Preface

The *Queensland Government's Response to Coronial Recommendations 2011* is a whole-of-government report responding to coronial recommendations and comments directed towards the Queensland Government during 2011. It also includes a response to any recommendation that remained under consideration in the *Queensland Government's Response to Coronial Recommendations 2010.* This is the fourth annual report produced by the Department of Justice and Attorney-General on behalf of the Government. The report aims to provide a public response to all recommendations or comments made by Queensland coroners which have been directed to Queensland Government entities.

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

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

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

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Inquest into the death of Phillip Glenn Spicer

Mr Spicer died on the evening of 21 January 2009 from self-inflicted razor blade wounds to his neck. This followed a confrontation with police officers in the home of his son and daughter-in-law in Ferny Hills. The State Coroner found that Mr Spicer had been experiencing delusional thoughts and agitated behaviour in the hours preceding his death.

The State Coroner delivered his findings on 9 February 2011.

Recommendation 1

I am of the view the officers displayed real courage in seeking to prevent Mr Spicer from further harming himself. After it had become clear to them that Mr Spicer was armed and delusional, and after he had made threats to kill them and had administered a serious wound to himself, they nonetheless advanced towards him and Senior Constable Schmidt kicked the straight razor from Mr Spicer's hand so his partner could render first aid. This clearly placed Senior Constable Schmidt in very real danger.

I recommend the Commissioner consider officially recognising Senior Constable Schmidt's bravery with an appropriate award.

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

This nomination has been extended to the second officer, Constable Stephen Keep, who was present at this incident.

In May 2012, the Commissioner of Police approved that both officers be presented with a 'Commissioners Certificate of Notable Action'. To date these Certificates have not been presented.

Additionally, both officers have been awarded a 'Royal Humane Society Award', which will be awarded by the Governor of Queensland at Government House. To date these awards have not been presented.

Comment 1, page 10

"The two officers were apparently allowed to spend time together and unsupervised in the period after the incident. The evidence given by both officers at the inquest was candid in that they admitted discussing aspects of the incident with each other.

Although there is a suggestion in the material before me that senior officers directed the two officers involved be separated it seems clear they were allowed to drive from the incident scene to Ferny Grove police station together and unsupervised.

There is absolutely no suggestion in this case that the officers colluded with respect to the versions of events they would later give in their interviews. However, the potential ramifications of allowing two or more officers involved to be left together and unsupervised following such an incident could be much more serious in other cases. Even if there is no collusion, family members of the deceased may suspect it has occurred and the coroner is unnecessarily placed in the invidious position of having to make assessments of credit that could otherwise be less complicated.

The QPS Operational Procedures Manual places the responsibility for isolations of officers involved in such incidents from colleagues also involved in the incident on the officers themselves. This is appropriate, but as was the case here, such incidents often leave officers traumatised and not in a position to apply their knowledge of policy and procedure as immediately as might otherwise be the case. There is always a role for senior officers attending the scene to take practical steps to ensure separation.

Both of these apparent lapses could usefully be bought to the attention of the District Duty Officer who attended this incident."

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

The issues raised by this inquest were bought to the attention of the District Duty Officer on 4 March 2011. The District Officer provided the District Duty Officer with guidance and advice, along with the findings.

The District Duty Officer was also shown:

- Commissioner's Circular 19/2009, titled "Investigations of deaths in custody or as a result of police operations" and specifically section 1.17.2: 'Regional duty officer or district officer responsibilities' which identifies policy and

procedures regarding duties and responsibilities at police related incidents, including wherever practicable, members involved in the incident do not leave the scene and who are witnesses to the incident, do not undertake or continue further duties regarding the investigation or other duties at the scene and ensuring that the officers are available for interview; and

- Section 1.17.6 of the Operational Procedures Manual (OPM), titled "Integrity of investigations", which provides policy regarding the responsibilities of all police involved in the police incident, to consider the impartiality and the requirement for police directly involved or who are witnesses to the police incident to refrain from discussing the incident amongst themselves prior to being interviewed, unless justifiable reasons for doing so exist.

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

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

The Coroner found that fatigue on the part of one of the drivers contributed to some extent in both accidents. In the case of Mr Brown and Senior Constable Mackenzie, the Coroner also found that the adverse weather conditions at the time of the accident were also significant contributing factors. In the case of Mr Wilson, the Coroner found that the width and condition of the road was an exacerbating factor.

Coroner Hennessy delivered her findings on 23 February 2011.

[The Coroner's numerous recommendations from this inquest cover a broad range of issues that involve overlapping agency responsibilities. For the sake of clarity, the recommendations have been grouped together and responded to according to the issues to which they pertain.]

Recommendation 1 - Queensland Police Service resources

That the Queensland Police Service conduct a review of the allocation of Traffic Accident Investigation Squad (now Forensic Crash Unit) officers to regional Queensland.

In particular, that a permanent Forensic Crash Unit be established in Rockhampton that is sufficiently resourced and staffed to ensure timely investigations of fatal and serious road crashes, taking into account the issues commented on in this inquest.

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

The Central Police Region has assessed the need and benefit of implementing a permanent Forensic Crash Unit in Rockhampton. The Queensland Police Service's (QPS) Strategic Workforce Planning Committee had decided to increase Central Police Region resources with the implementation of a Forensic Crash Unit,

including human resources, to ensure fatal and serious crashes are thoroughly investigated and reported in a timely manner.

As of 26 March 2012, a Forensic Crash Unit has been established in Rockhampton and adequately resourced. It comprises two full-time officers. A suitable vehicle to be used by the Forensic Crash Unit in Rockhampton is currently being sourced and is the main priority in 2012/2013 financial year.

Recommendation 3 - Queensland Police Service resources

That an urgent review be undertaken by the Minister for Police and the Queensland Police Service of the current police resources and police number allocations in the central region. Priority should be considered for the provision of additional police numbers and resources to assist in bolstering the policing presence on Central Queensland roads with a view to increasing the effectiveness of current enforcement activities, road surveillance and fatigue monitoring in light of mining activities in the region.

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

The Queensland Police Service (QPS) Strategic Workforce Planning Committee continually assess resource allocations, structures and capabilities of all units, regions and commands and submit recommendations, where a need is identified, for consideration of the Board of Management.

As identified in recommendation one, on 26 March 2012 the Rockhampton Forensic Crash Unit (FCU) was established, comprising two police officers. The establishment of this FCU has been resourced sufficiently with the purchase of a vehicle being of priority.

The approved police strength of the Central Police Region increased by 16 percent from 742 officers in early 2007 (the year of Robert Wilson's death) to 861 officers in early June 2011. In the last 12 months additional traffic officer positions have been allocated to the Central Police Region with one position allocated to both the Rockhampton and Longreach districts and two positions allocated to both the Gladstone and Mackay districts.

Recommendation 8 - Queensland Police Service resources

That the Queensland Police Service considers utilising the retrieval of in-vehicle information recording systems as part of standard investigative procedures for fatal car accidents.

