designed, the program will be rolled out to all other watch houses.

As the trial is based entirely on clinical findings there is no "24 hour" rule attached to it. As such, there is no longer a “24 hour rule”.

Inquest into the death of Peter David Howlett

Mr Howlett died on 21 April 2006 at the Mackay Base Hospital from a heart attack. There were delays in the Queensland Ambulance Service responding to the original Triple Zero (000) call made on the morning of his death which were the subject of investigation during this inquest.

Coroner Risson delivered the findings on 25 March 2010.

Recommendation 1

That the Queensland Ambulance Service use actual case studies such as this matter involving Mr Howlett including playing the actual tapes, with the consent of those involved, in training all staff.

Response and action
Agreed and completed
Responsible agency: Department of Community Safety

The Medical Priority Dispatch System education program includes scenario based learning using audio recordings of real cases. Previously these have been tapes of American origin provided through the Medical Priority Dispatch System Vendor.

From the 2010 academic year, Emergency Medical Dispatcher education has been enhanced with the utilisation of taped recordings of selected Queensland Ambulance Service acute incidents, including this incident. This action was approved for implementation late in 2009. Queensland calls are selected by a panel of auditors and educators for their training value, de-identified and held by the Communications Education Unit.

Inquest into the Queensland Police Service's pursuit driving policy

Between June 2005 and July 2008, ten people died in, or following, a police pursuit in Queensland: Niceta Madeo, Paul Moore, Caitlyn Hanrick, Peter and Nicole Ash, Matthew Cullen, Samantha Maslen, Joseph Duncan, Kristina Tynan and Craig Shepherd. Inquests were held investigating the circumstances in which each of these individuals died and in some cases, comments relating to the specific circumstances of an inquest were made. However, the State Coroner refrained from delivering formal recommendations about the pursuit policy until a further inquest was convened specifically examining the Queensland Police Service's pursuit driving policy.

State Coroner Barnes delivered his findings from this inquest on 31 March 2010.

Recommendation 1 - Refocus on Safety

The current pursuit policy stipulates safety is paramount but then directs officers to balance the safety risks of pursuing against the benefits to the community of apprehending the suspect, whether or not those benefits involve prevention of personal injury. I recommend the policy be recast to ensure it is only the danger to the safety of others posed by not immediately apprehending the suspect that is factored into the risk assessment process.

Recommendation 2 - No pursuits without evidence

That the prohibition on commencing a pursuit, when there is no evidence that a motorist who has failed to stop has committed another offence, and the suspicion that the motorist may have committed other offences is based only on that failure and/or the intercepting officer's instincts should be moved from "Non pursuit matters" to "Pursuit policy principles."

Recommendation 3 - Don't pursue drunk or drug affected drivers

In view of the practical difficulties involved in assessing the level of impairment of a drug or alcohol affected driver and the likelihood that chasing them will significantly increase the likelihood of such drivers crashing, I recommend that all of these offences be included in the "non pursuit" category.

Recommendation 4 - Pursuing stolen cars

Despite the minimal evidence that pursuing stolen cars has an impact on the prevalence or clear up of that offence, in view of the conviction of the Commissioner of the QPS that those responsible pose a safety risk more significant than the property crime aspects of the offence, I

will refrain from recommending the unlawful use of a motor vehicle become a non pursuit matter. However, I encourage the QPS to continue to review and consider the justification for the current policy.

Recommendation 5 - Abolish category 3

The current policy requires an officer who has unsuccessfully attempted an interception and who is contemplating commencing a pursuit, to weigh the evidence indicating a fleeing motorist may have committed an offence with sufficient precision to determine whether it is "known" he/she has committed an offence rather than just "reasonably suspected" that he/she might have. That is unreasonable and impracticable. I recommend the distinction be abolished by the deleting of category 3 from the policy.

Recommendation 6 - Reasonable belief is sufficient

In the current policy, each of the three pursuit categories refers to different offences and different levels of certainty that they may have been committed by a suspect who has failed to stop. In my view it is unreasonable and impracticable to require officers to make such fine judgments in the volatile and dynamic circumstances of an unsuccessful attempted interception. I also consider a mere suspicion is too low a threshold to justify an inherently dangerous activity such as a pursuit but that requiring an officer to know an offence has been committed is too restrictive. Accordingly I recommend category 2 be amended to require that an officer have a "reasonable belief" that a relevant offence may have been committed.

Recommendation 7 - Weighted considerations

The policy stipulates that safety is paramount and then lists 11 other matters that should also be taken into account when determining whether to commence and/or continue a pursuit, only some of which relate to safety, with no guidance as to how they should be factored into decision making. I recommend this aspect of the policy be reviewed to ensure the intent that safety is the overriding consideration is made clearer. For example, officers should be encouraged to disregard those factors which do not add to the risk.

Recommendation 8 - Consider impact of pursuing

I recommend the policy be amended to explicitly acknowledge the likelihood that pursuing a motorist who has failed to stop is likely to result in the other car driving more dangerously and require an officer considering whether to commence or continue a pursuit to factor this into the risk assessment and the manner in which the police car is driven.

Recommendation 9 - Development of best practice guidelines

For the reasons set out above, I recommend the QPS develop best practice guidelines that:

- prohibit officers pursuing, other than in category 1 pursuits, unless radio contact can be maintained and the police car contains two officers or a hands free radio
- require a pursuit to be terminated if nominated dangerous manoeuvres such as running red lights at speed etc occur
- insist on compliance with school speed zones and other particularly sensitive road management requirements
- deem a pursuit to continue until the police car ceases to follow or otherwise maintain contact with the other vehicle.

I leave it for the Service to determine whether these guidelines should form part of the policy or training materials.

Recommendation 10 - Commencement - reverse the presumption

Having regard to the vagaries of the current definition of when a pursuit commences that have the potential to undermine the efficacy of the policy's intent to ensure pursuits are not undertaken in connection with minor matters, I recommend the relevant definition be amended to deem a pursuit to commence whenever a driver fails to comply with an officer's direction to stop, unless the officer has reasonable grounds for believing the driver is unaware of the direction having been given.
I also recommend that if this definition is adopted, a corresponding amendment be made to the evade police offence if necessary.

Response and action
Agreed and partially completed
Responsible agency: Queensland Police service

Inquest into the Queensland Police Service's pursuit driving policy

On 24 December 2010 a whole-of-Government response to the State Coroner's Report on Police Pursuits – Policy Recommendations was released. It was developed by the Queensland Police Service in collaboration with the Department of Education and Training and the Department of Transport and Main Roads.

All 12 recommendations directed to the Queensland Police Service have been agreed to and the Safe Driving Policy has been developed and approved by the Commissioner of Police. This Safe Driving Policy includes the implementation of all of the State Coroner's recommendations.

Training in the revised Safe Driving Policy commenced in July of this year, with training aimed at all officers up to, and including, Inspectors. This training is set to be completed before the revised policy implementation date of 19 December 2011. The compulsory training completed by officers statewide involves a three-step process by way of two computer-based learning programmes and one hands-on workshop relating to the education of the new policy and procedures.

Recommendation 11 - Pursuit controller training

In view of the important role of the pursuit controller and the difficulties that can arise when the officer discharging the role is junior to the officers in the primary pursuit car, I recommend the QPS develop a training package especially for pursuit controllers.

I also recommend the project team consider whether training should be targeted at officers with in excess of 10 years service.

Response and action
Agreed and partially completed
Responsible agency: Queensland Police service

On 24 December 2010 a whole-of-Government response to the State Coroner's Report on Police Pursuits – Policy Recommendations was released. It was developed by the Queensland Police Service in collaboration with the Department of Education and Training and the Department of Transport and Main Roads.

All 12 recommendations directed to the Queensland Police Service have been agreed to and the Safe Driving Policy has been developed and approved by the Commissioner of Police. This Safe Driving Policy includes the implementation of all of the State Coroner's recommendations.

Training in the revised Safe Driving Policy commenced in July of this year, with training aimed at all officers up to and including Inspectors. This training is set to be completed before the revised policy implementation date of 19 December 2011. The compulsory training completed by officers statewide involves a three-step process by way of two computer-based learning programmes and one hands-on workshop relating to the education of the new policy and procedures.

Additionally, specific measures include a Police Communications Centre (PCC) pursuit controller training course. The Service ran 18 pursuit controller courses around the state of Queensland, to officers of varying rank and service. In total approximately 190 officers who work in dedicated communication centres, supervise on-road staff, or are shift supervisors attended the day-long training course.

Recommendation 12 - Evade police review

I recommend that as a part of its review of the "evade police" offence, the CMC consider recommending mandatory licence disqualification upon conviction and more flexible vehicle impounding arrangements to bolster the deterrence effect of the offence.

Response and action
Agreed and completed
Responsible agency: Crime and Misconduct Commission

As a part of its review of the 'evade police' provisions of the *Police Powers and Responsibilities Act 2000* (PPRA), ("An Alternative to Pursuit: A review of the evade police provisions" tabled in the Queensland Parliament on 29 June 2011) the Crime and Misconduct Commission (CMC) considered the merits of mandatory licence disqualification upon conviction and vehicle impounding as a sanction for those charged with evade police offences. However, after carefully weighing the arguments and available evidence for each punishment, the CMC decided not to make any recommendations to implement either proposal.

With regards to mandatory licence disqualification, the CMC concluded that on balance there is no compelling evidence that such a punishment would be effective either as a deterrent or an incapacitation strategy for evade police offenders. Most offenders are already unlicensed or driving under a licence suspension or disqualification and research indicates that the profile of drivers for whom licence disqualification has been shown to be most effective is not consistent with the evade police offending profile. The CMC considers that for drivers whose failure to stop constitutes simple non-compliance, licence disqualification is a disproportionately severe penalty. Further, there is a risk that a mandatory penalty may act as an incentive for offending drivers to take more extreme risks to avoid police interception and, as a result, further endanger community safety. Consequently, the CMC does not believe it would be effective or appropriate to fetter the court's sentencing discretion in relation to licence disqualification.

The State Coroner's suggestion for "more flexible" vehicle impounding arrangements was interpreted by the CMC as meaning arrangements which were more consistent with the vehicle impounding arrangements under Chapter 4 of the PPRA. Under this Chapter, police are able to impose an immediate 48-hour impoundment for 'hooning', motorbike excessive noise and repeat driving and vehicle-related offences.

However, the CMC's review identified persuasive arguments against providing police with such discretion over the vehicles of offenders evading police, such as:

- a substantial number of evade police offences are committed in a stolen vehicle, hence impounding the vehicle would not serve to punish, deter, incapacitate or inconvenience the offending driver.

- about half the drivers who evade police have committed other offences. If the driver is evading police to avoid police capture for an offence that carries a more severe penalty, it is unlikely that vehicle impoundment for the evade police offence would have a substantial deterrent effect. Furthermore, some offenders are also charged with unlicensed or disqualified driving and as such their offences are already captured by the existing impoundment arrangements in Chapter 4 of the PPRA.

- research suggests that the threat of immediate impoundment could be an incentive to take more risks to avoid police capture, an outcome which is contrary to the intent of the evade police provisions. Further, an immediate 48-hour impoundment may also serve to punish more quickly and severely those drivers who take fewer risks to evade police.

- providing police with the discretion to determine at what point the driving behaviour was serious enough to warrant immediate impoundment would lead to inconsistencies in how the penalty is applied.

Hence, the CMC considers that on balance providing police with the discretion to impound a vehicle used in an offence for an initial 48-hour period would not significantly bolster the deterrent effect of the offence. Any marginal positive effect might be outweighed by negative impacts. In particular, there is a risk of further endangering community safety by giving offenders an additional incentive to flee. Therefore, we do not recommend more flexible vehicle impoundment arrangements for these offenders.

Recommendation 13 - Engineered safety

I encourage the QPS to continue to explore developments in technology that will reduce the need for and the risk of police pursuits.

Response and action
Agreed and partially completed
Responsible agency: Queensland Police service

On 24 December 2010 a whole-of-Government response to the State Coroner's Report on Police Pursuits – Policy Recommendations was released. It was developed by the Queensland Police Service in collaboration with the Department of Education and Training and the Department of Transport and Main Roads.

All 12 recommendations directed to the Queensland Police Service have been agreed to and the Safe Driving Policy has been developed and approved by the Commissioner of Police. This Safe Driving Policy includes the implementation of all of the State Coroner's recommendations.

Training in the revised Safe Driving Policy commenced in July of this year, with training aimed at all officers up to and including Inspectors. This training is set to be completed before the revised policy implementation date of 19 December 2011. The compulsory

training completed by officers statewide involves a three-step process by way of two computer-based learning programmes and one hands-on workshop relating to the education of the new policy and procedures.

Additionally, the Queensland Police Service is conducting trials around the State involving the roll out of in-car camera technology. This trial period involves the roll out of four vehicles around the State that have been installed with this technology. It is anticipated that the trial period will be assessed in mid-2012.

Inquest into the death of Wayne Anthony Gillis

Mr Gillis was last seen in mid-August 1997 and subsequently reported missing by his sisters to New South Wales and Queensland police on 12 September and 3 December 1997 respectively. He has been missing for the last 12 years, having had no contact with family or friends, behaviour considered to be out of character for Mr Gillis.

Consequently, Mr Gillis was found to have died most likely at some point in time after mid-August 1997 in either New South Wales or Queensland. Unfortunately, the exact circumstances of when, where and how Mr Gillis died are unknown and are likely to remain so unless further evidence becomes available.

Coroner Lock delivered these findings on 19 April 2010

Recommendation 1

That police take formal statements from family and friends much earlier in the investigation so that the memory of the major witnesses is clearer and of more assistance to the investigation.

Response and action
Agreed and completed
Responsible agency: Queensland Police Service

The necessity to obtain statements in a timely manner is a recognised principle in conducting investigations and is reflected in investigative training and operational procedures. Section 2.13.1 of the Queensland Police Service Operational Procedures Manual, specifies that statements should be obtained at the earliest practicable opportunity.

The circumstances of this particular case presented a number of challenges to the investigation requiring inquiries by both Queensland and New South Wales Police over a number of years prior to the inquest taking place.

Additional measures in terms of training or procedural amendment are not proposed in this instance.

Inquest into the deaths of Ian Davy, Concetta Dell'Angelo and Takeshi Sakai

Mr Davy, Miss Dell'Angelo and Mr Sakai all died of multiple injuries sustained in two separate four-wheel-drive accidents on the eastern beach of Fraser Island. Mr Davy and Miss Dell'Angelo both died on the 18 April 2009 and Mr Sakai died on 13 December 2009. In both accidents, the deceased, all young backpackers, were passengers in four-wheel drive vehicles of which the driver lost control, causing them to roll over.

The findings from the joint inquest held into the deaths of these three young travellers were delivered by the State Coroner on 23 April 2010.

Recommendation 1 – Monitor uptake of guide-led tours

I consider tag-a-long tours to have significant safety, social and environmental advantages that will only deliver benefits if those visitors ill-equipped to safely and responsibly undertake independent travel utilise them. Accordingly, I recommend DERM monitor the success of the initiative with a view to encouraging greater participation by island visitors through further restrictions on independent travellers if that appears necessary.

Response and action
Agreed and completed
Responsible agency: Department of Environment and Resource Management

An interagency working group chaired by the Department of Environment and Resource Management was established. The work group was comprised of officers from the Department of Environment and Resource Management, the Department of Transport and Main Roads, the Queensland Police Service and the Department of Employment, Economic Development and Innovation (then containing the Office of Fair Trading).

In addition, officers conducted a review with industry representatives held in Rainbow Beach in late August 2010.

In December 2009 backpacker 4WD hire operators became formally commercial operators as a result of the Queensland Parks and Wildlife Service introducing tag along tours as a mandatory condition of Commercial Activity Agreements.

Monitoring to date has demonstrated that there has been a significant take-up of guide-led tours with 11 Fraser Coast 4WD hire operators that facilitate backpacker hire vehicle tours taking up Commercial Activity Agreements in tag-a-long tour arrangements with a maximum of four vehicles in a tour, with a driver guide in the lead vehicle.

Substantial benefits are already evident including better management of the backpacker segment of the tourist industry, improvements in the quality of the tourism experience and improved management of adverse environmental and social impacts associated with camping and visitor activities. Monitoring and feedback to date indicates that there has been compliance with all new restrictions and the Department of Environment and Resource Management has been advised by officials from the Department of Transport and Main

Roads that substantial improvement in the vehicle standards has occurred over the past months following compliance inspections that have been carried out.

Continuous monitoring of the conditions of Commercial Activity Agreements is a part of normal operations.

Recommendation 2 – Check comprehension

With such a significant volume of first time and foreign visitors seeking permits to drive on the island, I am of the view that there would be utility in ensuring they have understood the crucial safety measures conveyed in the DERM video and facts sheets. I therefore recommend that DERM consider introducing a set of questions to accompany the application for vehicle permits.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Environment and Resource Management

The Coroner's recommendation relates to the process for issuing vehicle access permits required for vehicles visiting the recreation management area on Fraser Island.

Introducing a set of questions as a test prior to applying for a vehicle access permit remains difficult to readily accommodate. The issuing of visitor access permits applies through a number of outlets, including through agents, on-line and privately and it would be difficult to ensure comprehension of the content through a set of questions that applied to the large number of visitors to the island.

Notwithstanding this the Department of Environment and Resource Management visitor information guides for Fraser Island and all other destinations that have sand driving, include best practice and safety information about driving on sand. These are available to all visitors to the island. This alert about the operating conditions is displayed on the Department of Environment and Resource Management website and in all brochures as being a primary issue to be considered when visiting these areas, particularly if visitors are not used to four-wheel driving on sand.

Ensuring that the limited regulated commercial operators are aware of the hazards of the operating environment on Fraser Island is relatively easy compared to guaranteeing that all visitors comprehend the risks associated with operating a 4WD in the hostile operating environment found on Fraser Island.

Officials from the Department of Environment and Resource Management are looking at Commercial Activity Agreements including a notice that requires that 4WD hire operators ensure that all tourists in tag-a-long tours watch the Department of Environment and Resource Management DVD that provides best practice tips and safety information on driving on sand. Consideration of this approach will by necessity take into account the effectiveness of this mandatory requirement from an enforcement point of view, as well as the outcome sought through a measure such as this.

Recommendation 3 - Review of speed limit

In view of the extensive evidence that in many circumstances driving at 80 km per hour on the eastern beach is unsafe and the evidence indicating it can be difficult for first time beach drivers to identify when this is the case, I recommend the Fraser Island Traffic Accident Committee consider recommending to DERM that the speed for hired 4WD vehicles on the island be limited to 60 km per hour.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Environment and Resource Management

The Fraser Island Traffic Advisory Committee has met and deliberated over this recommendation. The Department of Environment and Resource Management has been advised by the Traffic Advisory Committee to retain the existing speed limit to apply to all users. The Department of Environment and Resource Management supports this recommendation from the Advisory Committee.

One of the reasons for not adopting this recommendation was that it was considered that having two speed limits for vehicles (60 km/hr for hire 4WD vehicles and 80 km/hr for other vehicles) could possibly lead to dangerous overtaking situations and the creation of a "four lane highway" along the beach.

Recommendation 4 - Age restriction for independent drivers

In view of the evidence that the risk of crashing reduces with age, and in view of the impending introduction of tag-a-long tours, I recommend DERM consider only issuing vehicle permits to independent travellers hiring 4WD vehicles if they are 25 or older.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Environment and Resource Management

The current vehicle access permit pursuant to the *Recreation Areas Management Act 2006* as applied on Fraser Island requires drivers to be licensed and that all vehicles must be registered. They are silent on the question of age of the driver, instead, vehicle access permits defer to the other laws in force in Queensland that regulate vehicles and their licensed operation.

The Department of Environment and Resource Management has considered this recommendation and cannot support its application because it would impose a significant administrative burden and require the Department of Environment and Resource Management to:

- firstly, determine the age of the driver upon application for a vehicle access permit

- secondly, separate other 4WD drivers who may not be driving a hire 4WD, but be under 25 years old

- thirdly, it could potentially create an expectation that an age limit be applied to drivers of 4WD vehicles elsewhere in Queensland.

The 4WD hire industry as a whole applies premiums to drivers who are under 25 years old in recognition that the relative risk of drivers crashing reduces with age.

The Department of Environment and Resource Management ensures that relevant information about operating conditions is available to all 4WD hire outlets. The Department of Environment and Resource Management believes that the 4WD hire industry is best placed to determine whether they hire a vehicle to a suitably licensed driver and ensure the hirer is duly informed of the operating environment.

Recommendation 5 - Annual vehicle safety inspections

In view of the failure of self regulation to ensure the Fraser Island 4WD hire fleet is maintained to an acceptable safety standard, I recommend DERM only issue vehicle access permits to hire vehicles that have undergone an annual safety inspection.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Environment and Resource Management

Currently, the Department of Environment and Resource Management may issue a vehicle access permit for vehicles (irrespective of whether they are hired or not) and requires that the driver is licensed and that the vehicle is registered pursuant to the *Transport Operations (Road Use Management) Act 1995*. The vehicle access permit applies to all vehicles, not just hire 4WD vehicles.

In light of the extensive vehicle compliance activities already undertaken by officials of the Department of Transport and Main Roads, the Department of Environment and Resource Management understands that the compliance inspection regime is producing positive results. In particular, a demonstrable reduction in the number of vehicle defects has been identified.

The Department of Transport and Main Roads advises that such compliance actions include specifically targeting GVM and vehicle safety issues (with a focus on hire vehicles and tour vehicles); passenger transport requirements (particularly tag-a-long tour operators) that include seating configuration and other recovery technicalities associated with driving in difficult terrain. The Department of Environment and Resource Management supports the continuance of these compliance actions as a successful safety initiative.

The Department of Environment and Resource Management has been investigating the feasibility of imposing the requirement to have hire vehicles annually inspected through the Commercial Activity Agreement and the Interagency Working Group has been considering this suggestion. However, even if such a condition were to be included in Commercial

Activity Agreements, it would not capture all hire 4WDs as the Department of Environment and Resource Management only regulates commercial activities pursuant to its legislative requirements. The intent of the Coroner's recommendation is, on the face of it, to apply to all hire 4WDs, not just those regulated by the Department of Environment and Resource Management as commercial operators to Fraser Island. On this basis, the Department of Environment and Resource Management cannot support the recommendation in totality, but can consider relevant conditions on commercial operations through its legislatively based permit requirements and Commercial Activity Agreements.

The Department of Environment and Resource Management is not placed to provide clarification of how such annual safety inspections could be accommodated across the whole of the 4WD hire industry in Queensland. While there may be substantial argument that hire vehicles should be subject to an inspection regime, the Department of Transport and Main Roads has advised that the legislation administered in the Department of Transport and Main Roads portfolio does not extend to requiring inspection of hire vehicles on a periodic basis.

The Department of Transport and Main Roads investigated whether to amend the *Transport Operations (Road Use Management – Vehicle Standards and Safety) Regulation 2010* to mandate a periodic inspection regime. A statutory periodic inspection regime was determined to be impractical and would be largely ineffective. Furthermore, an issue of feasibility that is already apparent is that a 4WD could be hired from an interstate location and then, as a function of intending to visit Fraser Island, it may require an annual inspection. This could potentially have national and statewide implications for the 4WD industry, not just for the Fraser Island 4WD hire industry. Transport Inspectors have vehicle safety inspection powers under the *Transport Operations (Road Use Management) Act 1995* and the *Transport Operations (Road Use Management – Vehicle Standards and Safety) Regulation 2010* and include in their work programs random inspections of vehicles on Fraser Island.

Inquest into the death of Fay Cramb

Ms Cramb died on 27 May 2008 at Townsville Hospital from natural causes three weeks after undergoing an emergency cardiac procedure. Ms Cramb was formerly known as Valmae Beck and at the time of her death was serving a life sentence in Townsville Correctional Centre.

State Coroner Barnes delivered these findings on 7 May 2010.

Recommendation 1 - Facilitate AHCD

I recommend that as the primary provider of health care to the prison population, Offender Health Services facilitate the creation and periodic review of advance health care directives for prisoners reasonably in need of such a mechanism.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Offender Health Services has updated their procedure regarding consent, which includes advanced health directives for offenders. This will be in line with the Queensland Health Policy but amended to reflect the patient being in the correctional environment. The procedure will include the creation and periodic review of the health directive and aligns with the decision making regime set out in the *Powers of Attorney Act 1998* and the *Guardian and Administration Act 2000*.

Recommendation 2 - Consent to treatment policy

I recommend Offender Health Services review its Consent to Treatment policy to ensure it aligns with the substituted decision making regime set out in the *Guardian and Administration Act 2000* (GAA) and *Powers of Attorney Act 1998* (PAA).

Response and action
Agreed and completed
Responsible agency: Queensland Health

The Offender Health Services has updated their Consent to Treatment procedure. The procedure includes the creation and periodic review of the health directive and aligns with the decision making regime set out in the *Powers of Attorney Act 1998* and the *Guardian and Administration Act 2000.*

Inquest into the death of Mulrunji

Mulrunji (also known as Cameron Doomadgee) died on 19 November 2004 on Palm Island. At the time of his death, Mulrunji had been taken into custody and was found to have died from multiple internal injuries resulting from some force to the abdomen. The Coroner was not able to ascertain whether these fatal injuries were inflicted accidentally or by the deliberate actions of the arresting officer Sergeant Christopher Hurley.

Coroner Hine delivered these findings on 14 May 2010.

Recommendation 1

That the future investigation of deaths in police custody, which exhibit indicia of unnatural causes or which have occurred in the context of police actions or operations be undertaken solely or primarily by the CMC, as the specialist misconduct and anti-corruption body for the State of Queensland. To enable this to occur, I recommend that the CMC be resourced and empowered (by legislative fiat) to undertake the role.

Response and action
Agreed in part and partially completed
Responsible agency: Department of Justice and Attorney-General in consultation with the Crime and Misconduct Commission and the Queensland Police Service

Ongoing discussions between the Crime and Misconduct Commission (CMC), the State Coroner and the Queensland Police Service in relation to responsibilities for investigating police related deaths in Queensland, led to agreement about interim and proposed arrangements and their recording in a Memorandum of Understanding (MOU).

Implementation of those proposed arrangements were considered during the recent review of the police complaints, discipline and misconduct system. In the Government response to that independent review, released on 29 August 2011, the Government "supported the execution of a MOU between the CMC, the QPS and the Coroner in relation to the police-related deaths. The MOU will clarify roles and responsibilities, resourcing and conflict resolution." The timeframe for implementation of this is between 6 and 12 months from the release of the Government response.

Pending the formal execution of the MOU and the implementation of the agreed arrangements for investigating these deaths, CMC investigators are attending at the scenes of all police related deaths to oversee and assist with the conduct of initial inquiries, subject to the Coroner's direction.

Recommendation 2

That the CMC in future cases gives closer consideration to insisting upon separate legal representation for police witnesses in serious contentious matters where evidence may be in conflict, or where the testimony of one officer may inadvertently influence the account of

another officer, because of an unwitting disclosure by a common legal representative. If the Chairman considers that a legislative framework is needed, as described above, I would recommend such legislation to the Government.

Response and action
Agreed and partially implemented
Responsible agency: Crime and Misconduct Commission

This recommendation has been noted by the Crime and Misconduct Commission (CMC) and will be actioned in appropriate investigations where such issues arise.

Pending the execution of the MOU formally recording agreed arrangements between the Office of the State Coroner, the QPS and the CMC as to the investigation of police related deaths (see response to Recommendation 1) detailed investigation protocols are being developed that, among other things, address this issue and how it is to be approached by investigators.

Comment 1 (page 160)

That Local Community Justice Groups comprised of Elders and trusted members of Indigenous Communities should be established/ maintained in Indigenous communities. Questioning of Indigenous witnesses should be undertaken in the presence of members of the Community Justice Group and questioning of witnesses should be delayed until a member of the Community Justice Group is available. Police and other investigative officers should be trained or regularly re-trained on the appropriateness of indirect questioning and alerted to the nuances of silence, gratuitous concurrence and avoidance of eye-contact when questioning Indigenous witnesses.

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

The first Community Justice Group (CJG) in Queensland was established in 1993. The Department of Justice and Attorney-General (DJAG) has managed the CJG program since July 2006. Currently, there are 52 CJGs across Queensland being supported by DJAG with 21 of them established in discrete Indigenous communities (including Palm Island).

DJAG supports in principle CJG members being present at the questioning of Aboriginal or Torres Strait Islander witnesses. However, given that CJGs are comprised entirely of volunteers, it is not practicable to mandate their attendance at the questioning of witnesses.

In late 2010, an independent evaluation of the CJG program was conducted by the management consultancy firm KPMG. One of the main recommendations was for CJGs to focus on supporting court and criminal justice procedures.

In 2011-12 it is proposed that the operational model of the CJGs will be refined and a legislative review will be undertaken. This will include consideration of the findings and recommendations detailed in the 2010 independent evaluation, such as the need for a tighter focus on court-based activities. Whether CJGs have a role (and the nature and extent of that role) at the questioning of witnesses will be considered as a part of this process.

It is proposed that the refined model be trialled with a small sample (5-7) CJGs, including at least two in discrete Indigenous communities, during 2011-12. After analysis of this trial, it is proposed that the new model be progressively rolled out to all 52 CJGs across Queensland by 1 July 2014. However, the capacity of each individual CJG may still determine if they are able to provide this service.

In 2013, it is proposed that the Crime and Misconduct Commission (CMC) will audit and report on police officers' compliance with safeguards for Indigenous persons being interviewed under section 420 of the *Police Powers and Responsibilities Act 2000*.

Response and action
Agreed in part and completed
Responsible agency: Queensland Police Service

The advantages of Community Justice Groups in indigenous communities and their role in enhancing investigations are well recognised. The Cultural Advisory Unit within the Office of the Commissioner facilitates a range of training programs that aim to improve understanding and communication between police and members of indigenous communities. Of note are Community Specific Information Training packages specifically tailored to 15 indigenous communities. The Police Service is committed to ongoing enhancement of that training.

Chapter 6 of the Queensland Police Service Operational Procedures Manual requires investigators to have legal representatives or appropriate interview friends present when conducting interviews with indigenous people. The Coroner's recommendation implies those interview friends should be drawn from the membership of the relevant Community Justice Group. In most cases, Community Justice Groups will be an appropriate source of interview friends. However, the Police Service does not propose to mandate interview friends be members of Community Justice Groups in order to maintain sufficient flexibility to meet the individual investigative circumstances and needs of witnesses.

Comment 2, (page 160)

That counselling services be provided to witnesses involved in the coronial process. Further, that the availability of counselling services should be made known to each witness and should be directly offered to each witness before and after they give evidence.

Response and action
Not agreed and not being implemented
Responsible agencies: Joint response between Queensland Health (lead) and Department of Justice and Attorney-General

The Queensland Health Coronial Counselling Service works directly with the relatives of deceased persons whose deaths are the subject of coronial investigations. Wherever practicable, this service includes the provision of support to family members who are witnesses at inquests on a statewide basis. Extensions to cover non-family witnesses are not currently under consideration. This would require extensive redesign of the counselling service, including obtaining substantial additional resources and addressing the potential criticism by family members that counsellors are supporting witnesses seen as culpable for the death. Moreover, a range of counselling services is already available to witnesses through Lifeline and employee assistance services. Information about counselling services as well as coronial processes is available on the Office of the State Coroner website.

Comment 3 (page 160)
I desire to record my broad agreement with the adopted comments of the DSC (Deputy State Coroner) – in her section 46 comments at pages 28 and following of her findings dated 27 September 2006.

A response to DSC Clements 2006 recommendations was tabled in Parliament on 2 November 2006 and as such, these recommendations are not responded to individually in this report.

Inquest into the death of Dale Robert Welburn and Kerri Leigh McPherson

On 27 August 2007, the car Mr Welburn was driving, and in which Ms McPherson was the sole passenger, was involved in a three-vehicle accident at the intersection of the Bruce Highway and Lucketts Road approximately 2 km south of Childers. The impact inflicted significant injuries on both Mr Welburn and Ms McPherson from which they were found to have succumbed to instantly. Three factors contributing to the accident were found to be driver error, poor visibility and poor road design.

Coroner Batts delivered these findings on 21 May 2010.

Recommendation 1

That the relevant intersection be subject to a "left-in, left-out" arrangement. Accordingly, vehicles travelling south would be able to turn left from the Bruce Highway onto Lucketts Road or from Lucketts Road south onto the Bruce Highway. Northbound vehicles would not be able to turn right into Lucketts Road but would have the option of continuing through Childers or taking the next available right hand turn if they need to.

Response and action
Agreed in part and partially completed
Responsible agency: Department of Transport and Main Roads

Bundaberg Regional Council is concerned that traffic may be diverted to other local streets with intersections on the Bruce Highway. While there is a small risk of this occurring, overall crash savings will be achieved with the Coroner's recommendation.

The Department applied for Federal funding of the upgrade work, including an adjacent intersection (Goodwood Road) to where the majority of traffic will be diverted. Preliminary intersection designs have been completed.

Federal funding has been received with commencement of construction estimated to occur in 2013/2014. An external engineering consultant will be engaged in early 2012 to undertake preconstruction activities.

Interim safety measures have been taken to reduce the impact of Lucketts Road traffic (such as lowering the speed and banning heavy vehicles).

Inquest into the death of Timothy Gerard O'Neill

Mr O'Neill died on 20 September 2007 at the Princess Alexandra Hospital as the result of severe head injuries sustained in a boating accident seven days prior. Mr O'Neill and two friends were attempting to enter the mouth of the Brisbane River upon their return from a fishing trip when their boat collided with a rock seawall. This seawall is a part of the Port of Brisbane's reclamation area in Moreton Bay and was not included on the map made available to Mr O'Neill and his friends that day. Furthermore, it was not lit up on their return and the skipper did not recognise other buoyage markings indicating its presence.

Deputy Coroner Clements delivered these findings on 28 May 2010.

Issue A: the current recreation boat-licensing regime is insufficient to equip a licence holder to safely navigate at night.

Recommendation 1

The recreational boat licence should be reviewed to add an additional certification for operation of a boat between sunset and sunrise. The certification must require sufficient theoretical and practical testing of night navigation knowledge and on water practical skills.

Response and action
Agreed in part and partially completed
Responsible agency: Department of Transport and Main Roads

A BoatSafe course is typically comprised of classroom theory followed by an on water practical training and assessment undertaken in daylight hours. Candidates are assessed for competence in applying the International Association of Marine Aids to Navigation and Lighthouse Authorities (IALA) buoyage system, use of aids to navigation and the International Regulations for the Prevention of Collisions at Sea.

While the current course requires these competencies to be demonstrated in daylight hours it is not practical to require the more than 31,000 new Recreational Marine Driver Licence (RMDL) candidates each year to undertake on water competency assessment at night.

Maritime Safety Queensland is upgrading the content of the BoatSafe course that must be completed by RMDL candidates to include a night and electronic navigation training video that must be viewed by licence candidates. This will be completed by January 2012.

Issue A: the current recreation boat-licensing regime is insufficient to equip a licence holder to safely navigate at night.

Recommendation 2

If the recreational boat licence is changed as recommended, consideration also be given to restricting existing recreational boat licence holders to daylight operation until their licence is upgraded with the night navigation certification.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Transport and Main Roads

This recommendation is not being implemented as the BoatSafe Scheme is unlikely to be able to accommodate the large volume of existing licence holders that would need to upgrade their licence. The recommendation would also create inconsistencies with licence requirements in other jurisdictions.

If only those licence holders operating at night were required to hold a night endorsement, at least 101 400 people (about 15 percent of 676 000, existing licence holders) would need to obtain that endorsement. Face-to-face training through an expanded BoatSafe scheme is unlikely to be able to accommodate the volume of existing licence holders needing to upgrade their licence. Introducing endorsements or new licence classes in addition to the basic Recreational Marine Driver Licence will also create mutual recognition issues preventing interstate visitors from operating recreational boats at night in Queensland.

Maritime Safety Queensland will, however, upgrade the content of the current BoatSafe training course to include a night and electronic navigation training video that must be viewed by recreational marine driver licence candidates. This will only need to be completed by new licence candidates.

Issue A: the current recreation boat-licensing regime is insufficient to equip a licence holder to safely navigate at night.