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

The Queensland Police Service supports this recommendation and has conducted a trial of an investigative tool referred to as the Crash Data Retrieval (CDR) kit through the Forensic Crash Unit in Brisbane. This trial involved training current serving Forensic Crash Unit investigators in the use of the CDR kit.

The CDR kit was developed for use in the United States of America as legislation there mandates that if a vehicle records data, this information be made available to United States law enforcement agencies.

The CDR kit has been used in Brisbane, the Gold Coast and Cairns with the Forensic Crash Unit evaluating the CDR kit after having successfully downloaded airbag deployment data from Holden and Toyota vehicles. The data has been beneficial in corroborating other evidence in relation to speeds of vehicles. Advice received from the Forensic Crash Unit in Brisbane was that since the accidents involving Mr Brown, Mr Wilson and Senior Constable Mackenzie, Forensic Crash Unit investigators have successfully used data downloaded by a CDR kit in prosecutions.

The CDR kit is continuing to be used and is available to other police regions if required. However, the current cost / benefits of the CDR kit does not support the purchase of individual kits for each police region, nor is the current kit compatible with all vehicles. At this point it appears that European and most Asian manufacturers are not providing software to enable the CDR kit to download airbag data.

The Queensland Police Service notes that, though still limited, more passenger vehicles are being manufactured with electronic systems which can record data from various vehicle sensors including Anti-Lock Brakes, Traction Control and Electronic Stability Control. These systems are designed to assist a driver during an emergency. Recording any information from these systems is a secondary function through a diagnostic tool which assists the manufacturer should a fault be recorded. At this stage this information is not available to police agencies.

In addition, nearly all worldwide manufacturers have installed airbags as a secondary safety system. The computer modules in some vehicles record data such

as vehicle speed, RPMs, throttle percentage and brake application at the time of a crash when an airbag is deployed. It records this data for 1-2 seconds prior to deployment. Any information is primarily recorded to assist the manufacturer for research and if a fault is suspected in the system but this information is not currently available to police agencies.

It is reasonable to assume that in the years ahead more manufacturers will make this information available to crash investigators. Consequently, the introduction of crash data retrieval systems will assist Forensic Crash Unit investigators in analysing a serious and fatal crash. This may assist in determining vehicle behaviour and use of the vehicle immediately prior to a crash, information that is extremely valuable for Forensic Crash Unit investigators

Recommendation 20 – road safety audits and upgrades

That a Central Queensland Road Safety Committee be established to conduct ongoing safety audits of road surfacing to Central Queensland mines, mining towns and regional centres and that consideration be given to funding the Committee through existing mining royalties.

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

A Committee has been established that is comprised of representatives from the Department of Transport and Main Roads (DTMR) Transport Services Division and Project Delivery and Operations, the Central Highlands Regional Council, the Rockhampton Regional Council and the Mackay Regional Council and the Mackay Accident Action Group. The Committee is currently focussing on improving rest areas and stopping sites on roads.

The work of the Committee is being funded from DTMR's existing budget. While mining royalties are not specifically channelled to the Committee, the Queensland Government, through DTMR, funds the ongoing work of the Committee with the allocation of general revenue that is partly derived from mining royalties.

DTMR has undertaken risk assessments of all Central Queensland State government-controlled roads and local roads of regional significance. Based on these assessments, road safety audits and road works are prioritised and implemented throughout the region. This program of works is shared with government and non-government stakeholders through the Committee. The risk assessments of the road network which inform road works are ongoing activities.

Recommendation 21 – road safety audits and upgrades

That a comprehensive audit be engaged in by the Department of Transport and Main Roads of central Queensland roads to consider the appropriateness and risk posed by existing road width, road shoulders, the need or appropriateness of road signage, the adequacy and/or need for additional rest areas and the identification of fatigue zones where additional fatigue counter-measures might be considered.

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

A road safety auditor is being engaged to conduct the audit recommended by the Coroner.

The audit will include:

- updating the assessment of road risks;
- identifying existing fatigue counter-measures;
- an audit of fatigue signage;
- mapping of fatigue zones and other crash measures; and
- identification of high crash rate zones.

The audit report will be finalised in the second half of 2012.

Recommendation 22 – road safety audits and upgrades

That the Dysart-Middlemount Road be prioritised by the Department of Main Roads for road upgrade and road widening between Dysart and Norwich Park.

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

The Department of Transport and Main Roads completed the widening of the Dysart-Middlemount Road between Dysart and Norwich Park in August 2009.

Recommendation 7 – definition of fatigue

That Queensland Transport, in conjunction with the Queensland Police Service should review and adopt an operational definition of fatigue.

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

The Department of Transport and Main Roads has adopted an operational definition of fatigue for the reporting of crash data:

> "*A single vehicle crash (involving a motorised vehicle) in 100km/h or higher speed zone during typical fatigue times (2pm-4pm or 10pm-6am); or the reporting officer considered that fatigue was a contributory factor in the crash*."

This definition will be monitored and reviewed in light of any recommendations from research or national agreements.

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

The Queensland Police Service (QPS) has determined that operational definitions are based on more than the time of day, as indicated in DTMR's adopted definition above. QPS consider that further investigation of the relationship between the variables involved in the crash itself and other surrogate or proxy variables (such as a driver's sleeping patterns, if the driver is a shift worker and possible medically related causes) is required. An analysis of these operational variables can assist in providing an estimate of fatigue related crashes enabling strategies to be developed which can reduce the likelihood of these crashes and benchmark the effectiveness of any developed strategies.

With respect to QPS's differing view of operational factors contained within the fatigue definition advocated by DTMR, QPS and DTMR have indicated that the definition can be monitored and reviewed in light of any recommendations from research or national agreements, but do consider the matter complete.

Recommendation 12 – definition of fatigue

That the Minister for Transport and Main Roads seek the support of all Australian Transport Council (ATC) members for the

development of a standardised fatigue definition and reporting for road safety purposes.

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

A definition of fatigue for reporting at a national level has been agreed. The Department of Transport and Main Roads led a working group under the auspices of the National Road Safety Strategy panel in 2007. The definition will be used to monitor national trends in crashes which could be related to driving while fatigued.

In terms of definitional differences between the States and Territories, the consistency of crash data reporting was further considered by representatives of all Australian jurisdictions as a part of the project to develop a national database for serious injuries and performance indicators associated with the *National Road Safety Strategy 2011-2020*. This project identified that there is a high degree of consistency of crash data reporting and that areas of inconsistency generally involved low numbers of crashes.

It was agreed that jurisdictions would not pursue any further work at the national level to reduce inconsistency but that each jurisdiction would review the inconsistencies at the state/territory level to further improve national consistency where possible. Given the difficulties of measuring fatigue and the subjectiveness of determining fatigue related crashes, there was no desire to further review this definition at the national level. As part of this project it was resolved that the current definition and reporting practices for fatigue related crashes were sufficient.

Recommendation 10 – fatigue detection

That the Queensland Government through Queensland Transport and Queensland Health Commission or other appropriate bodies support/develop further research into a method or mechanism for the detection of fatigue impairment in drivers.

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

The Department of Transport and Main Roads (DTMR) actively liaises with other transport agencies, universities and industry representatives to further the research and development of a number of fatigue detection technologies.