Recommendation 3

Consideration of a five-yearly theoretical refresher test of knowledge of boating rules and navigational knowledge.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Transport and Main Roads

Consideration was given to a requirement that the renewal of a recreational boat licence require licence holders to successfully complete an online boating safety course. However, it was determined to not be appropriate as it would create an inconsistency with vehicle licensing where no refresher course is required.

Issue A: the current recreation boat-licensing regime is insufficient to equip a licence holder to safely navigate at night.

Recommendation 4

The evidence indicates there is common reliance on satellite navigation aids, and perhaps more reliance on these than paper charts

and guides. The evidence revealed that the satellite navigation aids can be used without an understanding of the scale of the map presented on screen, which can create a dangerous situation. It is recommended that future navigation skill testing should include both chart based understanding and interpretation, as well as the operation and understanding of satellite navigation devices. Cross-referencing between these aids to navigation should also be included in licensing requirements for night navigation certification.

Response and action
Agreed and partially completed
Responsible agency: Department of Transport and Main Roads

The use of electronic navigation devices or GPS systems onboard vessels can be beneficial. However, the accuracy of the GPS system is essential for safe navigation. The concerning aspect of a GPS system is that not every unit is completely accurate, either due to being set in the wrong datum or having outdated software. These inaccuracies can mean that map coordinates may be out by up to several hundred metres.

Maritime Safety Queensland has initiated a GPS project that will assist boat owners to check whether their GPS coordinates displayed on screen are accurate. The project will establish verified checking points at various boat ramps and on-water locations around Queensland. Each checking point will display a sign with the correct coordinates for its exact position. This will provide a point of reference for boat operators to check their own GPS systems against, showing them how accurate (or not) their system is. Armed with this knowledge, boat operators will then be aware that there may be an issue with their GPS unit and directed where to go for further detailed information.

As part of the project, an information flyer will be distributed which will alert boat owners of the location of the verified checking points and suggestions for correcting their GPS units. Additional information will also be provided on correctly using GPS for navigation and the dangers of relying solely on the electronic systems. Boat drivers will be encouraged to always 'keep a lookout' and consult navigation charts and publications such as Beacon to Beacon in addition to using their GPS.

It is intended to complete this project by the end of 2011. However, it is also subject to the flood damage that has been caused to the South East Queensland's waterways.

Maritime Safety Queensland is also upgrading the content of the prerequisite BoatSafe course that must be completed by Recreational Marine Driver Licence candidates to enhance the night and electronic navigation training components. The revised BoatSafe course will be implemented by January 2012.

A training video is in production with the content completed. Once finalised a copy of the video will be used by BoatSafe training providers to show to candidates during the BoatSafe course. It is expected that the video will also be able to be downloaded from the Maritime Safety Queensland website by January 2012.

Issue B: the visibility and warning of existence of the rock seawall perimeter of reclaimed land to the mouth of the Brisbane River, particularly in conditions of new moon and high tide.

Recommendation 5

It is recommended the light of the existing North Cardinal Mark indicating the seawall be changed to a "very quick" sequence to improve its visibility and attract mariners' attention, noting there is considerable background lighting on land, particularly from the perspective of small boat operators.

Response and action
Agreed and completed
Responsible agency: Department of Transport and Main Roads

The sequencing of the light of the North Cardinal Mark was changed immediately to meet the Coroner's recommendations

Issue B: the visibility and warning of existence of the rock seawall perimeter of reclaimed land to the mouth of the Brisbane River, particularly in conditions of new moon and high tide.

Recommendation 6

It is recommended that Maritime Safety Queensland direct the Port of Brisbane to light the face of the rock seawall, with due consideration of shrouding of lighting to ensure attention is drawn to the face of the rock seawall but does not add to light "clutter". When development of the reclaimed area reaches a stage where it becomes visibly obvious on approach from Moreton Bay at night-time, the lighting of the sea wall may no longer be necessary.

Response and action
Agreed and completed
Responsible agency: Department of Transport and Main Roads

The Port of Brisbane Pty Ltd at the direction of the Regional Harbour Master (Brisbane) installed 47 yellow warning lights on the sea wall placed at a distance of 50 metres apart. Notice to Mariners (No. 803) was promulgated to this effect.

Issue B: the visibility and warning of existence of the rock seawall perimeter of reclaimed land to the mouth of the Brisbane River, particularly in conditions of new moon and high tide.

Recommendation 7

Alternatively, to recommendation (6) above, consideration should be given to testing a series of marker buoys or "special markers", as deployed during the construction stage of the rock sea wall.

Response and action
Agreed and completed
Responsible agency: Department of Transport and Main Roads

In accordance with the Coroner's recommendation, Marine Safety Queensland established 12 litre temporary yellow buoys in positions stated in our Notice to Mariners (No. 654) on 3 August 2010. These buoys were meant to be a temporary measure pending the Port of Brisbane Pty Ltd establishing a more effective and permanent measure. The installation of a lighting system resulted in the buoys being ineffective and no longer necessary to ensure maritime safety.

Issue B: the visibility and warning of existence of the rock seawall perimeter of reclaimed land t the mouth of the Brisbane River, particularly in conditions of new moon and high tide.

Recommendation 8

It is recommended that Maritime Safety Queensland conduct an information and education campaign by mail and other forms of communication that will:

(a) reach each holder of a marine vessel driver's licence and each registered owner of any recreational vessel in Queensland;
(b) extend to New South Wales Boating Authorities to pass on to its licensees who may be visiting Brisbane;
(c) reach all charter operators and organisations that charter hire vessels and to people who may operate them in circumstances such as Club Exec 500;
(d) include information drawing attention of licence holders to:

- the need to ensure that navigation is carried out by use of ALL available information (charts etc) and not solely by relying upon navigation by GPS

- the need to have updated information available, including most particularly updated electronic charts in GPS units

- the need to travel at a safe speed when entering the Port of Brisbane, particularly at night and in other conditions of limited visibility

- clarify the apparent anomaly in instructions between the need to avoid large vessels in the channel and the need to safely navigate into the river

- the availability of ongoing information about new developments in this area, in particular the availability of Notices to Mariners and the way in which that information can be accessed.

Response and action
Agreed in part and partially completed
Responsible agency: Department of Transport and Main Roads

All feasible steps have been taken to implement the Coroner's recommendations. However, it is cost prohibitive to distribute educational materials to each registered vessel owner and licence holder by mail.

Action taken includes:

- Publishing the Guide to Recreational Boating and Fishing that includes information about navigating with a GPS. This publication is widely available to the boating public with 100 000 printed annually.

- Features on the Creek to Coast television show on boating safety, keeping a proper lookout and not relying on GPS for navigation. Segments were aired on 17 April 2010 and 17 July 2010.

- A project has been implemented to erect signs at boat ramps giving GPS coordinates for that location, so that boat owners can check the coordinates showing on their GPS. There will be information directing people to where they can find further advice should there be a significant difference in the coordinates on their GPS and the signs. Information will be posted on the Maritime Safety Queensland website and there will be some media with follow up editorial in appropriate boating publications. The first sign was installed at Manly Boat Harbour on April 18 2011. Eleven more signs were subsequently installed and their locations published on the Marine Safety Queensland website. Approximately 60 more sites have been identified and are awaiting local government approvals with roll out anticipated to be completed by the end of 2011 weather and local government approval permitting.

- Information has been published about interaction between ships and small craft in the Guide to Recreational Boating and Fishing along with posters indicating ship

navigation areas and recommended small craft courses for various ports in Queensland. This information was published in 2007 and posters were distributed to clubs and volunteer organisations through Marine Safety Queensland regional offices

- The Maritime Safety Queensland website, Beacon to Beacon, Queensland Tide Tables and boating safety charts provide information on ship navigation areas and recommended small craft courses for various parts in Queensland.

- A television segment on navigating near large ships and shipping channels was aired in September 2010.

- Notices to Mariners' and advice on using them to update charts are published in Beacon to Beacon and on boating safety charts.

- A television segment on navigating near large ships and shipping channels was aired in September 2010.

- Notices to Mariners' and advice on using them to update charts are published in Beacon to Beacon and on boating safety charts.

The Department will continue to develop, implement and maintain marketing and education programs to ensure community safety in Queensland. These programs and initiatives are ongoing and are an integral component of Maritime Safety Queensland's business plans.

Inquest into the death of Bradley John Muller

Mr Muller died on 1 November 2008 at his home in Gatton from an overdose of quetiapine (contained in his prescribed medication Seroquel) combined with alcohol. It could not be conclusively determined whether or not Mr Muller intended the overdose to be lethal but he did seek medical attention at the Gatton Hospital on three separate occasions in the early hours of the morning before his death, stipulating that he had taken more than the prescribed amount of his medication.

Coroner Ryan delivered these findings on 9 June 2010.

Recommendation 2(a)

That Queensland Health urgently provides:

(a) Full training in emergency and mental health to health professionals staffing regional/rural hospitals after hours.

Response and action
Agreed and completed
Responsible agency: Queensland Health

In 2008, the Queensland Centre for Mental Health Learning developed a mental health training module for emergency department staff, applicable to both urban and rural care settings. This training module comprised information on the use of Mental Health Triage Scales, the identification of specific risk factors associated with mental illness for emergency departments, the principles of mental health assessment, components of the *Mental Health Act 2000* and the Queensland Health Emergency Department Mental Health Management Protocols (May 2007). The module was included in the Emergency Events Management Program as a one-day training session on mental health to be delivered to medical and nursing staff working in emergency departments.

Responsibility for implementation of the Emergency Events Management Program was transferred to the Clinical Skills Development Service (CSDS) in 2008. The module continues to be provided by the Clinical Skills Development Service on a monthly basis to medical and nursing staff working in emergency departments.

Recommendation 2(b)

That Queensland Health urgently provides:

(b) a policy for dealing with mental health patients presenting to regional/rural hospitals after hours.

Response and action
Agreed and partially completed
Responsible agency: Queensland Health

The Mental Health, Alcohol and Other Drugs Directorate (MHAODD) developed draft Emergency Department Mental Health Management Protocols in 2006. This draft protocol is available on the MHAODD website and is useful for the management of patients presenting at emergency departments in need of mental health care.

Statewide standardised Models of Care have been and continue to be developed through the Clinical Reform Initiative. The Acute Care Team Model of Service, which is now finalised, standardises statewide practices regarding mental health presentations to emergency departments. Variances in options are recommended to accommodate the diverse range of service capability within Queensland Health services. The Queensland Health Clinical Services Capability Framework version 3.0, which was endorsed in January 2011 and published in May 2011, has incorporated these details.

However, all Statewide Policies, Protocols and Guidelines for Mental Health are currently in the process of being reviewed and put under the new Queensland Health Policy Management Framework.

Inquest into the death of Paul Gerard Joseph Robinson

Mr Robinson died on 25 September 2007 from multiple injuries sustained in a single-vehicle accident occurring on the Maleny-Kenilworth Road in Conondale. The accident occurred when Mr Robinson failed to negotiate a left-hand turn on a steep descent in the truck he was driving. Mr Robinson's truck did not slow sufficiently to successfully negotiate the bend and while there was evidence suggesting that the breaks were faulty, it could not definitely be determined that the accident would not have occurred if the breaks were operating normally. There were also concerns about the placement of signs alerting drivers to the descent.

Coroner Hodgins delivered these findings on 24 June 2010.

Recommendation 1

That when a request is made for a mechanical examination of an accident vehicle, that the request set out the known circumstances of the accident.

Response and action
Agreed and partially completed
Responsible agency: Queensland Police Service

Motor vehicle inspections are conducted by qualified members of the Vehicle Transport Section of the Queensland Police Service (QPS). They are accepted as expert witnesses by courts of all levels. Their independence from the investigation of any particular traffic crash is an important consideration when utilising their services.

Current QPS operational procedures pertaining to the involvement of motor vehicle inspectors require investigating officers to provide details of any alleged vehicle defects. An amendment has been drafted to the relevant section of the QPS Traffic Manual which will require brief details of the circumstances of the crash to be provided to vehicle inspectors in addition to allegations of vehicle defects.

The amendment will come into effect with the next edition of the QPS Traffic Manual scheduled for publication in December 2011.

Recommendation 2

Criticism was made by Dr Grigg of the positioning of the warning sign on the level section prior to the final descent. He recommended a sign be added prior to the final decline. This recommendation is agreed with. Queensland Transport is reviewing the signage for all roads with declines in South East Queensland as part of its management of hazardous grades.

The recommendation is that the Department of Transport and Main Roads consider Dr Grigg's recommendation as part of its review of signage for declines in South East Queensland.

Response and action
Agreed and partially completed
Responsible agency: Department of Transport and Main Roads

The Department of Transport and Main Roads has improved signage at the location of the fatal crash by changing the wording of the previous sign "Trucks Use Low Gear" to a new sign stating, "10% gradient – Next 2 km", to conform with the Manual of Uniform Traffic Control devices. The sign improvements also consist of duplicating signs associated with the grade on the right side of the road. After further assessment conducted at the site, the Department will install an additional set of signs stating "Trucks and Buses Use Low Gear" closer to the final descent (in line with Dr Grigg's recommendation). This work has been ordered and will commence as a matter of priority.

The Department also has a program to identify and treat safety deficiencies on all state-controlled roads with potentially hazardous grades (defined in the Manual of Uniform Traffic Control Devices Part 2 – Section 3.9). This work is being undertaken in accordance with an "Element Management Plan" developed as part of the Queensland Road System Performance Plan (QRSPP).

The hazardous grades element management plan requires all hazardous grade routes to be identified and 20% of these sites to be treated by June 2016.

Recommendation 3

Senior Constable Christiansen needed assistance as his investigation progressed. It progressed beyond the scope of a truck roll-over to the investigation of a company's vehicle maintenance. He was not equipped and did not have the resources to perform this aspect of the investigation. His core capability was in the investigation of motor vehicle accidents. The agency with the higher level of statutory responsibility for motor vehicles, Queensland Transport did not even report back to Senior Constable Christiansen the findings made on the audit of the company's accreditation system. Workplace Health and Safety merely audited plant and materials.

Lessons need to be learned by all agencies involved of a better way to work together in the future in such a situation as unfolded in this instance. A more co-operative approach is needed. There needs to be a commitment at senior level to commit resources to ensure a more co-operative professional investigation is carried out.

It is recommended senior officers of Queensland Police Service, Workplace Health & Safety Queensland and Queensland Transport confer and develop an action plan to ensure inter-agency co-operation

occurs through allocation of resources and priority to ensure timely investigation of any future truck accident.

Response and action
Agreed and partially completed
Responsible agency: Joint response between the Department of Justice and Attorney-General (lead), the Department of Transport and Main Roads and the Queensland Police Service

Interagency working group discussions commenced between Workplace Health and Safety Queensland (WHSQ), the Queensland Police Service (QPS) and the Department of Transport and Main Roads (DTMR) regarding the possible implementation of this recommendation.

The working group has agreed to develop a Memorandum of Understanding (MOU) between the three agencies that will document how each agency will respond to accidents that involve a work vehicle. WHSQ is leading the development of this MOU and anticipates that it will be finalised by March 2012.

An operational document is also being prepared by WHSQ to guide inspectors on this issue. The document will complement any future MOU with the DTMR and QPS.

Inquest into the death of a 9-year-old child in Rockhampton

A nine-year-old child died on 4 January 2007 at the Rock Pool Water Park in Rockhampton after he fell off an inflatable device he was playing on and subsequently drowned. The child had attended the water park that day with his family.

Coroner Hennessy delivered these findings on 24 June 2010.

Recommendation 1

That when items such as inflatable devices are in use in commercial or public pools, pool operators are to conduct a risk assessment on the use of the inflatable before commissioning it. The risk assessment should be conducted in accordance with the Royal Life Saving Society Australia (RLSSA) guidelines and take into account all information regarding the inflatable provided by the manufacturer.

Following the risk assessment, the pool operator should develop staff training on the issues raised in and procedures developed from the risk assessment and assess staff competency in the procedures. Those procedures should include scenario training relevant to the inflatable device in use. The Division of Workplace Health and Safety is to supervise the implementation of this recommendation.

Response and action
Agreed and completed
Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland has amended its guide (which is available on the Department's internet site) - *Managing drowning risks at publicly accessible pools* - to include a provision that requires operators of commercial or public pools, where large inflatable floating structures are installed, to conduct a risk assessment of the use of the structure before it is used by the public. The guide has also been amended to include that the pool operator must develop and implement procedures for the safe operation of the structure that eliminates or minimises the risks identified in the risk assessment process.

The revised guide has been forwarded to The Local Government Association of Queensland (representing councils) and the Australian Amusement, Leisure and Recreation Association for distribution to their members. The revised guide has also been forwarded to operators known to have large inflatable or floating structures.

The guide highlights the necessity for pool operators to train staff in safety procedures with a particular emphasis on emergency situations and encourages scenario-based training.

A specific Workplace Health and Safety Queensland audit campaign on operator compliance with the guide commenced on 1 September 2010. The audit campaign on operator compliance has been completed. A report has been drafted and it is anticipated that it will be available by the end of 2011.

Inquest into the death of a 9-year-old child in Rockhampton

Recommendation 3

That the Division of Workplace Health and Safety consult with industry and RLSSA and give consideration to establishing a Pool Industry Code of Practice as a Standard under the Workplace Health and Safety Act to provide a guide for commercial and public pool owners and operators on issues including risk management and which includes provision for effective monitoring and enforcement of the guideline.

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

Workplace Health and Safety Queensland is currently participating in the national harmonisation of work health and safety laws, which will see nationally harmonised laws adopted on 1 January 2012. The commitment to national harmonisation by Workplace Health and Safety Queensland is derived from the Inter-Governmental Agreement for Regulatory and Operations Reform in Occupational Health and Safety, which was agreed by the Coalition of Australian Governments on 3 July 2008.

This agreement prevents States and Territories from unilaterally adopting workplace health and safety legislation and codes of practice outside of the national harmonisation arena. To facilitate the implementation of nationally harmonised laws, a priority listing for the development of national codes of practice has been established. Due to the timeframes available, no new codes of practice are being considered.

Workplace Health and Safety Queensland has alerted all heads of Workplace Health and Safety Authorities in Australia and New Zealand of the Coroner's recommendations and that the Queensland guide was being reviewed.

In light of the national harmonisation agenda and the merits of the Coroner's recommendations, Workplace Health and Safety Queensland has prepared a submission to the Heads of Workplace Safety Authorities recommending that the Queensland guide *Managing drowning risks at publicly accessible pools* be adopted nationally.

Queensland proposed that this guide be adopted nationally. Some jurisdictions indicated their intention to place a link to the guide on their websites, however, it was agreed that it would not be adopted as a Heads of Workplace Safety Authorities document. Over time, through the process of harmonisation, this guide may potentially become the resource adopted nationally.

Recommendation 6

That the Department of Health, Local Government Association and the RLSSA consider conducting a public awareness campaign, reinforcing the need for continued supervision of children swimming at public pools by parents, carers, guardians or responsible adults.

Response and action
Agreed and completed
Responsible agency: Queensland Health

The Chief Health Officer (CHO) supports working in greater collaboration with the Royal Life Saving Society of Queensland (RLSSQ) to promote improved uptake of existing Keep Watch Programs which that includes the Public Pools Program. This program is run by the RLSSQ and is offered to local government authorities. As a consequence of this recommendation, the Healthy Living Branch of the Division of the Chief Health Officer has met with RLSSQ to discuss greater collaboration and promotional support for their existing water safety programs including this Public Pools Program. Outcomes of this meeting were: for RLSSQ to work up a proposal for the next funding round of Queensland Injury Prevention Council (QIPC); as well as to identify other cost neutral or minimal cost options for Queensland Health to promote existing water safety programs through existing statewide networks. However, the RLSSQ has not been able to progress this work due to capacity constraints (focused on the development and delivery of pool fence inspection training for new Queensland pool fencing legislation). The RLSSQ were made specifically aware of the latest funding round for the QIPC, however, they were unable to make a submission.

Through ongoing liaison with RLSSQ (for example with the QIPC funded evaluation of the Grey Medallion Program, the recent staging of the QIPC symposium in Townsville and the developmental trial of the pool fence inspection training program) it is clear that this collaborative work remains a priority and they still plan on developing a broader proposal in 2011 for progressing this work with Queensland Health.

Additionally, the QIPC funded evaluation of the Keep Watch Program has been completed and the final report has been recently received. Queensland Health is providing funding to RLSSQ by the end of 2011 to roll out the “Keep Watch @ Public Pools” program which will be rolled out to 15 locations statewide.

Recommendation 7

That the Department of Health and the RLSSA develop a program to promote and encourage parents and guardians to enrol children and other non-swimmers in learn to swim instruction, including skills to survive and sudden immersion event.

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

The Queensland Health Chief Health Officer is aware that the Royal Life Saving Society of Queensland has developed a program called Love 2 Swim targeted at primary and secondary school aged children. The Love 2 Swim program is a comprehensive swimming and water safety initiative that seeks to increase the swimming and water safety skills of all Australian children in order to prevent drowning and increase participation in safe aquatic activity.

The Department of Education and Training provides funding in the form of cash grants to eligible schools to assist in the provision of Learn to Swim programs. Principals may use the funds provided to support learn to swim programs in the most cost effective manner as determined by the school. On this basis, it is not considered that there is a need for Queensland Health to develop a new program.

The Department of Local Government and Planning has primary responsibility for the new pool fencing regulations and the associated pool safety awareness campaigns for domestic pools which will hopefully include a reference to encouraging more use of learn to swim classes. For example when a pool fence inspector does a home pool inspection, the opportunity will present itself to add value to the process by alerting parents to the availability of any local learn to swim classes and related safety advice.

Recommendation 9

That WPHS consider legislating a requirement for all operators of public pools in Queensland to hold membership of RLSSA to ensure operator compliance with safety guidelines offered by RLSSA and to promote greater safety awareness in the industry.

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

Workplace Health and Safety Queensland is currently participating in the national harmonisation of work health and safety laws, which will see nationally harmonised laws adopted on 1 January 2012. The commitment to national harmonisation by Workplace Health and Safety Queensland is derived from the Inter-Governmental Agreement for Regulatory and Operations Reform in Occupational Health and Safety, which was agreed by the Coalition of Australian Governments on 3 July 2008.

This agreement prevents States and Territories from unilaterally adopting workplace health and safety legislation and codes of practice outside of the national harmonisation arena.

Regardless of the impediments to adopting the recommendation within the current national harmonisation agenda, it has been assessed that the regulating of membership to the Royal Life Saving Society of Australia would not in itself ensure compliance with appropriate standards of safety with respect to drowning risks.

It is considered that the publication and promotion of the Queensland guide *Managing drowning risks at publicly accessible pools* and the carrying out of the current compliance

audits against the guide sufficiently achieve the objectives of the Coroner for improved safety awareness for operators of public pools in Queensland.

Further, Workplace Health and Safety Queensland's enforcement note (number 43) directs inspectors to the Royal Life Saving Society Australia guidelines to assess pool operation management of drowning risks.

Recommendation 10

That the Queensland Government reconvene a Queensland Water Safety Council including representation from Division of Workplace Health and Safety, Local Government Association, RLSSA, Qld Injury Surveillance Unit and other interested parties, perhaps under the auspices of the Commissioner for Children and Young People, in order to monitor issues and advise government on issues connected with public water safety.

Response and action
Agreed in part and completed
Responsible agency: Department of Local Government and Planning

Amendments to Chapter 8 of the *Building Act 1975*, which commenced 5 July 2010, included the establishment of the Pool Safety Council. The Pool Safety Council is made up of representatives from industry, water and child safety groups, departmental officers and other Government Agencies and is committed to contributing to national water safety initiatives.

Recommendation 11

That the Local Government Association of Qld and WPHSQ provide access to data involving public pools to RLSSA and approved researchers.

Response and action
Agreed in part and completed
Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland has written to the relevant organisations inviting access to particular data held by Workplace Health and Safety Queensland.

Recommendation 12

That the State Coroner improve the availability of appropriate information regarding drownings to approved researches at an early stage of the coronial investigation, allowing a more timely review of the event by experts and the development of prevention strategies. It is

noted that section 53(2) of the *Coroners Act 2003* makes provision for the supply of information in certain circumstances. Timing is the thrust of this recommendation.

Response and action
Agreed and completed
Responsible agency: Department of Justice and Attorney-General

In November 2009, the *Coroners Act 2003* was amended to simplify the approval process for researchers to access to coronial documents and facilitate earlier access by researchers. Specifically the State Coroner may approve access by researchers before the investigation is finalised if it is appropriate having regard to the importance of the research and the public interest. No applications have been received from genuine researchers for access to documents on open investigations of deaths involving drowning.

Recommendation 13

That WPHS improve the efficiency of the system for the issuing of Safety Alerts or other safety information to industry within a short period of time after an incident in order to protect public safety.

Response and action
Agreed and completed
Responsible agency: Department of Justice and Attorney-General

It is noted that the Coroner referred to the safety alert procedures that existed at the time of the inquest. A revised and more responsive safety alert procedure came into effect in the second half of 2009.

Experience within Workplace Health and Safety Queensland has demonstrated a more timely development and distribution of safety alerts under the new procedure.

Recommendation 14

That WPHS and QPS:

(a) develop a protocol for QPS officers to contact WPHS inspectors out of office hours in relation to incidents

(b) clarify the QPS Memorandum of Understanding with WPHS regarding the investigation of coronial matters and consider modification of the Operations Procedure Manual provisions which prohibit disclosure of information to external bodies without the authority of the Commissioner of Police in this regard

(c) Improve communication between WPHS inspectors and investigating Police when investigating a coronial incident.

Response and action
Agreed and completed
Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland and the Queensland Police Service have been working together on a Memorandum of Understanding that seeks to ensure a timely and constructive sharing of information, acknowledging arrangements established to ensure appropriate referral of matters arising out of hours.

The Memorandum of Understanding between the Department of Justice and Attorney-General and the Queensland Police Service has been agreed to and obtained final sign off in August 2011.

Workplace Health and Safety Queensland has also been liaising with the Coronial Support Unit, within the Office of the State Coroner, to ensure mechanisms are in place to facilitate a timely exchange of fatality related investigation material between Workplace Health and Safety Queensland inspectors and the investigating police officers.

In addition to the provisions in the Memorandum of Understanding for sharing information between the Queensland Police Service and Workplace Health and Safety Queensland, the State Coroner has authorised the release of any material to Workplace Health and Safety Queensland obtained as part of a coronial investigation. This process will enable more timely investigations by both agencies and will limit the duplications of resources.

Response and action
Agreed and completed
Responsible agency: Queensland Police Service

The existing Memorandum of Understanding between Workplace Health and Safety Queensland (WHSQ) and the Queensland Police Service (QPS) details after hours contact arrangements between the police and WHSQ Inspectors. The delay in contacting the WHSQ Inspector in this case is not considered to be attributable to the effectiveness of those arrangements.

The existing Memorandum of Understanding and the corresponding provisions of the Operational Procedures Manual outline arrangements for the timely exchange of investigative information between the parties. There is no necessity to obtain the direct approval of the Commissioner to release such information. However, a delay was incurred in this particular instance when advice was sought with respect to statements obtained from child witnesses.

The QPS is committed to maintaining and improving cooperative arrangements with WHSQ when investigating coronial incidents. A revised Memorandum of Understanding aimed at improving the overall QPS and WHSQ response to workplace incidents, has been signed and approved by the Deputy Commissioner (Specialist Operations), within the QPS.

Recommendation 15

That WPHS ensure that there is continuity of knowledge within the organisation when an Inspector responsible for an investigation leaves before it is complete, so that a report prepared by a subsequent investigator represents the entire details of the incident, and issues such as safety alerts or the dissemination of other safety information are advanced in a timely fashion.

Response and action
Agreed and completed
Responsible agency: Department of Justice and Attorney-General

The Coroner's recommendation has been highlighted to Workplace Heath and Safety Queensland staff through a combination of formal and informal mechanisms. Informal mechanisms have included discussions with Regional Directors regarding general oversight and hand over of investigation cases. Formal mechanisms have included the issuance of internal memorandums on the issue of data quality and exchange of information.

Recommendation 16

That WPHS develop, in conjunction with the State Coroner a more instructive and complete template or instructions to investigators to assist in preparation of coronial reports (reference might be had to the current QPS practice).

Response and action
Agreed and partially completed
Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland has initiated general discussions with the State Coroner regarding Workplace Health and Safety Queensland's report to coroners. Draft templates have been developed and are undergoing consultation internally. The drafting of the templates is attempting to take account of the varying types of information that is requested by coroners across the State and work being undertaken to nationally harmonise work health and safety authority operations.

Finalisation of the investigation template is imminent and it is anticipated that the template will be implemented from 1 January 2012.

Inquest into the death of Annette Lee Spencer

Mrs Spencer died on 21 November 2009 at the Royal Brisbane and Women's Hospital from head injuries she received the previous day when the balcony on which she was standing collapsed.

Coroner Lock delivered these findings on 28 June 2010.

Recommendation 2

That the Building Services Authority, the Brisbane City Council and other Local Government Authorities and Building Code and Residential Building Associations disseminate these recommendations to their members, stakeholders and the general public to highlight the need for an inspection of such buildings to identify any structural concerns and for remedial work to be carried out.

Response and action
Agreed and completed
Responsible agency: Department of Public Works

The Building Services Authority has implemented an awareness strategy in response to Coroner Lock's preliminary and final recommendations. This includes:

- a two page article regarding deck and balcony issues which was featured in the December 2009 edition of the Building Services Authority's Building Links publication which was available on the Building Services Authority's website in the week commencing 20 December 2009. A link to this publication was emailed to all Building Services Authority licensees in Queensland.

- a web link to the Coroner's preliminary recommendations of 12 November 2009 into the death of Ms Annette Lee Spencer has been published on the Building Services Authority's website since 13 November 2009 to alert Building Services Authority licensees, stakeholders and the general public to the Coroner's preliminary recommendations.

- a web link to the Coroner's "Findings of Inquest" (dated 28 June 2010) into the death of Ms Annette Spencer has been published on the Building Services Authority's website since 25 November 2010 to alert Building Services Authority licensees, stakeholders and the general public to the Coroner's final recommendations.

- fifty presentations including 13 super-shows, various regional shows and timber deck presentations were held by the Building Services Authority regarding, amongst other things, deck construction issues. From January to November 2010, approximately 3000 contractors attended these presentations.

- 40 Building Services Authority education seminars on issues relating to deck construction were held by the Building Services Authority which attracted 1000 consumers. Building Services Authority recommended that consumers obtain the advice of an independent expert on deck when buying or renovating homes; and

- handouts regarding deck construction were distributed at these presentations and seminars and have been published on the Building Services Authority's website since 23 April 2010. These handouts describe the cause of the deck collapse and the steps that should be taken to avoid this happening again. The handouts also recommend three strategies that contractors should adopt in order to significantly reduce the risk of deck failure.

Inquest into the death of Tofia Josen Mataia

Mr Mataia died on 18 October 2008 from cardiac arrest after a struggle with correctional officers at the Capricornia Correctional Facility in Rockhampton where he was an inmate. In the hour preceding his death, Mr Mataia had assaulted two correctional officers in an unprovoked attack most likely induced by a psychotic episode. A struggle ensued as five correctional officers restrained Mr Mataia and escorted him to a detention unit. It was found that the exertion from the continued violent struggle, the restraint applied by the correctional officers and Mr Mataia's underlying medical condition including schizophrenia and heart disease all contributed to the cardiac arrest to which Mr Mataia succumbed.

State Coroner Barnes delivered these findings on 9 July 2010.

Recommendation 1 - Safety Orders and Intensive Management Plans (IMPs)

I recommend QCS ensure all senior managers are aware of the limited number of officers authorised to make and cancel Safety Orders and of the requirement that upon the cancellation of such an order consideration be given to the need to make an Intensive Management Plan.

Response and action
Agreed and completed
Responsible agency: Department of Community Safety

The inquest findings were disseminated to all correctional centre general managers on 12 July 2010. General Managers were requested to read through the matter carefully, scan their centres for capability and knowledge and to ensure that the significant findings were generalised to all centres.

The Procedure - Safety Orders (published 8 October 2010) has been amended to provide:

- at section 7, titled "Reintegration", when prisoners are placed on a safety order as a result of problematic behaviour (e.g. violent/abusive bullying); concerns for the safety of the prisoner; or for an extended period of time, then consideration must be given to whether the prisoner should be managed under an Intensive Management Plan
- a Safety Orders Register that provides for recording of required information
- a Safety Orders Checklist that provides an accountability tool for approval of individual safety orders.

Recommendation 2 - CSOs to call QAS

In my view whenever an employee of a correctional centre has reason to believe a medical emergency exists, he or she should be required to call the QAS without waiting for a nurse from the health centre to come

and examine the prisoner. I recommend that the Commissioner of Corrective Services cause all correctional centres to amend their policies accordingly.

Response and action
Agreed and completed
Responsible agency: Department of Community Safety

In accordance with this recommendation, suitable amendments have been made to the Medical Emergency procedure and relevant attachments.

The procedure has been approved by the Commissioner of Queensland Corrective Services and was published in March 2011.

Recommendation 3 - Scene and evidence preservation

In view of the evidence that regional correctional centres such as Capricornia and Townsville have limited procedures in place to ensure the integrity of a death in custody investigation is not compromised by the initial response of officers at the scene, I recommend the Queensland Corrective Services Commissioner seeks the assistance of the CSIU to review existing policies at all correctional centres and where necessary assist in the provision of training to CSOs.

Response and action
Agreed and completed
Responsible agency: Department of Community Safety

In accordance with this recommendation, the Corrective Services Investigation Unit has reviewed and compiled a new training package relating to crime scene and evidence preservation.

Since completion of the package, training has been delivered to all correctional centres with the exception of Numinbah and Palen Creek, which will be done in due course. Training is ongoing and feedback to date has been positive.

Enhancements to the package are to be added in due course. These include posters (pictorial instructions as to correct and incorrect methods of crime scene preservation, exhibit handling and related subjects) for distribution to all centres and actual footage of actual crime scenes handled poorly.

The Corrective Services Investigation Unit provided the training package to the Queensland Corrective Services Academy and it is incorporated into training for all new staff. The package is an attachment to the new procedure that all centres have to abide by.

Progress made in relation to the incorporation of Corrective Services Investigation Unit advice into accredited training and procedural amendments was reviewed by the Queensland Corrective Services Incident Oversight Committee in April 2011. At the meeting, based on

the work completed to date, the Incident Oversight Committee considered that this recommendation had been satisfactorily addressed.

Recommendation 4 - Obligation to provide information

Prisons can be dangerous places. The public has an abiding interest in ensuring they are managed as safely as possible and that the actions of those in charge of them be effectively scrutinised. Neither prison officers nor prisoners should be able to decline to assist police officers investigating a death in prison. Accordingly, I recommend the Commissioner of Corrective Services consider seeking to have the *Corrective Services Act 2006* amended to require any person suspected of having information about a death in a correctional centre to provide that information to CSIU officers with the proviso that any information provided can not be used against them in criminal or disciplinary proceedings.

Response and action
Under consideration
Responsible agency: Department of Community Safety

Such a legislative amendment is being discussed with the Queensland Police Service, given the existing powers police have to assist coroners in the *Police Powers and Responsibilities Act 2000*. The Department of Community Safety is awaiting a response from the Queensland Police Service.

Inquest into the death of Andrew John Bornen

Mr Bornen died on the night of 7 February 2009 at Albion Street in Brassall from internal injuries sustained when he was hit by an oncoming motor vehicle after being detained by police. Mr Bornen was detained by police on Albion Street in the minutes before his death after it was reported a young man was roaming the area with a machete. The attending officers handcuffed Mr Bornen as he lay on the road. However, an approaching driver did not see either the police officer motioning to her to stop or Mr Bornen lying prone on the road with enough time to stop or avoid him. Consequently, the car struck Mr Bornen causing the fatal injuries to which he succumbed soon after.

State Coroner Barnes delivered these findings 16 July 2010

Recommendation 1

I recommend the QPS Uniform Review committee consider changes to the standard QPS uniforms that would enhance visibility of officers at night.