DTMR is investigating fatigue detection technologies that have the capacity to prevent fatigue-affected road users from driving and detect when drivers are likely

to be fatigued. For example, DTMR is investigating the trialling of electronic diaries and the use of Automatic Number Plate Recognition and the Intelligent Access Project for detecting heavy vehicle drivers who have exceeded driving hour requirements.

DTMR is also a signatory to the *National Road Safety Strategy 2011-2020* that has identified fatigue as a road safety issue to be addressed. DTMR is monitoring a number of projects relating to fatigue, including operational field trials of devices that measure drowsiness currently being conducted by New South Wales and Victoria as part of the National Road Safety Strategy. DTMR has also implemented national medical reporting guidelines, which require medical practitioners to identify drivers whose driving may be affected by medical conditions related to sleep disorders or which may induce drowsiness.

Recommendation 2 – fatigue detection

That Queensland Transport and Queensland Police Service review:

a) police traffic accident documentation, training manuals and the First Response Handbook to promote the accurate recognition and recording of fatigue-related crashes

b) current basic training and the Forensic Crash Unit specialist training syllabus in order to ensure comprehensive training for traffic and general duties officers who attend crashes. Such a review should include a focus on specific training to assist in identification of fatigue-related crashes and the detection of drivers who are impaired by fatigue

c) in consultation with appropriate fatigue experts and or road safety experts, the current crash data collection forms (PT51) to consider the development and inclusion of a list of extended categories and enquiries required for classification of crashes by police as being fatigue related for use as an aide memoir in operational field conditions.

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

The Queensland Police Service's (QPS) Forensic Crash Unit in Brisbane has provided information to the QPS Flexible Learning Unit within the Education

Services Branch in relation to questioning drivers suspected of being fatigued. This information is currently being incorporated into a Competency Acquisition Program (CAP) booklet, which once completed will be referred to as QCP0003: 'Traffic Crash Investigation'. This CAP Booklet, like all others produced, will be available for all police officers and is considered by the QPS to be an important training tool. It is anticipated that this CAP book will be published in 2013.

The Forensic Crash Unit training syllabus' 'Basic Course' has been amended to include information on identifying and questioning drivers in relation to fatigue driving. Further to this, the training of general duties police officers in identifying physical symptoms of fatigued drivers has been discussed with members from the Education Services Branch and Forensic Crash Unit. This has resulted in the decision that a quasi-medical diagnosis and input from medical practitioners would be required. Due to this and other changes being implemented as a result of this recommendation, part (b) of the coroner's recommendation will not be implemented.

The data crash fields within the QPS QPRIME Traffic Crash Report have been reviewed. The review recommends that the PT51 'Traffic Crash Report' be discontinued and an Aide Memoire be implemented. This recommendation is currently being considered by the Commissioner of Police. The proposed Aide Memoire includes questions in relation to fatigue. It is currently expected to be published and released in early 2013, when it will be available for use by all police officers (including general duties officers) to assist them in the investigation of traffic crashes.

Additionally, the First Response Handbook has been reviewed and its current version, due for publication late 2012, has included some questions in relation to fatigue to assist first response officers investigating traffic crashes.

A Road Crash Operational Support Working Group has been established to resolve data quality, coding and other operational issues associated with road crash data. This group includes representatives from the Queensland Police Service, Department of Transport and Main Roads and the Office of Economic and Statistical Research which provides advice based upon academic research and best practice. The work of the Road Crash Operational Support Working Group is ongoing.

Recommendation 9 – fatigue detection and fatigued related driving offences

That ongoing consideration be given by Queensland Police Service to:

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

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

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

Response and action
Under consideration
Responsible agency: Joint response between the Queensland Police Service (lead) and Department of Transport and Main Roads

The Queensland Police Service (QPS) is yet to make a decision on the Coroner's recommendation.

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

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

However, while a police officer can stop a driver whom they reasonably believe is behaving dangerously, the ability to accurately detect, and later prove successfully in a prosecution, that the driver was affected by fatigue is difficult. The signs of fatigue as well as other factors that the QPS considers significant in contributing to fatigue in drivers – like lack of recent sleep, shift work, driving long distances and driving for long periods of time – might be known to drivers themselves but can be difficult for police to detect. In comparison, detection of drivers of heavy commercial vehicles is uncomplicated due to the regulated nature of that industry ensuring that there is evidence of driving times, usually in the form of log books. This is something that would obviously be harder to enforce for drivers of private vehicles.

The QPS currently has no training for general duties police officers in this fatigue related area. However, the officer in charge of the QPS Brisbane's Forensic Crash Unit has started discussions with the QPS Education Services Branch to identify suitable training methodologies in relation to driver observations and behaviour or indicia associated with fatigued driving.

DTMR is responsible for legislating dangerous driving offences under the *Transport Operations (Road Use Management) Act 1995* but the difficulties that police face in detecting and stopping fatigued drivers of private vehicles would also arise in trying

to define a fatigued driving offence for private drivers. DTMR is considering the appropriateness of such an offence, in conjunction with the QPS. A joint position on this issue will be put forward in late 2012.

Recommendation 4 – data collection on fatigue related incidents

That Queensland Transport in conjunction with the Queensland Police Service undertake a review of current crash data collection procedures, classification of fatigue, the veracity of the surrogate measures and methodologies for the analysis of crash data by the Queensland Police Service and Queensland Transport in association with appropriate external experts.

Response and action
Agreed and partially completed with ongoing implications
Responsible agency: Joint response between the Department of Transport and Main Roads (lead) and the Queensland Police Service

A Road Crash Operational Support Working Group has been established to resolve data quality, coding and other operational issues associated with road crash data. The Department of Transport and Main Roads (DTMR) and the Queensland Police Service (QPS) have an ongoing commitment through this Working Group to review and improve crash data collection.

The work undertaken by the Road Crash Operational Support Working Group and DTMR is informed by other transport agencies, universities and industry representatives. For example, the Queensland Road Safety Advisory Group, consisting of key road safety partners/stakeholder groups such as the Royal Automobile Club of Queensland and the Centre for Accident Research and Road Safety Queensland at the Queensland University of Technology, provides a forum on road safety issues.

DTMR also undertakes and monitors research regarding fatigue to ensure data recording, classification of fatigue, the veracity of the surrogate measures, and methodologies for the analysis of crash data reflects current best practice.

DTMR in conjunction with the Department of Natural Resources and Mines (formerly the Department of Employment, Economic Development and Innovation) commissioned the Central Queensland University to conduct a research project into the effects of shiftwork in Central Queensland on driver fatigue. The research by Central Queensland University was completed in early 2012.

This is an ongoing activity involving research, policy development and data recording and reporting.

The QPS collects traffic crash related information and data from Traffic Crash Reports, which is transferred to the QPS computer based occurrence system, QPRIME. The data crash fields within the Traffic Crash Report have been reviewed. It was recommended that the Traffic Crash Report be discontinued and an Aide Memoire be implemented. This is currently under consideration for approval by the Commissioner of Police. The information recorded in the proposed Aide Memoire is based on the Australian Transport Safety Bureau's guidelines and a minimum common dataset identified by the members of AUSTROADS (2000), the association of Australian and New Zealand road transport and traffic authorities.

Recommendation 5 – data collection on fatigue related incidents

That Queensland Police Service conduct a trial within a limited geographic area for a set period of time to collect enhanced data on fatigue-related road crashes as discussed in these findings.

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

A review of the Coroner's recommendation has been conducted and as part of this review, the Queensland Police Service (QPS) identified that there are currently no trials or projects involving fatigue management. However, Traffic Intelligence Officers monitor all crashes to identify causal factors. Local Department of Transport and Main Roads (DTMR) engineers also attend fatal crash scenes and discuss with Forensic Crash Unit officers all contributing factors, including fatigue.

The QPS considers that current legislation relating to fatigue management is restricted to heavy vehicles and therefore the QPS is unable to implement this recommendation.

While not directly targeting fatigue management, the QPS has conducted enforcement operations involving heavy vehicles (Operation Dickson and Operation Blue Stone respectively) within the Central Police Region, specifically in the Mackay and Rockhampton Districts.

Additionally, the QPS has determined that there are current external projects and/or stakeholder consultation being conducted by other agencies that are ongoing and contribute to this recommendation.

DTMR, in conjunction with the Department of Natural Resources and Mines (DNRM - formerly the Department of Employment, Economic Development and Innovation) have sponsored research being conducted by Professor Di Milia from the Central Queensland University. Professor Di Milia's research used information gathered from QPS enforcement operations Dickson and Blue Stone and a copy of

Professor Di Milia's research paper into fatigue driving has been provided to the QPS.

The mining industry in Central Queensland through the community managed Road Accident Action Group is a recipient of the 2006 Premiers Award, presented for the work done by the Fatigue Management Team in relation to the risks and consequences of driving when fatigued.

The Centre for Accident Research and Road Safety – Queensland (CARRS-Q) has an innovative advanced driving simulator that will help enhance Australian road safety research and provide insight into driver behaviour. CARRS-Q has eleven projects involving the simulator already planned and has listed driver fatigue first in those projects.

The QPS continues to support and assist in research undertaken by DTMR and DNRM, as well as the Central Queensland University and the mining industry, through identifying resource needs and reporting on policing impact, traffic safety and road management for every Environmental Impact Statement for new mining projects.

Recommendation 11 – data collection on fatigue related incidents

That additional effort be committed to improving the quality of data maintained by Queensland Transport and obtained by Queensland Police identifying the location of fatigue hot spots on the roads so that engineering initiatives and other control measures to combat fatigue-related crashes might be considered for continuing deployment throughout Queensland in these identified zones.

Response and action
Agreed and completed with ongoing implications
Responsible agency: Joint response by the Department of Transport and Main Roads (lead) and the Queensland Police Service

A Road Crash Operational Support Working Group has been established to resolve data quality, coding and other operational issues associated with road crash data. The Department of Transport and Main Roads (DTMR) and the Queensland Police Service (QPS) have an ongoing commitment through this Working Group to review and improve crash data collection. Crash data is currently analysed to detect possible fatigue 'hotspots' and this analysis is used to identify locations for interventions such as audible edge-lining, roadside signs and billboards, and regional media campaigns. Work of the Road Crash Operational Support Working Group is ongoing.

The QPS is currently rolling out Intelligent Traffic Analysis System (I-TAS) which is an integrated solution that enables operational police to plan, roster and record all traffic-related activities. I-TAS also facilitates the capture and allocation of resourcing to manage traffic related enforcement activities (including hours worked and identified measurable key performance indicators) and enable managers to plan and target traffic operations/initiatives more effectively.

Recommendation 6 – investigating fatal car accidents occurring during commutes to or from a mine site

That a Memorandum of Understanding be negotiated between the Queensland Police Service and the Mines Inspectorate to notify the Mines Inspectorate of road crashes where persons are travelling to and from a mine to enable the Mines Inspectorate to investigate at the mine in relation to the effectiveness and compliance with the health and safety management system and for the sharing of information for the purpose of an investigation by either entity.

Response and action
Agreed and completed
Responsible agency: Joint response between the Department of Natural Resources and Mines (lead) and the Queensland Police Service

On 26 July 2012, a Memorandum of Understanding (MOU) between the Queensland Police Service and the Department of Natural Resources and Mines (DNRM - formerly the Department of Employment, Economic Development and Innovation) was agreed to and signed.

This MOU provides for the sharing of information when mine workers are involved in journey incidents to and from mine sites.

The Mines Inspectorate is developing a system for the Inspectorate to request information on fatigue risk management systems from mine sites. DNRM is also considering developing new protocols for investigating a mine's possible non-compliance with fatigue management standards. However, this can only be done after the development of standards for fatigue risk management and commute management, which is a part of the National Mine Safety Framework harmonisation project.

Recommendation 18 – fatigue related risk management standards and strategies within the mining industry

That the Mines Inspectorate, in conjunction with the Queensland Resources Council and the CFMEU, sponsor targeted research at both the industry and mine level into shiftwork fatigue risk management and commuting to ensure risk is at an acceptable level.

Response and action
Agreed and completed
Responsible agency: Department of Natural Resources and Mines

The Department of Natural Resources and Mines (DNRM) and the Department of Transport and Main Roads (DTMR) jointly funded and coordinated the research on fatigue in road users in the Bowen Basin by Professor Lee Di Milia of Central Queensland University. Professor Di Milia presented his preliminary findings at a number of forums including the Mining Safety and Health Conference in Townsville and for local road safety forums. Professor Di Milia's final research report has been delivered and is currently being reviewed jointly by DTMR and DNRM Mines, and will be shared with the industry. DNRM may need to consider further research and results from research conducted by the Construction, Forestry, Mining and Energy Union. The research findings will also be incorporated into other regulatory and advisory communications by both departments.

Recommendation 14 – fatigue related risk management standards and strategies within the mining industry

That the matter of fatigue be referred to the Ministerial Advisory Council (MAC) for the Council to consider:

a) the appropriateness or otherwise of "competency based" fatigue training for the mining industry'; and

b) any other matters considered appropriate by the Council to further enhance the mining industry's contribution to fatigue management.

Response and action
Agreed and partially completed
Responsible agency: Department of Natural Resources and Mines

The two Mine Safety and Health Advisory Committees (referred to as the MAC above) have just been reconvened to align with new government processes.

The Department of Natural Resources and Mines (DNRM) has prepared Queensland Guidance Note no. 16 titled *Management of Safety and Health Risks Associated with Hours of Work Arrangements at Mining Operations*, which references training programs by Boylan, Simpson and Simpson, a corporate psychology service, which appears to be the leading practice in competency based fatigue training programs. The Guidance Note calls for the updated content of fatigue management to be included in training for mine workers and supervisors. The Guidance Note's endorsement by the Minister for Natural Resources and Mines is on hold subject to the endorsement by the two Mine Safety and Health Advisory Committees.