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

The recommendation was considered by the QPS Uniform Committee. Officers are issued with a reflectorised vest, which meets ANZS Standard for Day/Night Wearing. Policy requires officers to wear reflectorised vests but allows for discretion in emergent situations or where safety may be compromised through their use. The Uniform Committee is opposed to making any part of the standard uniform reflectorised as it would unnecessarily place officers at risk of being seen in certain operational situations where concealment is necessary. The QPS Issue Reflectorised Vest provides a more effective and flexible option.

Inquest into the death of Gordon John Bellamy

Mr Bellamy died on 20 December 2008 from multiple injuries sustained from a motorcycle accident in Emerald. Mr Bellamy was heavily intoxicated and attempting to evade police officers who were attempting to intercept him. A short pursuit ensued but was terminated when Mr Bellamy rode off at high speed. Minutes later, Mr Bellamy struck a pedestrian before losing control of his motorcycle and colliding with a tree.

Coroner Barnes delivered his findings on 25 August 2010.

Comment 1

I am aware the Safe Driving Project Team is continuing to evaluate the current policy in conjunction with recommendations I have made previously. I am confident they will review this matter to determine whether it can assist with that review.

Response and action
Agreed and partially completed
Responsible agency: Queensland Police Service

On 24 December 2010 a whole of Government response to the State Coroner's Report on Police Pursuits – Policy Recommendations was released. It was developed by the Queensland Police Service in collaboration with the Department of Education and Training and the Department of Transport and Main Roads.

All 12 recommendations directed to the Queensland Police Service have been agreed to and the Safe Driving Policy has been developed and approved by the Commissioner of Police. This Safe Driving Policy includes the implementation of all of the State Coroner's recommendations.

Training in the revised Safe Driving Policy commenced in July of this year, with training aimed at all officers up to and including Inspectors. This training is set to be completed before the revised policy implementation date of 19 December 2011. The compulsory training completed by officers statewide involves a three-step process by way of two computer-based learning programmes and one hands-on workshop relating to the education of the new policy and procedures.

Inquest into the death of John Douglas Simpson-Willson

Mr Simpson-Willson died on 3 June 2005 at the Central Rotunda in the Brisbane Botanic Gardens from head injuries. These head injuries were deliberately inflicted by Daniel Patel who had recently been released from the Maryborough Correctional Centre. Mr Patel has a history of mental illness and admitted to a psychiatrist and the police that he intended to kill Mr Simpson-Willson.

While the subject of the inquest was Mr Simpson-Willson, Coroner Lock recognised that regrettably the focus of the inquest ultimately came to rest on Mr Patel, his mental illness, incarceration and release from prison. This was done so as to consider whether any changes to policies or practices could reduce the likelihood of deaths occurring in similar circumstances in the future.

Coroner Lock delivered these findings 7 September 2010.

Recommendation 1

That the Queensland Government fund Prison Mental Health Services (PMHS) to ensure prisoners receive mental health services to a level comparable to community members; and that there be sufficient staff and resources available to PMHS such that they are able to spend sufficient time in being able to access all available information concerning those who are being assessed by them and to be able to spend sufficient time with individual prisoners to be able to properly assess their needs and mental health/intellectual state.

With regards to the CIMHA not being available to practitioners within a custodial setting, I recommend that this be resolved at the earliest opportunity.

Response and action
Agreed and partially completed
Responsible agency: Queensland Health

Queensland Health (QH) is committed to ensuring that prisoners with a mental illness have access to equivalent mental health service provision to that provided to mental health consumers in the wider Queensland community. The Queensland Plan for Mental Health 2007-2017 (QPMH) notes the benefits of providing ongoing support, liaison and service provision to offenders with a mental illness. This commitment has been acknowledged and acted upon through funding increases to allow expanded mental health service provision of the Prison Mental Health Service (PMHS). The 2007-2008 State Budget Outcomes for Mental Health allocated $5.833 million over four years to the PMHS for an additional 14 full time equivalent positions, as part of implementation of the first four years of the QPMH. This equates to a current total of 35 full time positions in 2010-11, representing a 66 per cent increase since 2006-2007.

The High Secure Unit at The Park, Centre for Mental Health, is expanding the current 61 bed service and providing a purpose built secure environment for males and females who

require initial assessment and treatment of their mental illness. It is designed for consumers who cannot be treated within a less restrictive environment. The expansion will include a nine-bed acute assessment unit and 20 upgraded or redeveloped extended forensic unit beds. The nine bed acute assessment unit is completed and due to open by the end of November 2011. The 20 extended treatment beds are expected to be completed in 2012.

In addition, Stage 2 of the QPMH proposes an addition 58 full-time equivalent Prison Mental Health positions by 2014, as well as an expansion of the High Secure Unit at West Moreton, and the High Secure Assessment Unit in Southern Queensland.

Access to the Consumer Integrated Mental Health Application (CIMHA) from within correctional centres has not been possible as the network within correctional centres is not configured to access QH systems and QH staff are not permitted to take laptops into the centres. This is both a technical and policy limitation that both departments are seeking to resolve.

The QH Mental Health Alcohol and Other Drugs Directorate and Information Division are actively working with Queensland Corrective Services to identify options to enable access to CIMHA in correctional centres.

Recommendation 2

That the Queensland Government explore opportunities with the Commonwealth Government to provide access for prisoners to the Medicare Rebate Scheme.

Response and action
Agreed and completed with ongoing implications
Responsible agency: Department of Community Safety

State and Territory corrective services agencies have lobbied the Commonwealth Government for many years without success, to provide prisoners with access to Medicare. This has occurred through the Corrective Services Administrators' Council and the Corrective Services Ministers' Conference. State and Territory health ministers have also lobbied the Commonwealth through the Australian Health Ministers' Conference.

Following the change of Commonwealth Government in 2007, the New South Wales Minister for Health wrote, on behalf of the Corrective Services Ministers' Conference, to the new Commonwealth Health Minister arguing for a change in policy. The Commonwealth's position not to provide prisoners with access to Medicare is unchanged.

The Commonwealth Government has interpreted section 19(2)(d) of the *Health Insurance Act 1973* to provide that prisoners are ineligible to receive Medicare benefits, as prisoners are held in a facility established under the authority of State law. Unless the Commonwealth Health Minister directs otherwise, Medicare benefits are not payable for professional services provided by an authority established by a law of the Commonwealth, a law of a State or a law of an internal territory.

Queensland Corrective Services will continue to argue, through the Corrective Services Administrators' Council, for prisoners to be able to access Medicare benefits. No progress has been made with the Commonwealth Government to change their interpretation of the *Health Insurance Act 1973.*

The former National Health and Hospitals Agreement signed in 2010 specifically referred to States and Territories continuing to be responsible for the funding of primary health care of prisoners. However, this agreement was nullified by the National Health Reform, which was signed on 13 February 2011. The National Health Reform does not make specific reference to the funding of primary health care for prisoners. There is currently no indication as to what impact the new agreement will have on the provision of health care services to prisoners.

The Corrective Services Administrators' Council will monitor the implementation of the National Health Reform and its impact on primary health care services for prisoners under Queensland's sponsorship.

Recommendation 3

DCS and DSQ review service delivery models, policy and procedure such that prisoners with impaired cognition are able to fully participate in prison activities and programs suitable for their particular vulnerabilities; and that DSQ be funded such that service delivery for their clients does not cease upon them being incarcerated.

Response and action
Agreed and partially completed
Responsible agency: Joint response between the Department of Community Safety (lead) and the Department of Communities

The Department of Community Safety participates in an Interdepartmental Working Group (IDWG) on People with an Intellectual Impairment in the criminal justice system, which is led by the Department of Communities. The remit of the IDWG includes consideration of coordinated efforts to improve outcomes for people with impaired cognitions who come into contact with the criminal justice system.

Within Queensland Corrective Services' existing processes, prisoners with an intellectual disability have access to prison activities and programs appropriate to their needs. This includes literacy, numeracy and educational programs flexible to cater to different ability levels; a range of employment activities with varying difficulties; specific programs such as the Inclusion Sexual Offending program; the *Bridging the Gap* project, a three year pilot project which commenced in 2009-10 to support prisoners with a cognitive impairment who are moving from custody to the community and the expansion of transitional programs and services across the state, including the Offender Reintegration Support Service, which works with offenders during the transitional period between custody and the community, to provide practical resettlement assistance.

As a deliverable under the *Bridging the Gap* pilot project, specialist disability support workers, in conjunction with the contracted specialist non-government organisations, deliver

specialist interventions targeted at offenders with impaired cognitive functioning. These intervention packages include skills training in fields such as basic personal organisation and appropriate interpersonal communication. As part of the Bridging the Gap pilot project, support is being provided to individual correctional centres to develop individual management plans for offenders with impaired cognitive functioning. The *Bridging the Gap* pilot project will continue until the end of the 2011-12 financial year.

In January 2011, Queensland Corrective Services commenced delivery of the "Awareness to Action – Working Effectively with People with Impaired Cognitive Functioning" training package. As part of this, process 35 Queensland Corrective Services staff are trained trainers in the facilitation of this package in order to provide delivery capacity across the State in both Probation and Parole and correctional centres. The package has also been incorporated into the Custodial Officer Entry Program for new custodial officers. Opportunities for incorporating into the Probation and Parole entry level training program are being investigated. Accordingly, training in working with offenders with impaired cognitive functioning will be an ongoing activity for Queensland Corrective Services

In September 2011, a senior executive steering committee was established in Queensland Corrective Services to oversee the completion and implementation of the Rehabilitation Framework and to direct ongoing rehabilitation efforts across the organisation. It is anticipated the Rehabilitation Framework will be finalised in the 2011-12 financial year. This framework will provide a model policy and supporting procedure for working with prisoners with impaired cognition in line with this recommendation.

One of the key initiatives in the recently launched *Absolutely everybody: enabling Queenslanders with a disability* ("Absolutely everybody") aims to improve support for people with a disability, with an intellectual disability or cognitive impairment in or at risk of entering the justice system. "Absolutely everybody" is accompanied by a three-year whole-of-government action plan 2011–14, which highlights individual action to be taken by Queensland Government departments. In particular, strategy 1.2.2.8 will establish a cross-agency team to improve pre-release preparation and transition from prison for people with cognitive and intellectual impairment, due to be completed by June 2012. The cross-agency team will include representatives from the Department of Community Safety and the Department of Communities.

The Department of Community Safety and Disability and Community Care Services (DCCS within the Department of Communities) will work together to investigate improvements relating to information sharing prior to incarceration so that assistance may be provided to prisoners with intellectual and cognitive impairments enabling them to fully participate in prison activities and programs suitable to their vulnerabilities.

Strategy 1.2.2.6 under the three year whole-of-government action plan provides for the facilitation, early identification and enhanced sharing of information in relation to people with intellectual or cognitive impairment. This strategy is due for completion by 2013.

The IDWG, led by the Department of Communities will progress these strategies and progress will be reported under each agencies' Disability Service Plans. Under the *Disability Services Act 2006*, every Queensland Government department is required to develop and implement a Disability Service Plan. In the plans, departments identify issues regarding service delivery by their department to people with a disability and the way these

issues will be addressed. The Disability Service Plan of a department must be published every three years on each department's website.

The extension of services funded or provided by the Department of Communities to people in prison will need to be explored further, as this has significant policy and resource implications for the Department of Communities.

Recommendation 4

DCS, in collaboration with Queensland Health and DSQ, continue to progress the development of a routine intake screening process which identifies prisoners with disabilities which impair cognition, their vulnerabilities and needs when entering corrective services facilities and assists and informs individual offender case management planning.

Response and action
Agreed and partially completed
Responsible agency: Joint response provided by the Department of Community Safety (lead), the Department of Communities and Queensland Health

Queensland Corrective Services has implemented a routine screening process using the Hayes Ability Screening Index to identify prisoners impacted by cognitive impairment in south-east Queensland reception centres as part of *Bridging the Gap* project funding.

The screening assessment does not identify specific information regarding an individual's vulnerabilities and needs, but flags those individuals who have very broad indicators of having an intellectual disability who would therefore require further assessment.

This further assessment provides a more detailed picture of individual needs and vulnerabilities to inform day to day management, case management planning and potential placement within the Personal Support Unit at Woodford Correctional Centre.

The Queensland Health Prison Mental Health Service has conducted research to develop a screening tool, the Intellectual and Cognitive Impairment Screen, which may have some advantages, in terms of ease of use, when compared to the Hayes Ability Screening Index currently used by Queensland Corrective Services. Queensland Corrective Services currently has a licence to use the Hayes Ability Screening Index until December 2011. Discussions will occur in December 2011 regarding which tool will be used in the future. These discussions and any decision will also depend upon whether the Intellectual and Cognitive Impairment Screen, as developed by Prison Mental Health Service, is ready for release. Further work is required before it can be used clinically. It will be made freely available for use by Queensland Corrective Services and Department of Communities when the work is completed.

The Department of Communities will work with the Department of Community Safety, the Department of Justice and Attorney General, Queensland Health and the Queensland Police Service to facilitate the early identification and enhanced sharing of information in relation to people with intellectual or cognitive impairment. This is part of strategy 1.2.2.6 under the

Whole-of-Government action plan 2011-14, which accompanies the "*Absolutely everybody: enabling Queenslanders with a disability*". The aim of this strategy is to facilitate the early identification of offenders with intellectual or cognitive impairment at all stages of the criminal justice process, including when they enter correctional services facilities.

Recommendation 5

DCS, in collaboration with Queensland Health and DSQ, collect, collate and report statistical information about prisoners with disabilities which impair cognition, to inform ongoing policy and program development, monitoring and evaluation.

Response and action
Agreed and partially completed
Responsible agency: Joint response between Department of Community Safety (lead), Department of Communities and Queensland Health

Queensland Corrective Services collects statistical information about prisoners' disabilities, including those that impair cognition. Additional and more detailed information is now collected through assessments conducted in the *Bridging the Gap* project.

Queensland Corrective Services will work with the Department of Communities to identify what mechanisms are required to allow sharing of statistical information. Statistics are being collected through the Bridging the Gap projects to inform the development of appropriate specialist intervention packages for the target population. The Department of Communities via Housing and Homelessness Services, and the Department of Community Safety are working together to prepare a Memorandum of Understanding which would facilitate the sharing of information and provide clarity in the roles and responsibilities of each department.

A new Memorandum of Understanding between Queensland Corrective Services and Queensland Health is being progressed. It is anticipated that once the Privacy Commissioner has been consulted and the Memorandum of Understanding has been agreed to by signatories of both Department of Community Safety and Queensland Health, the Memorandum of Understanding will include enhanced communication protocols and remove impediments to appropriate and timely information sharing between the Department of Community Safety and Queensland Health regarding joint clients. Finalisation of the Information Sharing Memorandum of Understanding between Queensland Corrective Services and Queensland Health is imminent.

Recommendation 6

DCS ensure that substitute decision-makers are involved in the planning processes and in decisions regarding the release of adult prisoners with impaired decision-making capacity, for relevant matters that may include accommodation and support upon release.

Response and action
Agreed and partially completed
Responsible agency: Department of Community Safety

Under the auspices of the *Bridging the Gap* pilot project Queensland Corrective Services has had discussions with the Queensland Civil and Administrative Tribunal, the Office of the Adult Guardian and the Public Trustee to develop mechanisms for identifying prisoners who have an appointed guardian and the processes by which they can be involved in transitional planning for the target group.

A process has been implemented by which Queensland Corrective Services can receive advice from the Office of the Adult Guardian regarding appointed substitute decision makers for adult prisoners with impaired cognitive functioning.

Advice has been sent to all correctional facility general managers and all Probation and Parole Service regional managers outlining the process for the management of offenders under Guardianship and Administration orders.

Queensland Corrective Services will formalise arrangements regarding the involvement of substitute decision makers in planning processes and decisions regarding the release of prisoners with impaired decision-making capacity.

Further discussions will be held to formalise arrangements between Queensland Corrective Services and substitute decision makers. This is anticipated to be progressed in the 2011-2012 financial year.

The Integrated Offender Management System enhancements involving the introduction of flags to identify offenders with a known substitute decision maker have been tested and are due to be released in Integrated Offender Management System version 2.8, scheduled for release in November 2011.

Recommendation 7

DCS ensure that relevant staff have training and induction policies and procedures to incorporate professional development education concerning the Guardianship and Administration regime, the role of Guardians as substitute decision-makers and health decision-making including those of Statutory Health Attorneys, Guardians and Attorneys for health matters.

Response and action
Agreed and partially completed
Responsible agency: Department of Community Safety

Through the *Bridging the Gap* pilot project, training was organised with and delivered by the Office of the Adult Guardian to staff at Brisbane Women's, Wolston, Brisbane and Woodford correctional centres from May to July 2010 in relation to statutory functions of the Office of the Adult Guardian and the role of substitute decision makers. Queensland Corrective Service will liaise with the Office of the Adult Guardian regarding future training needs.

Queensland Corrective Services have also implemented informal processes to seek information from the Office of the Adult Guardian. Queensland Corrective Services will continue to liaise with Queensland Civil and Administrative Tribunal, the Office of the Adult Guardian and the Public Trustee to formalise the mechanisms for making applications for prisoners needing an independent guardian and for identifying prisoners who have an appointed guardian.

Recommendation 8

DCS review its current staff training and induction programs to include components that ensure that staff at all levels have a working knowledge of disability awareness and case management.

Response and action
Agreed and completed with ongoing implications
Responsible agency: Department of Community Safety

The Queensland Corrective Services Academy in conjunction with Prison Mental Health has developed training in mental health awareness. Three Custodial Officer entry-level courses commenced in November 2010 at the Queensland Corrective Services Academy and the Townsville and Lotus Glen correctional centres.

As a part of the *Bridging the Gap* pilot project, a specialist module on working with offenders with impaired cognitive functioning has been developed by and purchased from Interact Australia, a specialist non-government organisation with expertise in the field of impaired cognitive functioning. The module has been incorporated into the Queensland Corrective Services entry-level training programs for custodial staff commencing from January 2011.

A "Train the Trainer" component incorporated into the "Awareness to Action – Working Effectively with People with Impaired Cognitive Functioning" training package has been delivered. Thirty-five Queensland Corrective Services staff are trained to deliver the package on an ongoing basis across the State.

The package has also been incorporated into custodial officer entry-level training and Queensland Corrective Services is in the process of investigating implementation into entry level training for Probation and Parole officers. The investigation into the incorporation of the "Awareness to Action – Working Effectively with People with Impaired Cognitive Functioning" into entry level training for Probation and Parole officers is to be finalised.

Through the *Bridging the Gap* pilot project, training was organised with and delivered by the Office of the Adult Guardian to staff at Brisbane's Women's, Wolston, Brisbane and Woodford correctional centres from May to July 2010 in relation to the statutory functions of the Office of the Adult Guardian and the role of substitute decision makers. Office of the Adult Guardian training on the statutory functions of the Office of the Adult Guardian will be delivered as required.

Recommendation 9

That the draft set of communication protocols developed by DCS and Queensland Health annexed to this decision and marked "A" be implemented forthwith.

Response and action
Agreed and partially completed
Responsible agency: Joint response between Department of Community Safety (lead) and Queensland Health

In-principle communication protocols have been implemented by the Department of Community Safety and Queensland Health through existing inter-departmental governance arrangements. Agency procedures have been reviewed to ensure consistency with these protocols. Advice in relation to the exchange of information between the two agencies has been provided to management and operational staff.

An inter-departmental case review committee has been established to ensure appropriate information exchange and service coordination in relation to high risk and very vulnerable prisoners.

The Integrated Offender Management System, including case note information, is available to Offender Health Services.

A new Memorandum of Understanding between Queensland Corrective Services and Queensland Health is being progressed. It is anticipated that once the Privacy Commissioner has been consulted and the Memorandum of Understanding has been agreed to by signatories of both Department of Community Safety and Queensland Health, the Memorandum of Understanding will include enhanced communication protocols and remove impediments to appropriate and timely information sharing between the Department of Community Safety and Queensland Health regarding joint clients. Finalisation of the

Information Sharing Memorandum of Understanding between Queensland Corrective Services and Queensland Health is imminent.

The Department of Community Safety and Queensland Health continue to work together to improve communication and service delivery. Site based Offender Health Services staff meet regularly with custodial centre management to ensure the timely and appropriate exchange of information. Communication between the two agencies will continue to be regularly considered at established joint performance reviews, governance committees and inter-departmental working groups.

Inquest into the death of David Robert Petersen

Mr Petersen died on 25 January 2007 at Beaudesert Hospital as the result of an undetected blood clot in his spleen rupturing. The actual cause of this blood clot could not be conclusively determined. Mr Petersen had been experiencing symptoms in the day preceding his death but unfortunately, it was not diagnosed in time for him to gain effective treatment.

State Coroner Barnes delivered these findings on 16 September 2010.

Recommendation 1

The (*Health Practitioner National Law)* Act confers on the Medical Board to investigate and commence disciplinary proceedings as a result of a notification.

I am of the view the apparent failure of Dr Martin to provide an adequate standard of medical care to Mr Petersen on 24 January 2007 could provide a basis for a voluntary notification under either or all of the grounds detailed above. I also consider the Board could conclude Dr Martin's deliberate and repeated attempts to mislead the court indicate he is not a fit and proper person to be registered.

Accordingly, I intend referring the material gathered during these proceedings to the Board for its consideration.

Response and action
Agreed and partially completed
Responsible agency: Queensland Health

Information from the Notifications section of the Australian Health Practitioner Registration Agency (formerly the Medical Board of Queensland) is that this matter was discussed on 23 February 2011 and a decision made to further investigate the matter.

The investigation was completed and the investigation report was considered by the Queensland Board of the Medical Board of Australia. However, the Board’s decision has not yet been made public.

Inquest into the death of Alan Kent Dyer

Mr Dyer died on 31 May 2008 at his home in Pacific Pines as the result of being shot by a police officer whom he had threatened with a knife. Mr Dyer had a history of mental illness and suicide attempts and it was the opinion of the State Coroner that Mr Dyer attacked the police officer with the intention of causing the officer to kill him.

The State Coroner delivered these findings on 29 September 2010.

Recommendation 1

In view of the inherent danger in managing incidents such as this, the increased frequency with which they are likely to occur and the tendency for officers to become desensitised to such risks, I recommend officers in the Operational Skills and Tactics Program review this incident with a view to utilising it as a training scenario. The officers involved in the incident might also make a valuable contribution by participating in such training, were they minded to do so.

Response and action
Agreed and completed
Responsible agency: Queensland Police Service

The Operational Skills and Tactics Program reviewed the incident leading to the death of Alan Kent Dyer. The scenario will be incorporated into Recruit training and service training from 2012. The recruit training program will focus on the need to conduct immediate threat assessments in response to sudden situational changes. One of the officers involved in the incident is a Regional Operational Skills and Tactics instructor and has been consulted with respect to the development of the training programs.

Inquest into the death of Little Gungallida Girl

Little Gungallida Girl died on 23 July 2009 at Doomadgee Hospital from aspiration of vomitus due to rheumatic carditis. Little Gungallida Girl had been admitted to Doomadgee Hospital on the day before her death and was being treated for a viral respiratory tract infection before her condition quickly deteriorated.

Coroner Priestly delivered these findings on 18 October 2010

Recommendation 1

That Queensland Health develop a specific guideline for health staff which deals with the cultural sensitivity issues surrounding the death of a person in an Aboriginal and Torres Strait Islander community.

Response and action
Agreed and completed
Responsible agency: Queensland Health

The Cultural Capability Team within the Aboriginal and Torres Strait Islander Health Branch of Queensland Health has completed this guideline. The document, titled *Sad news, Sorry Business – guidelines for caring for Aboriginal and Torres Strait Islander people through death and dying*, was completed in June 2011. Dr Michael Cleary, the Deputy Director-General of the Policy, Strategy and Resourcing Division provided the document to the Northern Coroner, Kevin Priestly, in June 2011 and the document has been promoted and published on Queensland Health's intranet site.

Further Comment (pg 14)

It may also be that the open disclosure process, a process that encourages frank and full disclosure to family of the findings of an internal review of clinical management, needs reworking or adaptation for use in indigenous communities to make it culturally appropriate and sensitive.

Response and action
Agreed and partially completed
Responsible agency: Queensland Health

The Open Disclosure (OD) Program within PSQIS has commenced assessing the need for OD to be conducted in a way that is culturally appropriate. The approach to adapting the current OD process to the needs of the indigenous communities will be multi-pronged and include:

- the enhancement of the current OD training to include specific indigenous awareness through, for example, appropriate case studies and culturally sensitive simulation training

- training of indigenous OD consultants

- management of situations where the Hospital Indigenous Liaison Officer is dislocated from their own community and/or not from the same family/language grouping as the local community

- consultation with the Aboriginal and Torres Strait Islander Health Branch or the local Indigenous Health Worker for current disclosures with indigenous families as an interim measure before the training is adapted and/or an indigenous OD consultant is available

- the inclusion of cultural awareness training (where appropriate) as part of the Clinician Disclosure training currently under development

- a formal request to the Australian Commission on Safety and Quality in Health Care to adapt the OD brochures/publications to include specific reference to indigenous issues.

Work has commenced on the development of appropriate case studies and culturally sensitive simulation training. These activities will likely take several months and completion is expected in mid to late 2012.

Inquest into the death of Gregory Clifford Paterson

Mr Paterson died on 15 June 2007 at Townsville Hospital as the result of a ruptured blood clot which formed due to a head injury sustained in an industrial accident involving a concrete pump hose eleven days earlier.

Coroner Priestly delivered these findings on 18 October 2010.

Comment 1

WHSQ indicated that it intended to take action to remedy the problem. It will issue an alert to relevant industry groups about the hazard of hose whip and the control measures that might be used to minimise the risk of injury.

Response and action
Agreed and completed
Responsible agency: Department of Justice and Attorney-General

A safety alert highlighting the hazards and risks to workers caused by hose whip on concrete pumps was published on the Department of Justice and Attorney-General website on 16 March 2011. The publishing of the safety alert on the website was highlighted in an eSAFE safety alert on 22 March, which was distributed to 2373 construction industry eSAFE subscribers and 1030 'all industries' subscribers.

Comment 2

It will amend the Concrete Pumping Code of Practice to include a description of the risk of hose whip, the contributing factors and the means of reducing the occurrence or potential of hose whip.

The amendments to the Code of Practice will also include a requirement that all persons engaged in concrete pumping work involving an overhead boom must wear appropriate Personal Protective Equipment at all times, including hard hats.

Response and action
Agreed and partially completed
Responsible agency: Department of Justice and Attorney-General

Ministerial agreement has been obtained to amend the *Code of Practice for Concrete Pumping*, to address the issues highlighted by the Coroner.

Consultation will be undertaken with industry and other relevant stakeholders on the proposed amendments to the *Code of Practice for Concrete Pumping*. These changes are being prepared alongside amendments required for national harmonisation of work health and safety laws. The amended Code of Practice will be finalised for commencement on 1 January 2012.

Comment 3

The implementation of a suggested exclusion zone for workers (at times where the risk of hose whip is present) will be considered after industry and expert consultation.

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

Consultation was undertaken with industry on the merits of persons conducting concrete pumping activities establishing an exclusion zone.

Feedback from industry indicated that the establishment of an exclusion zone would not be appropriate in light of operational and safety considerations (particularly the introduction of unintentional risks in situations involving the uncontrolled flow of concrete).

The Department has concluded that the safe operation of the concrete pump and safe work practices by the line hand are considered to be the key ways of avoiding injury from hose whip during concrete pumping operations. Therefore, the Department will continue to focus awareness of the industry towards ensuring line hands are suitably competent to safely operate concrete pumping equipment.

Comment 4

In addition, WHSQ will consider further auditing, in conjunction with an information campaign targeting the concrete pumping industry, in relation to he safety alert and amendments to the Code.

Response and action
Agreed and completed
Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland has included in its 2011-12 interventions program an audit of concreting pumping operations safety, which will have a focus on the safety advice set out in the *Concrete Pumping Code of Practice* and safety alert with respect to hose whip.

Comment 5

WHSQ will raise the issue of hose whip for inclusion in the National code to be developed.

Response and action
Agreed and completed
Responsible agency: Department of Justice and Attorney-General

Workplace health and safety law is currently undergoing national harmonisation. As of October 2011, it is not proposed that a national code of practice be established for concrete pumping operations. The current Queensland Code of Practice, and any subsequent amendments, will continue to operate until such time as a national code is established. Should a national code of practice be contemplated, the Department will seek to ensure that national code include the advice about hose whip contained in the Queensland Code of Practice.

Inquest into the death of Samantha Rose Spence

On 7 April 2007, Miss Spence died at the Mater Children's Hospital as the result of increased intracranial pressure due to the exacerbation of chronic hydrocephalus, associated with an existing neurological condition. Two days prior to her death, Samantha underwent an essential spinal operation that aimed to correct her scoliosis. While this operation did not directly cause the increased intracranial pressure, it was considered a factor in the sequence of events leading to her death.

Deputy Coroner Clements delivered these findings on 29 October 2010.

Recommendation 1

The Mater Health Services have completed a detailed review and response. I recommend that the changes and improvements they have implemented are circulated to both the private and public health sectors within Queensland. It is hoped this will assist in improving patient safety.

Response and action
Agreed and completed
Responsible agency: Queensland Health

The Patient Safety and Quality Improvement Service (PSQ) wrote to the Mater Health Services in November 2010 to gather further information regarding the specific changes and improvements they had made in order to share this information across the State. This information was received in early February 2011.

The Spence case was then discussed at a PSQ Coronial Case Management Meeting held on 24 February 2011. It was considered necessary to better understand what was required in implementing this coronial recommendation appropriately. One of the issues identified within this meeting was the very narrow scope of the information and therefore the appropriate audience to receive it. It was determined that a statewide memorandum to all Health Service Districts would not reach the relevant target audience. The appropriate audience was deemed to be neurosurgeons, orthopaedic surgeons and radiologists within private and public hospitals that perform scoliosis correction surgery.

It was also identified that the most notable improvement from the Mater Health Service was the decision to include both spinal and brain MRI scanning of children who are to undergo scoliosis surgery. While there was some indication this may not be warranted and is considered an added precaution, the coroner’s findings noted there was also persuasive expert evidence that suggested this is a wise course of action and considered best practice. The coroner noted that expert radiological review may be able to add additional critical information to identify underlying hydrocephalus associated with Chiari Malformation. This may then require further assessment prior to surgery, including consideration of neurosurgical opinion.

Consequently, letters were sent in early June 2011 to the Royal Australian College of Surgeons, the Royal Australasian College of Physicians, and the Australian and New Zealand College of Radiologists requesting the colleges share the lessons learnt in this case

with their relevant college fellows. The following attachments were included in this correspondence:

- the coronial findings of Samantha Spence
- the Mater Health Services Posterier Spinal Rods Carepath (Pre-admission Phase)
- Mater Health Services Posterier Spinal Rods Carepath
- Mater Health Services Posterier Spinal Rods Carepath, days 8 to 10.

Recommendation 2

I recommend a review of the processes to ensure the primary treating general practitioner is kept informed of the ongoing treatment of the patient.

Response and action
Agreed and completed with ongoing implications
Responsible agency: Queensland Health

The exchange of information from the hospital facility to the patient's general practitioner is a form of "clinical handover". Clinical handover refers to the "transfer of professional responsibility and accountability for some or all aspects of care for a patient, or groups of patients, to another person or professional group on a temporary or permanent basis". Handovers permeate the heath-care system and can occur at shift change, when clinicians take breaks, when patients are transferred inter-and intra-hospital, and during admission, referral or discharge.

In Queensland Health, the Patient Safety and Quality Improvement Service has developed a statewide Clinical Handover Strategy 2010-2013, with progressive implementation of the actions occurring from 2010. The three-year plan covers shift handover, unit to unit transfers and inter-hospital transfers only.

At this stage, it does not cover referrals and discharges due to work being done elsewhere, such as the Enterprise Discharge Summary (EDS) project under the E-Health Strategy. The EDS is a computerised discharge summary intended to create a new standard for Queensland Health. It will improve the way QH generates, manages and distributes discharge summaries and will allow summaries to be delivered electronically to General Practices in a secure, timely and standardised format. The EDS Project has been completed having been delivered to all Queensland Health Service Districts. All sites have access to view and print patient discharge summaries, supported by paid project officers at each district.

Inquest into the death of 2-year-old girl in Kallangur

On 21 October 2008, a two-year-old girl ('L') died after drowning in the backyard pool of the rental house she lived in. L was able to enter the pool area due to a faulty lock on one of the entrances to the pool and was found to have been inadequately supervised.

Coroner Lock delivered these findings on 13 December 2010.

Recommendation 1

To the extent it is necessary, it is recommended the amendments to the swimming pool fencing legislation as set out in Chapter 8 of the *Building Act 1975* and which commenced on 11 December 2010 be implemented and regulated in full. I note the website of the Department of Infrastructure and Planning relating to pool fences and safety has a comprehensive list of information and resources concerning the new laws and pool safety in general.

Response and action
Agreed and completed
Responsible agency: Department of Local Government and Planning

Comprehensive regulatory and administrative systems have been established to support the amendments to swimming pool safety legislation which commenced on 1 December 2010 and are operational.

Recommendation 2

It is apparent that with such major changes real estate and property managers will need to be made aware of the new legislation and it would be expected the appropriate professional bodies are engaged in that process. I heard no evidence on that issue and cannot presume that this would not be the case but to the extent necessary I endorse the submission of Mrs Plint that the Real Estate Institute of Queensland and independent real estate agents be educated and informed of the new laws and protocols for pool/spa safety in Queensland and this would require some form of ongoing awareness campaign.

Response and action
Agreed and completed (with ongoing implications)
Responsible agency: Department of Local Government and Planning

A communications plan has been developed to support the amendments to swimming pool safety legislation which commenced on 1 December 2010 and is being implemented.

The communications plan involves the use of radio, television, newspapers and a range of other media with an expenditure of $1 million.

The communications plan includes working in partnership with the real estate industry and the peak industry stakeholder, the Real Estate Institute of Queensland. A guideline, fact sheets and web advice has been published for the real estate industry. Through the Office of Fair Trading, a mail out advising of the new laws has been sent to real estate agents and advertising and editorial material has been placed in industry magazines.

While the key actions from this particular communication plan have been completed, the 2011/12 communications plan (currently in draft form), includes a continuation of key messages and actions for this specific target group of real estate agents/property managers.

Inquest into the death of Jennifer Elizabeth Bell

Ms Bell died on 2 October 2007 from multiple injuries sustained when she deliberately stepped into the path of truck on the Bruce Highway at Forest Glen. Ms Bell had been treated for post-natal depression in the year leading up to her death.

Coroner Hodgins delivered these findings on 16 December 2010.

Recommendation 1

Where a patient has a history of engaging with a number of services and does not have the stability of residence, that a consultant psychiatrist reviews the patient within seven days of contact with any new service. The purpose is to not only review medication but also assess the mental state and risk of suicide.

Response and action
Agreed and partially completed
Responsible agency: Queensland Health

This recommendation is currently being addressed in the review of the statewide standardised suite of documents. The statewide standardised suite of documents was an outcome of the Achieving Balance Report (2005) and was fully implemented across the State during 2008. The suite of documents provides mental health services with a standardised approach to mental health assessment, risk assessment and treatment. The templates have been available online on the Consumer Integrated Mental Health Application (CIMHA) since 2008.

The office of the Principal Advisor in Psychiatry has assumed responsibility for the review and implementation of the statewide standardised suite of documents, effective 1 July 2010. The evaluation of the suite of documents and a corresponding statewide clinical audit pilot enabled an evidence base to support changes to a number of components within the documentation. The revised suite of documents will have prompts to ensure that any inter-team, district or state transfer of a consumer is reviewed within seven days by the multidisciplinary team that must include a consultant psychiatrist. This review will be a full review of mental state and risk status to identify a pathway of care.

The proposed changes to the clinical content of the Adult Mental Health Standardised Suite of Clinical Documentation have been made further to the evaluation and clinical audit done in 2010. Once the content and format of these proposed changes have been endorsed, the amended forms will be uploaded into the CIMHA and the redundant versions removed.

The Child and Youth and Older Persons Mental Health Standardised Suite of Clinical Documentation will also be amended further to the evaluation and clinical audit done in 2010. The same consultation and endorsement process will be undertaken. Once any proposed changes are endorsed, these updated suites of clinical documentation will also be uploaded into the CIMHA and the redundant versions removed.