In the interim, DNRM proposes to issue a Directive to audit the effectiveness of current safety and health management systems with regards to fatigue. Also a safety alert/bulletin is to be distributed about the issue of fatigue management which will reference the Guidance Note, the Memorandum of Understanding with the Queensland Police Service, the Coroner's findings and these particular commuting incidents. DNRM will continue to reference the Guidance Note in its audits and in providing help and advice.

Recommendation 15 – fatigue related risk management standards and strategies within the mining industry

That the Mines Inspectorate investigate:

a) the implementation of a fatigue management Recognised Standard incorporating a workable definition of fatigue including consideration of parameters for a maximum number of hours in a day, a week and a shift cycle; and

b) enforcement powers being implemented, either within a statutory framework or the employment contract, or both, to ensure compliance with the fatigue management standard rests on the shoulders of the employer and the employee.

Response and action
Agreed and completed
Responsible agency: Department of Natural Resources and Mines

The Department of Natural Resources and Mines (DNRM) will disseminate the latest version of Queensland Guidance Note no. 16, which addresses the issue of compliance with the working conditions referred to by the Coroner. DNRM is also involved in the National Mine Safety Framework. This project is aimed at addressing the harmonising mining safety legislation across each state and territory

and includes investigating the issue of implementing enforcement powers to ensure compliance.

Recommendation 17 – fatigue related risk management standards and strategies within the mining industry

That mine operators fully explore control measures to reduce or eliminate the risks associated with workers commuting whilst fatigued.

Response and action
Agreed and completed
Responsible agency: Department of Natural Resources and Mines.

The Department of Natural Resources and Mines (DNRM) wrote to the Queensland Resources Council in May 2012 to address this issue.

DNRM has also identified and organised key stakeholders with which to share information on the effectiveness of control measures, knowledge of fatigue research as well as results from audits of metal mines. The following control measures are in use in the mining industry:

- short shifts on the final shift of a roster;
- use of bus transport to and from the mine for each shift;
- accommodation on site or adjacent to the mine; and
- fly-in fly-out arrangements.

Mining operations use one or a combination of the above control measures and their wider adoption is being encouraged.

Recommendation 19 – cover for workers complying with fatigue-related risk management standards within the mining industry

To remove doubt, the Department of Industrial Relations and Q-Comp should review the current rules for journey claims to ensure clarity and cover for fatigue-reducing rest breaks before commuting on public roads to make it clear that a worker who is complying with a Fatigue Management Policy which comes under the Health and Safety management system of the mine is covered in the event of a journey claim.

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

In March 2011, Workplace Health and Safety Queensland (WHSQ), in the Department of Justice and Attorney-General (DJAG) wrote to the Coroner to indicate support of the recommendation.

DJAG's Workers Compensation Policy Branch, within Fair and Safe Work Queensland, met with WorkCover Queensland and the Workers Compensation Regulatory Authority (Q-COMP) to clarify the policy position of the treatment of journey claims where a rest break is involved.

The Workers Compensation Policy Branch, Q-COMP and WorkCover Queensland are consulting with the Queensland Resources Council and other stakeholders to clarify the policy position regarding journey claims. The agreed policy position will be published on the Q-COMP website. This publication is currently in development.

WHSQ will seek to raise the outcomes of this project at the Fatigue Management Forum that being planned by the Department of Transport and Main Roads.

Recommendation 16 – whole-of-government fatigue related risk management standards and strategies across all Queensland industries

In order to ensure a whole-of-government response to the occupational health and safety issue of shiftwork and commuting across all the industrial sectors, that Queensland Transport, in conjunction with the Division of Workplace Health and Safety and the Mines Inspectorate, review the current regulatory framework, standards and guidelines to identify risks to workers and the public from shiftwork, commuting and fatigue to ensure the legislative framework manages risk at an acceptable level and make a formal reference of the issue to a joint session of the Coal and Metals Advisory Councils.

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

In September 2011, a policy workshop was held with representatives from the Department of Transport and Main Roads (DTMR), Workplace Health and Safety

Queensland (WHSQ) within the Department of Justice and Attorney-General (DJAG), the Department of Natural Resources and Mines (DNRM - then the Department of Employment and Economic Development and Innovation or DEEDI) and the Queensland Police Service (QPS). A number of strategies to address these issues were discussed. A presentation was also given on the preliminary findings of the Bowen Basin road survey research project, commissioned by DTMR and DNRM and conducted by Professor Lee Di Milia from the Central Queensland University. Based on this information, it was agreed to convene a Fatigue Management Forum while continuing the wider discussion of initiatives that could be shared in the Bowen Basin on an ongoing basis. The Fatigue Management Forum is being planned, led by DTMR, with the format, timing and terms of reference for the Forum currently being considered.

Ongoing meetings and discussions between DNRM Mines and DTMR at the local level in the Bowen Basin are continuing in order to formulate further regulatory approaches as the basis of further discussion. The agreed approach will focus on voluntary adoption of journey management or commute management plans incorporating the findings of the Central Queensland University research.

The Commissioner for Mine Safety and Health will refer this matter to the inter-departmental Safety Regulators Council for discussion by safety regulators from DTMR (including Maritime Safety Queensland), DJAG (including the Office of Fair and Safe Work Queensland and the Electrical Safety Office), and representatives from the Department of the Premier and Cabinet and Queensland Treasury. An agenda paper is to be developed for the Safety Regulators Council that will include the requirement for a review of the regulatory framework.

A similar agenda paper was considered by the sub-committee of the mining safety and health advisory committees' sub-committee meeting on 13 March 2012.

Further, WHSQ have also undertaken a considerable amount of work to address various aspects of fatigue as a general workplace health and safety issue. The *Preventing and Managing Fatigue in the Workplace* draft model Code of Practice is currently being revised based on public comment. It is expected to be finalised in mid-2013.

Recommendation 13 - whole-of-government response to fatigue related risk management standards and strategies across all Queensland industries

That a Fatigue Management Forum be convened to develop best practice fatigue management guidelines for road transport authorities, road users and public and private sector employers across Queensland. The guidelines should:

a) address the development of a definition of fatigue;
b) review the extent of fatigue-related crashes and the causes for them;
c) review the effectiveness of fatigue management standards across the State (including the Queensland Resources Council's "Fatigue Management Principles") in addressing the causes of fatigue related crashes;
d) development of benchmarks for measuring the effectiveness of the standards and practices;
e) determination of how existing standards and practices can be improved; and
f) review of the most effective ways to reduce the incidence of fatigue related crashes.

Response and action
Agreed and partially completed
Responsible agency: Joint response from the Department of Transport and Main Roads (lead), the Department of Natural Resources and Mines, the Queensland Police Service and Workplace Health and Safety.

A research project into driver fatigue in the Bowen Basin was jointly commissioned by the Department of Transport and Main Roads (DTMR) and the then Department of Employment, Economic Development and Innovation (DEEDI - now the Department of Natural Resources and Mines (DNRM)) in 2010. An inter-governmental policy workshop was convened on 27 September 2011 to discuss the preliminary findings of this study as well as this recommendation. The workshop focussed on the implications of the research findings for policy changes or development, and strategies to ensure a whole-of-government response to the occupational health and safety issue of shiftwork and commuting across all the industrial sectors. DTMR, DEEDI, the Queensland Police Service (QPS) and Workplace Health and Safety Queensland (WHSQ) were represented at this workshop.