Recommendation 2

That a written handover summary be provided when a patient is being transferred from one service to another. The purpose being to ensure that the new service can easily be informed of current issues and develop strategies to address those issues. The Workplace Instruction for Clinical Handover policy procedure is a good starting point; but needs to be developed further to address transfer from one geographical region to another region.

Response and action
Agreed and partially completed
Responsible agency: Queensland Health

The revised statewide suite of documents referred to in response to recommendation 1 that are to be uploaded into the CIMHA also includes a definitive clinical handover which will incorporate the concepts of, and include a hyperlink to the OSSIE Handover Guide. This is a nationally endorsed protocol for clinical handover, which has been trialled in several interstate settings across health care and is applicable to mental health settings. The protocol has been endorsed by the Australian Commission on Quality and Safety in Health Care.

The proposed changes to the clinical content of the Adult Mental Health Standardised Suite of Clinical Documentation have been made further to the evaluation and clinical audit done in 2010. Once the content and format of these proposed changes have been endorsed, the amended forms will be uploaded into the CIMHA and the redundant versions removed.

The Child and Youth and Older Persons Mental Health Standardised Suite of Clinical Documentation will also be amended further to the evaluation and clinical audit done in 2010. The same consultation and endorsement process will be undertaken. Once any proposed changes are endorsed, these updated suites of clinical documentation will also be uploaded into the CIMHA and the redundant versions removed.

Recommendation 3

That Queensland Health adopts a policy of enabling greater collaboration with the families of mental health patients by providing:

(a) publications that assist families to understand the mental health process, including a flow chart of the process

(b) first point of contact for families

(c) a liaison worker to enable contact and involvement of families.

Response and action
Agreed and completed
Responsible agency: Queensland Health

There are a number of initiatives currently in progress within the mental health sector that address this recommendation:

- In August 2010, the Executive Director of the Mental Health, Alcohol and Other Drugs Directorate (MHAODD) launched the Consumer, Carer and Family Participation Framework. This framework adopts a set of principles, implementation strategies and key performance indicators to guide the involvement and participation of consumers, carers and families in mental health services in Queensland.

- The Carers Matter website has been established to provide information and support to carers and family members of mental health consumers. There are currently five fact sheets available on a range of subjects. The Carers Matter Reference Group monitors the development of fact sheets, the content of the website and other carer and family initiatives.

- Consumer, carer and family participation is supported through the development of a consumer and carer workforce that includes a range of consumer and carer positions, such as Recovery Support Workers and Consumer and/or Carer Consultants. There are currently 54 consumer and carer workers employed in mental health services across Queensland to support consumers, carers and families and to work in strategic roles ensuring their participation.

- In addition to these workers, approximately 90 Consumer Companions are employed across all 17 acute adult inpatient units in Queensland. Companions provide peer support and interaction to consumers during their inpatient admission. Companions identify as having a lived experience as a mental health consumer. The support and positive interaction the patients receive from companions helps them to become more positive about their care and treatment.

- The MHAODD to date has engaged 25 consumer and carer representatives to provide input and advice on the Statewide Mental Health Network and its associated clinical clusters, advisory groups and collaboratives.

- During 2010, the Consumer, Carer and Family Team from the MHAODD conducted public education forums, Mental Health First Aid training and information sessions for consumers, carers and families.

Recommendations profiled in the *Queensland Government's Response to Coronial Recommendations 2009*

The following recommendations appeared in the *Queensland Government's response to coronial recommendations 2009*. 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 have provided the following responses.

Inquest into the death of Samantha Anne Maslen

On 5 June 2005, Ms Maslen was the front seat passenger in a car that was the subject of a police pursuit. The vehicle rolled when it swerved to avoid a tyre deflation device. Ms Maslen died as a result of her injuries.

State Coroner Barnes handed down findings on 28 August 2008.

Ms Maslen was one of ten individuals to have died in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests were held into each of these individuals' deaths and comments were made by the Coroner in some of those cases.

In addition to these 10 inquests, a further hearing was convened by the State Coroner to hear evidence from the Queensland Police Commissioner, Mr Robert Atkinson APM and the leader of the project reviewing the Queensland Police Service pursuit policy, Inspector Tony Fleming. In the subsequent report, the State Coroner delivered 13 recommendations, the Government's responses to which are outlined separately in this report.

Comment 1, page 16

Ms Maslen's death is one of seven that followed a police pursuit in the period of June 2005 to December 2006. In relation to each, the conduct of the officers involved will be judged against the Queensland Police Service policies in force at the relevant time. However, as those policies have changed significantly during that period, I shall refrain from making any recommendations for future change until the evidence from all seven inquests has been considered and the impact of the changes are evaluated.

Response and action
Agreed and partially completed
Responsible agency: Queensland Police Service

On 24 December 2010 a whole of Government response to the State Coroner's Report on Police Pursuits – Policy Recommendations was released. It was developed by the Queensland Police Service in collaboration with the Department of Education and Training and the Department of Transport and Main Roads.

All 12 recommendations directed to the Queensland Police Service have been agreed to and the Safe Driving Policy has been developed and approved by the Commissioner of Police. This Safe Driving Policy includes the implementation of all of the State Coroner's recommendations.

Training in the revised Safe Driving Policy commenced in July of this year, with training aimed at all officers up to and including Inspectors. This training is set to be completed before the revised policy implementation date of 19 December 2011. The compulsory training completed by officers statewide involves a three-step process by way of two computer-based learning programmes and one hands-on workshop relating to the education of the new policy and procedures.

Inquest into the death of Samantha Anne Maslen

Comment 2, page 21

Arising from the evidence at this inquest, the issue of training of pursuit controllers has been raised and warrants further evidence and consideration.

The policies surrounding the use of tyre deflation devices give rise, at least on first consideration, to some concerns, particularly in relation to the safety of officers deploying them and potentially other members of the public. The State Coroner acknowledges that this observation is based upon the limited information arising in this inquest and expressed no opinion other than that it warrants further consideration.

Response and action
Agreed and partially completed
Responsible agency: Queensland Police Service

Specific measures include a Police Communications Centre (PCC) pursuit controller training course. The Service ran 18 pursuit controller courses around the state of Queensland, to officers of varying rank and service. In total approximately 190 officers who work in dedicated communication centres, supervise on-road staff, or are shift supervisors attended the day long training course.

A review was conducted of existing policy regarding the usage of Tyre Deflation Devices (TDD). From this review, it was established that the current policy relating to the deployment of a TDD is sufficient and this deployment must be authorised by the Pursuit Controller prior to using.

Additionally, the Queensland Police Service is conducting trials around the State involving the roll out of in car camera technology. This trial period involves the roll out of four vehicles around the State that have been installed with this technology. The assessment of the trial period is expected to be completed by mid 2012.

Inquest into the death of Joseph Douglas Duncan

Mr Duncan died on 9 January 2006 in Moorooka from head injuries sustained in a car crash. Mr Duncan was a passenger in a car that was involved in a police pursuit in the immediate lead up to the accident.

The State Coroner delivered these finding on 24 October 2008.

Mr Duncan was one of ten individuals to have died in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests were held into each of these individuals' deaths and comments were made by the Coroner in some of those cases.

In addition to these 10 inquests, a further hearing was convened by the State Coroner to hear evidence from the Queensland Police Commissioner, Mr Robert Atkinson APM and the leader of the project reviewing the Queensland Police Service's pursuit policy, Inspector Tony Fleming. In the subsequent report, the State Coroner delivered 13 recommendations, the Government's responses to which are outlined separately in this report.

Comment 1 (pg 15)

At the completion of the seven inquests connected to police pursuits, the coroner will address the policy issues thrown up by these cases. In this case, there seemed a degree of uncertainty about when the pursuit controller assumed control of the pursuit. The policy is silent on that issue and on whether the transfer of control should be communicated to the pursuing officer.

Response and action
Agreed and partially completed
Responsible agency: Queensland Police Service

On 24 December 2010 a whole of Government response to the State Coroner's Report on Police Pursuits – Policy Recommendations was released. It was developed by the Queensland Police Service in collaboration with the Department of Education and Training and the Department of Transport and Main Roads.

All 12 recommendations directed to the Queensland Police Service have been agreed to and the Safe Driving Policy has been developed and approved by the Commissioner of Police. This Safe Driving Policy includes the implementation of all of the State Coroner's recommendations.

Training in the revised Safe Driving Policy commenced in July of this year, with training aimed at all officers up to and including Inspectors. This training is set to be completed before the revised policy implementation date of 19 December 2011. The compulsory training completed by officers statewide involves a three-step process by way of two computer-based learning programmes and one hands-on workshop relating to the education of the new policy and procedures.

Inquest into the death of Craig Robert Shepherd

Mr Shepherd was the driver of a motorcycle that was the subject of a police pursuit. Mr Shepherd died from injuries sustained when he attempted to take a tight turn at too high a speed, causing him to lose control.

State Coroner Barnes handed down findings on 12 December 2008.

Mr Shepherd was one of ten individuals to have died in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests were held into each of these individuals' deaths and comments were made by the Coroner in some of those cases.

In addition to these 10 inquests, a further hearing was convened by the State Coroner to hear evidence from the Queensland Police Commissioner, Mr Robert Atkinson APM and the leader of the project reviewing the Queensland Police Service's pursuit policy, Inspector Tony Fleming. In the subsequent report, the State Coroner delivered 13 recommendations, the Government's responses to which are outlined separately in this report.

Comment 1, page 15

“However, as those policies have changed significantly during that period, I shall refrain from making any recommendations for further change until the evidence from all seven inquests has been considered and the impact of the changes are evaluated.”

Response and action
Agreed and partially completed
Responsible agency: Queensland Police Service

On 24 December 2010 a whole of Government response to the State Coroner's Report on Police Pursuits – Policy Recommendations was released. It was developed by the Queensland Police Service in collaboration with the Department of Education and Training and the Department of Transport and Main Roads.

All 12 recommendations directed to the Queensland Police Service have been agreed to and the Safe Driving Policy has been developed and approved by the Commissioner of Police. This Safe Driving Policy includes the implementation of all of the State Coroner’s recommendations.

Training in the revised Safe Driving Policy commenced in July of this year, with training aimed at all officers up to and including Inspectors. This training is set to be completed before the revised policy implementation date of 19 December 2011. The compulsory training completed by officers statewide involves a three-step process by way of two computer-based learning programmes and one hands-on workshop relating to the education of the new policy and procedures.

Comment 2, page 21

The Coroner is of the view that Queensland Police Service policy was breached when the pursuit was not terminated when the motorcycle

entered onto Beechmont Road. The State Coroner is of the view the policy was breached when the police communications centre was not advised the pursuit was underway.

Comment 3, page 25

The Coroner intends referring the conduct of the four officers to the Queensland Police Service for the consideration of the taking of disciplinary action.

Response and action
Agreed and partially completed
Responsible agency: Queensland Police Service

Allegations of misconduct against the officers involved in the pursuit have been subject to a disciplinary Investigation and a subsequent internal disciplinary process. The Crime and Misconduct Commission (CMC) indicated its intentions to appeal the outcome with Queensland Civil and Administrative Tribunal (QCAT). This matter has been reviewed by the CMC and finalised at QCAT. The Queensland Police Service is currently awaiting QCAT's decision.

Inquest into the death of John Ernest Venturato

Mr Venturato died on 6 September 2005 while driving his vehicle along the Bruce Highway. His car collided with a house being transported in the opposite direction. The house, which spanned the entire width of the two lane highway, was being transported in a convoy in the early hours of the morning.

Coroner Brassington handed down findings on 22 December 2008.

Recommendation 5

That the lighting practices be reviewed to demonstrate if issues of glare are likely to be a problem for drivers, particularly older drivers.

Response and action
Agreed and under consideration
Responsible agency: Department of Transport and Main Roads

The requirement for utilising warning lights on oversize vehicles in all jurisdictions is a reflection of National Model Law, which falls under the responsibility of the National Transport Commission. Any changes to heavy vehicle lighting will have to be agreed to by all State and Territory vehicle standards jurisdictions. The matter of adopting alternative lights for use in oversize vehicles is a complex issue. Previously the use of strobe lights has been rejected.

The National Transport Commission has advised that any consideration to review national rules relating to movement of oversized vehicles, including alternative lights, may be considered as part of the National Heavy Vehicle Regulator Reform as agreed by the Council of Australian Governments. The National Regulator is to be in operation at the end of 2012. Until the National Heavy Vehicle Law is introduced, changes to the current national regulations are not being considered as resources are allocated to the development and implementation of the current national standards.

Inquest into the death of Phillip Henry Scholl

Mr Scholl died on 20 October 2005 when the micro light aircraft he was piloting crashed at Mareeba. The Coroner found neither recklessness nor misadventure contributed to the accident but it was likely the cause was a combination of frayed and corroded wires coupled with a degraded sail.

Coroner Braes delivered these findings on 20 January 2009.

Comment 3

'In recommending that there be a review by CASA, ATSB, HGFA , RA-AUS, QPS and WHSQ of policies and procedures in respect of all matters relating to the recreation aviation industry, I point out that the QPS OPM at 17.3.3 specifically provides that, “officers who attend an aircraft incident where any person has been killed or injured or where there has been damage to property, are to ensure that the following agencies are advised of the incident; (ii) if the aircraft incident may have occurred at a workplace (see Section 9 of Workplace Health and Safety Act), a local Workplace Health and Safety inspector. This procedure appears to limit the police officer’s duty to report the incident to WHSQ to the occasion where the incident occurred at a workplace. With respect to the many dedicated police officers involved in investigating accidents of all sorts, a police officer may not necessarily be appropriately equipped to determine whether an event occurred at a workplace.'

‘The procedure is in conflict with the memorandum of understanding between QPS and WHSQ paragraph 10 Schedule I “dealing with incidents and complaints where aircraft are involved”, which is to the effect, “QPS agrees that QPS officers who attend an aircraft incident where any person has been killed or injured will advise the local DIR office”. Although paragraph 10 does go on to say that, “if the aircraft incident falls within the scope of the Workplace Health and Safety or Electrical Safety legislation, DIR procedure, “dealing with incidents and complaints where aircraft are involved” will apply”. The latter part obviously is an obligation on the DIR officer to determine the procedure to be adopted whereas the obligation on the police officer is to report every death and injury to the DIR office. The QPS OPM should be reviewed to ensure consistency with the memorandum of understanding.’

Response and action
Agreed and completed
Responsible agency: Queensland Police Service

A revised Memorandum of Understanding (MOU) between the Queensland Police Service (QPS) and Workplace Health and Safety Queensland has been negotiated. The MOU incorporating the provisions recommended by the Coroner has been signed and approved by the Deputy Commissioner (Specialist Operations).

The issue noted by Coroner Braes has been specifically raised for clarification with the State Coroner during the renegotiation of the MOU. The QPS will conduct a review of the relevant policies and procedures contained in the OPM to ensure consistency with the content of the MOU.

Inquest into the death of Niceta Maria Madeo

Mrs Madeo was the sole occupant of a stationary vehicle which, on 20 June 2006, was struck by a stolen vehicle being pursued by police. The police pursuit, commencing on the Bruce Highway and ending in the township of Proserpine, lasted three and a half minutes and travelled seven kilometres.

State Coroner Barnes delivered these findings on 26 March 2009.

Mrs Madeo was one of ten individuals to have died in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests were held into each of these individuals' deaths and comments were made by the Coroner in some of those cases.

In addition to these 10 inquests, a further hearing was convened by the State Coroner to hear evidence from the Queensland Police Commissioner, Mr Robert Atkinson APM and the leader of the project reviewing the Queensland Police Service's pursuit policy, Inspector Tony Fleming. In the subsequent report, the State Coroner delivered 13 recommendations, the Government's responses to which are outlined separately in this report.

Comment 1, pg13

The policy required the pursuing officers to balance the utility of a pursuit against the risks it generates. The utility is gauged by considering the consequences of failing to intercept the pursued. In this balancing exercise, issues of safety are to be paramount.

Quite specific and useful examples are given of characteristics which will be relevant to assessing the risk of the pursuit resulting in injury or death. No guidance is given to assist officers to calculate the necessity of the pursuit with reference to the diminution of law enforcement.

Response and action
Agreed and partially completed
Responsible agency: Queensland Police Service

On 24 December 2010, a whole-of-Government response to the State Coroner's *Report on Police Pursuits – Policy Recommendations* was released. It was developed by the Queensland Police Service in collaboration with the Department of Education and Training and the Department of Transport and Main Roads.

All 12 recommendations directed to the Queensland Police Service have been agreed to and the Safe Driving Policy has been developed and approved by the Commissioner of Police. This Safe Driving Policy includes the implementation of all of the State Coroner’s recommendations.

Training in the revised Safe Driving Policy commenced in July of this year, with training aimed at all officers up to and including Inspectors. This training is set to be completed before the revised policy implementation date of 19 December 2011. The compulsory training completed by officers statewide involves a three-step process by way of two

computer-based learning programmes and one hands-on workshop relating to the education of the new policy and procedures.

Comment 2, pg 18

I have found the QPS pursuit policy was not adhered to by the senior officer in the pursuing vehicle or by the pursuit controller. I readily acknowledge that in neither case was this the result of a wilful disregard of those policies: rather, serious errors of judgement were involved. I also acknowledge no malicious or improper purpose was involved in these errors. They were made by officers attempting to do their jobs.

Response and action
Agreed and completed
Responsible agency: Queensland Police Service

The senior officer in the pursuing vehicle and the pursuit controller were both subject to disciplinary action and received managerial guidance over their respective roles in the incident.

Inquest into the death of Paul James Moore

Mr Moore died on 22 September 2006 from multiple injuries sustained after the car he was driving collided with a tree near the town of Injune. At the time of the accident, Mr Moore was attempting to evade interception by police officers who were pursuing him.

State Coroner Barnes delivered these findings on 22 April 2009.

Mr Moore was one of ten individuals to have died in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests were held into each of these individuals' deaths and comments were made by the Coroner in some of those cases.

In addition to these 10 inquests, a further hearing was convened by the State Coroner to hear evidence from the Queensland Police Commissioner, Mr Robert Atkinson APM and the leader of the project reviewing the Queensland Police Service's pursuit policy, Inspector Tony Fleming. In the subsequent report on this hearing, State Coroner Barnes delivered 13 recommendations, the Government's responses to which are outlined separately in this report.

Comment 1, pg 9

Mr Moore's death is one of seven that followed a police pursuit in the period of June 2005 to December 2006. Five inquests have already been held and a final inquest will be held next month. In relation to each, the conduct of the officers involved will be judged against the Queensland Police Service policies in force at the relevant time. However, as those policies have changed significantly during that period, the State Coroner refrained from making any recommendations for future change until the evidence from all seven inquests has been considered and the impact of the changes is evaluated.

Response and action
Agreed and partially completed
Responsible agency: Queensland Police Service

On 24 December 2010, a whole-of-Government response to the State Coroner's *Report on Police Pursuits – Policy Recommendations* was released. It was developed by the Queensland Police Service in collaboration with the Department of Education and Training and the Department of Transport and Main Roads.

All 12 recommendations directed to the Queensland Police Service have been agreed to and the Safe Driving Policy has been developed and approved by the Commissioner of Police. This Safe Driving Policy includes the implementation of all of the State Coroner’s recommendations.

Training in the revised Safe Driving Policy commenced in July of this year, with training aimed at all officers up to and including Inspectors. This training is set to be completed before the revised policy implementation date of 19 December 2011. The compulsory training completed by officers statewide involves a three-step process by way of two

computer-based learning programmes and one hands-on workshop relating to the education of the new policy and procedures.

Inquest into the death of Raleigh Hoy

Mr Hoy died on 6 January 2007 at the Tarampa After Care Centre, a privately owned level-three care facility where he had been a resident for 2 years. An ambulance was called when Mr Hoy said he was unable to breathe but he was unable to be revived. Mr Hoy died from dilated cardiomyopathy.

Coroner MacCallum handed down findings on 5 May 2009.

Recommendation 1a

The employment of sufficient and appropriately trained staff to ensure the comfort and safety of residents.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Communities

The proposal for staff to resident ratio is not agreed because of the difficulties associated with establishing appropriate benchmarks, differing service models and the adverse impact on industry viability because of the high wages cost.

It is proposed to mandate a minimum staffing level requiring all level-three services to have at least one staff member available on site at all times or available to attend the site within 15 minutes.

This response will see a minimum requirement established for the industry for the first time.

While this minimum is below that in the service at the time of Mr Hoy's death, the range of supports and care needs of residents makes it inappropriate to mandate a universal minimum ratio for the sector.

Approval has been sought from the Minister to proceed on projects that aim to address the coroner's recommendations. In anticipation of this approval, strategies are currently being developed to give effect to the proposed projects, in line with policy aims.

Recommendation 1b

Ensuring that all staff employed in a level-three facility are trained and competent in both first aid and CPR.

Response and action
Agreed in part and partially completed
Responsible agency: Department of Communities

It is agreed that all personal care staff only should be trained in first aid and CPR.

It is not seen as appropriate or necessary to train administrative or domestic/cleaning staff who have no direct care experience in CPR or first aid.

Approval has been sought from the Minister to proceed on projects that aim to address the coroner's recommendations. In anticipation of this approval, strategies are currently being developed to give effect to the proposed projects, in line with policy aims.

Recommendation 1c

Ensuring that medications are appropriately stored and distributed.

Response and action
Agreed and partially completed
Responsible agency: Department of Communities

The existing legislated accreditation system requires service providers to demonstrate that medication is stored appropriately. The distribution of medication and instances where medication is refused this is also recorded in the resident's medication record.

A Draft Medication Management Guideline has been developed for release to the sector as part of industry wide consultations to accompany the implementation of the Coroner's recommendations.

Approval has been sought from the Minister to proceed on projects that aim to address the coroner's recommendations. In anticipation of this approval, strategies are currently being developed to give effect to the proposed projects, in line with policy aims.

Recommendation 1d

Ensuring that procedures are in place for advising doctors etc. if the medications are not apparently taken.

Response and action
Agreed and partially completed
Responsible agency: Department of Communities

The existing legislated accreditation system requires service providers to demonstrate they properly store and distribute medication and where medication is refused this is noted in the resident's medication records.

A Draft Medication Management Guideline has been developed for release to the sector as part of industry wide consultations to accompany the implementation of the Coroner's recommendations.

Approval has been sought from the Minister to proceed on projects that aim to address the coroner's recommendations. In anticipation of this approval, strategies are currently being developed to give effect to the proposed projects, in line with policy aims.

Recommendation 1e

Ensuring that appropriate training of staff in the particular facility is such that they are aware of emergency procedures and the whereabouts of emergency equipment.

Response and action
Agreed and partially completed
Responsible agency: Department of Communities

The existing legislated accreditation system requires service providers to ensure appropriate emergency procedures are in place and that staff are trained in these procedures.

The existing accreditation process will be adjusted to ensure that at every site visit/audit steps are taken to verify staff are aware of emergency procedures and the location of emergency equipment.

Approval has been sought from the Minister to proceed on projects that aim to address the coroner's recommendations. In anticipation of this approval, strategies are currently being developed to give effect to the proposed projects, in line with policy aims.

Recommendation 1f

Depending on the size of the facility and the type of residents, whether the employment of a registered nurse is required to maintain accreditation.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Communities

Notwithstanding the Coroner's view that the resident required full personal care services, residential services provide assistance to residents in managing their medication and finances. They are not specialist high care nursing facilities that receive funding from government.

This recommendation does not reflect that those living in level-three services are generally not frail or suffering from illness. Generally, residents are mobile and functional not requiring significant medical care.

The financial impost of employing a registered nurse would effectively result in the closure all level-three residential services in Queensland resulting in approximately 1750 residents becoming homeless. This would place significant pressure on public housing and ancillary support services e.g. mental health services.

Inquest into the death of Raleigh Hoy

Recommendation 1g

The installation of an emergency phone in close proximity to each of the residences and/or panic/alert buttons.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Communities

Notwithstanding the Coroner's view that the resident required full personal care services, residential services provide assistance to residents in managing their medication and finances. They are not specialist high care nursing facilities that receive funding from government.

This recommendation does not reflect that those living in level-three services are generally not frail or suffering from illness.

It is understood the staff member in this case was trained in CPR but never attempted to provide it. Staff at the service now carry a mobile phone to enable them to call for emergency services while remaining with the resident.

The significant capital costs linked to this recommendation would be likely to force a number of operators to leave the sector. This would have the effect of making a number of vulnerable people homeless and placing significant pressure on public housing and ancillary support services e.g. mental health services.

Inquest into the death of Caitlyn Hanrick

Miss Hanrick died on 4 December 2006 from fatal injuries sustained when she was struck by a vehicle whilst crossing the road at Redcliffe State High School where she was a pupil. The car that struck Miss Hanrick had been stolen and at the time of the accident, was being pursued by police after the driver attempted to evade interception.

State Coroner Barnes delivered these findings on 17 July 2009.

Miss Hanrick was one of ten individuals to have died in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests were held into each of these individuals' deaths and comments were made by the Coroner in some of those cases.

In addition to these 10 inquests, a further hearing was convened by the State Coroner to hear evidence regarding the Queensland Police Service's pursuit policy. The Queensland Police Service co-ordinated the Government's response to the specific recommendations delivered by the State Coroner in relation to Miss Hanrick's death as well as the 13 recommendations arising from the State Coroner's report on the Queensland Police Service's pursuit policy which are addressed separately in this report.

Comment 1, pg 21

I am of the view the senior officer in each of the pursuing vehicles and the pursuit controller breached the policy in the following manner:

All three failed to confirm the category of the pursuit. Although it makes no difference in this case, the three officers say they proceeded on the erroneous belief it was a category two incident.

Constable Jones failed to advise the communications centre he was participating in the pursuit.

Constable Jones and Sergeant Lindsay failed to ensure the pursuit controller was advised of all matters relevant to the risk assessment they and he were required to undertake during the course of the pursuit.

Constable Jones and Sergeant Lindsay failed to terminate the pursuit when a reasonable officer having regard to the matters the policy required a pursuing officer to consider would have concluded it was unacceptably dangerous to continue.

Sergeant Bruyensteyn was hindered in the discharge of his responsibilities by the failure of the officers in the pursuing vehicles to adequately inform him of the risks as they occurred. However, even when told the pursuit was passing the school, was travelling at 120 km/hr or that the pursued vehicle had travelled onto the wrong

side of the road, he made no comment. He was completely passive and accepting of what he was told. He did not proactively control the pursuit as envisaged by the policy'.

Further Comments, pg 23-24

"The Department of Education and Training has no statutory or administrative responsibility for the management of road traffic in and around school; nor does it receive a budget allocation to undertake road safety initiatives. The Department obviously has a duty of care to its students but because of these administrative arrangements, it has a limited capacity to discharge its obligation in so far as it relates to road safety. The main mechanisms are participation in SafeST Committees established under the School Environment Safety Guidelines and Traffic Advisory Committees convened by local authorities. Surprisingly the Department does not even have a road safety policy…

It is of concern though that the development of the guidelines and the Department's (of Transport and Main Roads) application of them had regard only to injury causing incidents. No attempt seems to have been made to gather qualitative data that may have allowed a more accurate assessment of the risk to road safety around schools…

The inquest was provided with no evidence as to what was done to re-enforce road safety around the other split campus schools. The Department (of Transport and Main Roads) indicated traffic and speed surveys to measure compliance with speed limits around schools are planned It is also planned to investigate responses to various measures to reduce traffic speed in school zones although the results of that action are not expected to be available until the end of 2010.

I am concerned by this delay and the continuing limited involvement of Education Queensland in the management of traffic around its facilities."

Response and action
Agreed and partially completed
Responsible agency: Joint response between the Queensland Police Service, the Department of Education and Training and the Department of Main Roads and Transport

The Queensland Police Service developed a whole-of-government response, collaboratively with the Department of Education and Training and the Department of Transport and Main Roads, to the issues raised in the Coroner's report including the Coroner's comments about policing matters and crossings at split-campus schools. The report was released on 24

Inquest into the death of Caitlyn Hanrick

December 2010 and outlined the government response to the State Coroner's *Report on Police Pursuits – Policy Recommendations* handed down on 31 March 2010. That report included 13 recommendations, based on a series of inquests related to police pursuits, which included the inquest into the death of Caitlin Hanrick.

Prior to the inquest, significant improvements were made to the road safety infrastructure at the Redcliffe State High School with the construction of a pedestrian overpass. Caitlin's death also prompted a review of 27 split campus schools in Queensland. This resulted in four of those schools having over or underpasses constructed.

The Department of Transport and Main Roads and the Department of Education and Training have undertaken a number of measures to improve safety for school students particularly where school campuses are split by a major road. A trial was conducted during 2010 of school zones on multi lane roads. Consideration is being given to a new policy for school zones on multi-lane roads, new signage guidelines for split campus schools and standardisation of school zone times in Queensland. Greater emphasis is to be placed on road safety in the School Environment Safety Guidelines and in the educational curriculum.

Inquest into the death of Leon Streader

Mr Streader died on 22 February 2004 at Pinjarra Lodge, a privately owned level-three care facility where he was a resident. Mr Streader died due to the effects of coronary atherosclerosis, which was exacerbated by heat stroke.

Deputy State Coroner Christine Clements handed down findings on 1 October 2009.

Recommendation 1

Where a doctor has a financial interest in a level-three accredited facility in which the doctor treats a resident, the doctor is not to issue a cause of death certificate for that resident, or alternatively the certificate is to be countersigned by another independent doctor.

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

Current Queensland legislation protects vulnerable people and maintains the integrity of the death certification process. There is no legislation in any Australian jurisdiction restricting a doctor who has a financial interest in a care facility or nursing home from signing a cause of death certificate for a resident.

Under the *Coroners Act 2003*, coroners are responsible for investigating reportable deaths that occur in Queensland. In 2009, amendments to the *Coroners Act 2003* imposed a duty on service providers to report "deaths in care" to a police officer or coroner regardless of whether the death had been reported by someone else. A "Death in care" is defined in section 9 of the *Coroners Act 2003* to include the death of a person with a disability within the meaning of section 11 of the *Disability Services Act 2006* who is living in a level-three accredited residential service. If the service provider fails to report the death, it is an offence under the *Coroners Act 2003* and carries a maximum penalty of 25 penalty units ($2500). This provision was not in effect at the time of Mr Streader's death. However, if the provision had been in effect at that time, the service provider would have had an obligation to report Mr Streader's death to the coroner.

Mr Streader's death was not initially recognised as a "death in care" by the staff at the facility. The Department of Communities through the Office of Fair Trading, Residential Services Unit, regulates the conduct of residential services through registration and accreditation and monitors compliance with the *Residential Services (Accreditation) Act 2002*. Awareness of the reporting requirements among service providers will be raised by including information relating to the reporting requirement in the next Residential Services Unit quarterly newsletter, Residential Services Update.

Additional safeguards include that under the *Cremations Act 2003* a doctor who signs the cause of death certificate for a deceased person can not sign the permission to cremate. Further, the *Births, Deaths and Marriages Registration Act 2003* and the *Cremations Act 2003* prohibit a doctor from signing the cause of death certificate or permission to cremate certificate if the doctor reasonably suspects that the doctor, or the doctor's spouse, may receive a benefit because of a person's death.

Recommendation 2

That a review be undertaken by the accrediting authority for level-three accommodations to consider an appropriate ratio of residents to staff, and an appropriate level of training of staff and procedures.

Response and action
Agreed and partially completed
Responsible agency: Department of Communities

The agency have reviewed the issue and do not support the proposal for a staff to resident ratio because of the difficulties associated with establishing appropriate benchmarks, differing service models and the adverse impact on industry viability because of high wages costs.

It is proposed to mandate a minimum staffing level requiring all level-three services to have at least one staff member available on site at all times or available to attend the site within 15 minutes.

This response will see a minimum requirement established for the industry for the first time.

While this minimum is below that in the service at the time of Mr Streader's death, the range of supports and care needs of residents makes it inappropriate to mandate a universal minimum ratio for the sector.

It is proposed to mandate CPR and first aid training for all care staff in residential services.

Approval has been sought from the Minister to proceed on projects that aim to address the coroner's recommendations. In anticipation of this approval, strategies are currently being developed to give effect to the proposed projects, in line with policy aims.

Recommendation 3

That those level-three facilities which distribute medication are required to properly document this process and that consideration be given to some form of audit to ensure medication is being received regularly by the residents.

Response and action
Agreed and partially completed
Responsible agency: Department of Communities

Since Mr Streader's death, the accreditation system has been implemented. The accreditation system requires that services provide evidence to the Chief Executive that they are administering medication in accordance with medical directions at least once every three years.

A Draft Medication Management Guideline has been developed for release to the sector as part of industry wide consultations to accompany the implementation of the Coroner's recommendations.

Approval has been sought from the Minister to proceed on projects that aim to address the coroner's recommendations. In anticipation of this approval, strategies are currently being developed to give effect to the proposed projects, in line with policy aims.

Inquest into the death of John Arthur Harvey

Mr Harvey died on 16 August 2007 from injuries he sustained when driving a hired truck. Mr Harvey lost control of the vehicle and it left the road and crashed.

Coroner Springer delivered these findings on 1 October 2009.

Recommendation 2

That Queensland Transport seek legislative change to require:

(a) The tare mass weight to be included on the registration label of vehicles designated to transport loads (other than passenger cars in addition to the gross vehicle mass)

(b) The actual load carrying capacity to be clearly visible on the vehicle.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Transport and Main Roads

The requirement to amend the registration label information is not necessary as vehicle owners and operators are usually familiar with the load carrying capacity of their vehicles. The available capacity to carry goods varies and depends on the number of passengers being carried. Display of such information does not ensure or assist compliance. Enforcement authorities can assess this information independently and do not necessarily depend on the information displayed on the side of a vehicle. If this information were displayed on Queensland registration labels, Queensland would not be consistent with other States and would not be following the national trend of reviewing the need for labels on vehicles. The Department of Transport and Main Roads consider that rental companies have a responsibility to inform and advise their customers about the actual load carrying capacity of the vehicle being hired.

Inquest into the death of Yvonne Davidson

Mrs Davidson died on 11 September 2007 at Rockhampton Hospital after failing to recover from complications arising from a tracheotomy.

Coroner Hennessy delivered these findings on 16 December 2009.

Recommendation 2

Where protocols or policies have been developed in Queensland hospitals to ensure best practice and the highest levels of patient safety, Queensland Health ensure that those polices are shared and communicated to doctors in all Queensland Hospitals for consideration and adoption in order to promote consistent safe practice in the performance of medical procedures across Queensland.

Response and action
Agreed and partially completed
Responsible agency: Queensland Health

The need to improve consistency and communication regarding policy implementation has been recognised by Queensland Health as a priority for reform. The Queensland Health Policy Management Policy provides that any policy developed in Queensland Health will be singular and applies statewide, ensuring that only one policy position exists on the same issue. Executive Management Team (EMT) members will be responsible for approving policy development/policy for implementation, and all polices will require a Policy Custodian. A Policy Register will be developed and monitored to ensure regular policy reviews are not missed. Health Service Districts will be able to have local procedures and protocols that may be developed to meet a District or program need for an agreed set of practices, either to support the implementation of a statewide policy or to address a specific District or program issue.

The Policy Management Policy was approved by the Director-General in August 2009, and full implementation of the policy is expected to occur over a three-year period. The completion of key elements in the implementation of the Policy Management Policy include development of:

- a single policy register as repository for all Queensland Health policy documents
- processes for registering policies
- a single location on both the Queensland Health internet and intranet websites for access to policy
- a suite of documents to support consistency in the format and nature of content of policies.

The development and migration of Queensland Health policies to the Policy Management Policy framework is still in progress.

In addition, the Statewide Intensive Care Clinical Network (SICCN) is currently exploring the development of a website similar to the New South Wales Government Intensive Care

Coordination and Monitoring Unit that will enable the housing of statewide guidelines. The SICCN has developed and maintains an intranet site with guidelines for advanced ventilation techniques and links to the Australian and New Zealand Intensive Care Society percutaneous dilatational tracheostomy consensus statement. Guidelines are developed by various subcommittees of the SICCN.