As an outcome of this, a Fatigue Management Forum looking at practical solutions for fatigued driving is being planned. Key stakeholders from the relevant government agencies (DTMR, QPS, WHSQ and DNRM, mining, oil and gas stakeholders and representatives from industry and the road safety research field are expected to participate in the Forum. The format, timing and terms of reference for the Forum are currently being considered. However, a specific outcome of the initial workshop for DNRM is to promote the idea of a commute and journey management plan. DNRM intends to table Queensland Guidance Note no. 16, which addresses the issue of compliance with the working conditions referred to by the Coroner, after

it has been amended following an independent review. DNRM will also conduct a survey on which major companies have a journey management procedure in place.

The final research report on driver fatigue in the Bowen Basin has also been delivered and its outcomes will be considered by the agencies involved in the Forum. In addition to issues identified in this recommendation, it is expected that the key findings from the driver fatigue research project will be discussed, including:

- primary predictors of risk of a fatigue-related incident;
- promising opportunities for intervention identified in the academic and industry domains; and
- ways to encourage the adoption and success of countermeasures.

Recommendation 24 – whole-of-government response to driver fatigue

That the Queensland Government prioritises initiatives to address fatigued driving as a critical public safety issue.

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

The issue of fatigued driving is recognised as a road safety priority and was identified as such in the *Queensland Road Safety Strategy 2004-2011* and associated Action Plans. The issue of fatigue will continue to be a key element of the Department of Transport and Main Roads' (DTMR) future strategic direction for road safety.

DTMR has committed to implementating of the *National Road Safety Strategy 2011-2020* that has identified fatigue as a road safety issue to be addressed. DTMR is participating in a number of projects relating to fatigue as a public safety issue. Initiatives that have been undertaken to address fatigued driving include:

- **Blackspot Program**: This program aims to reduce crash numbers and severity by applying engineering measures at high crash locations.
- **Safer Roads Sooner Program**: This Queensland Government program uses similar site identification and treatment as the federal Blackspot program. One component involves the provision of more forgiving roadside environments which are beneficial in the event of a crash.
- **Audio Tactile Line Markings (ATLM)**: These aim to reduce fatigue crashes by using a noise (audio) and vibratory (tactile) warning to drivers who stray across lines due to fatigue or fog. Research into ATLM treatments have revealed a reduction in run-off road crashes of 20%.

- **Medical condition reporting:** From 2006 all licence holders have been required to notify DTMR of any permanent or long term medical condition, such as narcolepsy, which may affect their ability to drive safely. This may impact drivers who have sleep disorders as previously drivers were only required to notify DTMR upon initial licensing or renewal.
- **Road engineering improvements**: DTMR is currently trialling road engineering improvements to prevent crashes occurring and to reduce the severity of crashes when they occur. This includes widening and sealing road shoulders, curvilinear rather than straight road alignment and removal or shielding of trees and other hazards within the clear zone.
- **Public education campaigns:** These are regularly run to create an awareness of the dangers of driving tired, the symptoms of fatigue and trip planning.
- **Driver Reviver:** This program operates during holiday periods, providing a place for motorists to take a break. Sites are located in key fatigue blackspot locations and volunteers provide refreshments and trip planning advice.
- **Rest areas:** Rest areas are important for alleviating driver fatigue. DTMR is delivering new rest areas and improved facilities at existing rest areas across the State.

These are ongoing actions as crash data, research and other evidence is continually reviewed and evidence based interventions are identified. Fatigue will continue to be a priority of DTMR's road safety program.

Recommendation 23 – public awareness campaigns on driver fatigue

That Queensland Transport and the Queensland Police Service, in conjunction with suitable road safety organisations (such as RAGG and MIRSA) and taking advice from fatigue experts, review existing public education campaigns on driver fatigue and develop and implement new public education campaigns on driver fatigue and driver inattention to improve effectiveness of the campaigns.

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

DTMR has sole responsibility for this recommendation as these matters relate directly to public education and road infrastructure and environment issues managed by DTMR.

A fatigue public education campaign was undertaken in both the 2009-10 and 2010-11 financial years. The campaign was based on research with the target audience. The campaign was reviewed and evaluation showed the campaign performed well in terms of attitude, awareness and self-reported behaviour change.

Funding was allocated in the 2011-12 financial year to continue the long-term outdoor presence of fatigue-related billboards throughout the State. Fatigue-related messages have been placed in suspected fatigue-related crash zones on regional roads and roads in south-east Queensland.

DTMR is currently working on a new and innovative approach to improve awareness of community safety and to achieve a change in community attitude and behaviour relating to safety (including road safety). The launch of the new approach is expected to be announced in late 2012. Fatigue will be one of the road safety issues addressed through this new approach.

Inquest into the death of Daniel James Clarke

Mr Clarke died on 4 March 2009 from a self-inflicted gunshot wound after a protracted siege with police at his mother's property in Booie, east of Kingaroy.

The State Coroner delivered his findings on 25 March 2011.

Recommendation 1

I recommend incident management policies be reviewed to ensure adequate emphasis is placed on the need to comprehensively de-brief witnesses who may have intelligence relevant to the management of the siege.

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

A review was conducted of the Queensland Police Service's (QPS) Operational Procedures Manual, specifically chapter 17/3 "Incident Management" as recommended by the State Coroner.

As a result of this review, it was considered that the current QPS policy within the Operational Procedures Manual is sufficient. The current policy identifies:

- the safety and risk assessment to all persons involved;
- the tactical position, such as establishment of inner and outer cordons, including the requirement for medical or interpreter assistance;
- the investigation, identifying witnesses as well obtaining details regarding the victim(s) and/or suspect(s), where practicable prior to any witnesses leaving the scene; and
- intelligence and the reasons for the suspect(s)' behaviour as well as the number and description of hostages (including the psychological or medical condition of all persons involved in the incident).

It was considered that it was not necessary to draft a new policy (regarding the comprehensive de-brief of witnesses who may have relevant intelligence to the incident) for inclusion in the Operational Procedures Manual as this is adequately covered within current QPS policy.

Inquest into the death of Samara Hoy

On the evening of 8 November 2008, Samara Hoy, a newborn baby, died at the John Flynn Private Hospital from birth asphyxia after a prolonged labour during which the umbilical cord became tightly wrapped around her neck.

Coroner Hutton delivered his findings on 5 April 2011.

[The Coroner's numerous recommendations from this inquest cover a broad range of overlapping issues. For the sake of clarity, the recommendations have been grouped together and responded to according to the issues to which they pertain.]

Recommendation 1 – access and availability of adequate antenatal information and classes

All women should have access to balanced antenatal information and classes clearly outlining normal and abnormal labour, when intervention may be required and why it may be necessary. The classes should clearly outline:

- the possible risks of the intervention and the possible risks of not utilising the intervention method;
- that the parents should be encouraged to raise any issue, discuss and ask any questions they feel an inclination to during the classes, pregnancy and labour; and
- the circumstance of the attendance of each medical professional during labour so that the parents are more likely to have an understanding of the expectation of the attending medical professional.

The classes should involve both midwife and obstetric facilitation.

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

Queensland Health's (QH) Statewide Maternity and Neonatal Clinical Network (SMNCN) notes this recommendation.

The SMNCN comprises of a balanced, multidisciplinary mix of clinicians from obstetrics, midwifery, neonatology, allied health, general practice, public health, Indigenous Australian and consumers. It was established in September 2007 to advise, guide and direct QH and the Queensland Government on a range of maternity and neonatal service issues and activities across Queensland.

Antenatal care throughout Queensland takes place via a number of maternity models of care including primary care, obstetric and midwifery practice and public and private hospitals. It is important to acknowledge that irrespective of the type of maternity model of care that a woman chooses, or how her pregnancy is categorised and defined, not all women will take up the option of attending Childbirth Education Classes.

QH encourages antenatal classes delivered by multidisciplinary staff to be held in community settings with after hours classes conducted where possible. Intending parents are made aware of the roles of different health professionals who may be involved in their maternity care, the complementary nature of the skills each one brings to the maternity care team and how care is escalated in the event of an emergency.

Clients of QH's maternity services are encouraged to participate in all aspects of the classes and are offered the opportunity to discuss issues and, through the provision of education and information, involve themselves in the decision making process.

The Pregnancy Health Record (PHR) has been implemented in all QH Maternity Services. The PHR is a standardised record of the woman's antenatal care. The PHR is held by the woman and completed (written in) by clinicians. This approach allows the woman to ensure that her antenatal information is available, and is with her, wherever she receives care. The PHR is not, nor should it be treated as, a complete obstetric record for the woman. Copies of the complete obstetric record for the woman will be made available to the woman's treating health practitioner/s on request. Any notes in the PHR must be read in conjunction with the documents attached to it. The PHR will be updated at each clinical visit. QH does not warrant that the PHR is a comprehensive or up to date record.

At each of the scheduled antenatal visits in the PHR, there are prompts and the opportunity for women and their significant other/s to receive written information and to discuss with their maternity provider any issues, preferences and/or care throughout the pregnancy.

QH has agreed that by the end of 2013, 10% of all births in QH public maternity services will be in a continuity of midwifery carer model (where the woman sees the same midwife or small group of midwives during her pregnancy, at birth and post-natally). To achieve the target, QH will focus on the 15 facilities that currently have fewer than 200 births a year to provide all women who access their service with continuity of carer, and the doubling of current birthing numbers in existing continuity of carer models (birth centres and midwifery group practices) that are already running in Queensland.

Continuity of care reduces fragmented care, conflicting advice and enables the development of a relationship between the woman and her maternity care provider.

Pregnant women are encouraged to source information and discuss their queries with their maternity care provider.

The Queensland Centre for Mothers and Babies (QCMB) has developed:

- online resources;
- a "Having a Baby in Queensland" book; and
- decisional aids and supplementary Parent Information Sheets that complement the Queensland Maternity and Neonatal Clinical Guidelines.

It is noted that, at present, there is no statewide consistency in the content provided at antenatal classes. A systematic approach to the content covered in antenatal classes, including by whom the classes are delivered, that also allows for flexibility in local service provision ought to be considered. The SMNCN planned to raise this issue with clinicians at the statewide forum for consideration in May 2012. However, it was decided that this issue would be placed onto an issues register for discussion at a future network forum with clinicians.

Recommendation 3 – birth plans

The underlying guiding principle of maternity care is to achieve the outcome of a healthy mother and infant. If a couple choose to have a "birth plan", they should write their preferences down so their wishes are clearly communicated to the staff caring for them during labour. The plan should recognise that intervention may be required if necessary. Couples should be made aware that it is not realistic to have a birth plan for "natural childbirth" at all costs as natural childbirth is not always normal and intervention may be required under certain circumstances to give the best possible outcome.

Recommendation 16 – birth plans

The issue of birth plans needs to be re-cast. It needs to be reinforced with both patients and staff that a birth plan is a guide only and does not dictate the only method of delivery. Nor does it mean that the patient is not open to assisted labour if the need arises, with suitable explanation. Expectant mothers need to be told that birth plans are important but are only a guide and that all concerned need to be flexible and prepared to swiftly change the birth plan and do whatever is required to deliver baby safely.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health's Statewide Maternity and Neonatal Clinical Network (see page 28) agrees with these recommendations.

A birth preferences page is included in the Pregnancy Health Record (PHR) (refer to page 29) and should be completed by 34 weeks gestation by the woman after talking with her maternity care provider. Additionally, there is an awareness statement at the bottom of the birth preferences page, which is required to be signed by the mother and her provider that acknowledges that circumstances can change and that options will be discussed with the mother should unexpected events arise.

Recommendation 2 – discussing the possibility of intervention

Women should have an opportunity to discuss their labour antenatally with their midwife and obstetrician and address the issue of when and why intervention may be required.

Recommendation 4 – discussing the possibility of intervention

Intervention when required should be carefully explained by the attending midwife and obstetrician to ensure patients understand:

- why the intervention is necessary;
- the scientific evidence behind the need to intervene; and
- the appropriate risks and benefits of intervention in accordance with the duty to provide fully informed consent.

Recommendation 5 – discussing the possibility of intervention

A mother refusing intervention despite recommendations by an obstetrician to use an intervention method is very serious. Both the risks of using the intervention and not using the intervention should be clearly outlined in antenatal classes and discussed with the woman antenatally by her obstetrician and midwife.

Any refusal should be carefully documented both at the time of discussion and during labour.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health's (QH) Statewide Maternity and Neonatal Clinical Network (SMNCN – see page 28) agree with these recommendations.

A birth preferences page is included in the Pregnancy Health Record (PHR) (see page 29), and should be completed by 34 weeks gestation by the woman after talking with her maternity care provider. Additionally, there is an awareness statement at the bottom of the birth preferences page, which is required to be signed by the mother and her provider that acknowledges that circumstances can change and that options will be discussed with the mother should unexpected events arise.

In addition to the functions of the PHR, there is provision in the statewide Intrapartum Record, for maternity staff to document clinical variation, communication and consent. The statewide Intrapartum Record is a standardised clinical record (kept in the client's medical record) which is completed by clinicians during labour. This document was implemented statewide as part of a suite of tools inclusive of early labour, induction of labour and instrumental delivery documentation. The suite of tools was endorsed at the SMNCN on 30 November 2011 and made available to services for use in January 2012.

It is important to acknowledge that irrespective of the type of maternity model of care that a woman chooses, or how her pregnancy is categorised and defined, not all women will take up the option of attending childbirth education classes.

Effective models of antenatal care provide a focus on the woman's needs and preferences, collaboration and continuity of care.

It is expected that the following measures will contribute to improved maternal care experiences:

- the achievement of the statewide continuity of carer target by 2013 where 10% of births in QH maternity services will be in a continuity of midwifery carer model;
- the doubling of current birthing numbers in existing continuity of carer models (birth centres and midwifery group practices); and
- the Rural Maternity Initiative program, which is funded through the Nursing and Midwifery Office within WH. Funding has enabled maternity services to develop or enhance continuity models of maternity care within rural health services.

Recommendation 6 – ongoing professional training and development

All midwives and obstetricians should:

- be familiar with the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) cardiotocography (CTG) foetal surveillance guidelines and implement these CTG guidelines in their clinical practice;
- attend regular CTG courses as part of their ongoing development and training; and
- attend regular CTG review meetings to review and improve outcomes in maternity units.

Midwives must be trained to recognise abnormal FHR patterns.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health's (QH) Statewide Maternity and Neonatal Clinical Network (SMNCN – see page 28) agrees with this recommendation.

The Clinical Skills Development Service (CSDS) and the SMNCN has ensured that all QH maternity clinicians have access to the K2 Perinatal Training Program which was developed by K2 Medical Systems, a private maternity technology provider. Over the last two years, 2551 maternity staff have registered as users of the K2 Perinatal Training Program. Of these, 630 have completed the training.

QH maternity staff also have the opportunity to complete the RANZCOG Foetal Surveillance Education Program. This program is run by the Victorian branch of the RANZCOG and information regarding the number of QH staff who have attended this program is not obtainable.

QH's Clinical Services Capability Framework (CSCF) for Public and Licensed Private Health Facilities version 3.0 (CSCF v 3.0) places specific requirements on staff in private and public maternity services in relation to electronic foetal monitoring. This includes the completion of:

- electronic foetal monitoring training (e.g. RANZCOG foetal surveillance education program or similar) at least every 12 to 18 months;

- obstetric emergency training (e.g. Advanced life Support in Obstetrics/Maternity crisis Resource Management or similar) at least every three years, where possible; and
- neonatal resuscitation program or similar with a refresher at least two yearly.

The Queensland Maternity and Neonatal Clinical Guideline Program developed and published the Intrapartum foetal surveillance guideline in August 2010. This guideline is congruent with and builds upon the Intrapartum foetal surveillance clinical guideline published by RANZCOG. All Maternity Services in Queensland have received Clinical Practice Improvement Payments after having demonstrated their achievement in successfully implementing the clinical guideline within their maternity service.

Attendance at regular CTG review meetings is the responsibility of individual maternity services.

Recommendation 7 – ongoing professional training and development

All maternity units should encourage their midwifery and obstetric staff to attend:

- obstetric emergency courses such as ALSO/MaCRM/MOET to encourage and optimise professional teamwork and collaborative practice in the maternity unit between midwives and obstetricians; and
- neonatal resuscitation workshops.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health's (QH) Statewide Maternity and Neonatal Clinical Network (SMNCN – see page 28) agrees with this recommendation.

The Clinical Services Capability Framework v 3.0 (CSCF v 3.0) contains maternity and neonatal modules.

The CSCF v 3.0 includes requirements for obstetric emergency training (such as Advanced Life Support in Obstetrics (ALSO)/ Maternity Crisis Resource Management (MaCRM) or similar) at least every three years, where possible. This training pertains to maternal emergencies.

The Office of the Chief Nursing Officer (OCNO) provided funding to the Clinical Skills Development Service (CSDS) for maternity emergency training for doctors and nurses / midwives. The MaCRM training program for clinicians delivering maternity care in QH facilities is run statewide at a number of regional and affiliate centres. Courses are also conducted from the CSDS for QH, private hospitals and private consultants/obstetricians. The aim is to continue setting up affiliate and pocket centres to become self-sufficient in running MaCRM courses in their local areas with only administrative support from the CSDS. Over the last two years, a total of 2000 maternity health care professionals have received training.

Clinical Education and Training Queensland is developing online modules for midwives who have not practiced for up to five years to re-enter the workforce as safe and competent clinicians.

K2 Medical Systems, a private maternity technology provider, has developed a series of e-learning modules within the K2 Perinatal Training program, which are designed to provide clinicians with a comprehensive review of maternity crisis management principles prior to attending the skills-based MaCRM one-day workshop. The CSDS provides QH midwives and obstetric clinicians with access to the K2 Perinatal Training Program.

In 2009, the Central Maternity and Neonatal Clinical Network (CMNCN), which is a regional network linked with the SMNCN, funded the development and delivery of education on the Administration of Continuous Positive Airway Pressure (CPAP) for newborn babies, building the capacity of non-tertiary maternity services to provide CPAP. Materials were provided to the Mater Mothers Hospital, Brisbane and the Townsville General Hospital for them to run the program. Scheduled workshops are open to public and private maternity facilities. They are promoted through the SMNCN and are well attended. Additionally, the CMNCN have offered three “Stabilisation of the Sick Neonate prior to Transfer” full day courses in Longreach, Biloela and Emerald. This course is offered upon request from small maternity facilities. Another course was offered to hospitals within the Bundaberg region in 2011.

The CSCF v3.0 also places specific requirements on QH Districts in relation to a Neonatal Resuscitation Education Program (NREP). The CSCF v 3.0 stipulates that Neonatal Services and Maternity Services clinical staff participate in a neonatal resuscitation program or similar with refresher training at least every two years. This training pertains to neonate emergencies.

The Royal Brisbane and Women’s Hospital offer outreach education such as a Neonatal Resuscitation Program in Longreach. The Townsville Hospital also offers outreach neonatal education, including resuscitation as well as stabilisation to smaller rural and remote maternity services.

As requested by the SMNCN and funded through OCNO, the CMNCN developed an options paper for a Statewide Neonatal Resuscitation Education Program (NREP). The options paper recommended that QH adopt a two level neonatal resuscitation education program. The neoResus Advisory Steering Committee of the SMNCN was convened in early 2012 to progress the phased implementation of neoResus (a neonatal resuscitation education program currently administered by the Victorian Newborn Resuscitation Project, Victoria) into QH's maternity services. By the end of June 2012, neoResus was implemented in all metropolitan and regional maternity services currently conducting a Neonatal Resuscitation Program.

The SMNCN have secured funding to progress phases two and three of the Statewide NREP, which are the development of a "train-the-trainer" package and its implementation into QH rural and remote maternity services. The project will be achieved by the end of June 2013.

Recommendation 8 – ongoing professional training and development

Ongoing professional development for midwives is recommended to ensure they:

- are competent in distinguishing and documenting abnormal from normal progress in pregnancy;
- refer to obstetricians in a timely and appropriate manner for ongoing care when pregnancy and labour become abnormal; and
- follow evidenced-based guidelines and scientific evidence in their clinical practice.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health's (QH) Statewide Maternity and Neonatal Clinical Network (see page 28) agrees with this recommendation.

Midwives are registered to practice under the Australian Health Practitioner Regulation Agency and have to demonstrate ongoing professional development to maintain their licence to practice. Professional development is the responsibility of each individual midwife. Included in the QH midwife enterprise bargaining agreement provides for funding for professional development in clinical guidelines and practices.

The Intrapartum Record (the clinical record kept during labour) incorporates principles for the 'recognition and management of the deteriorating patient' (referred to as RMDP). Recognition and management of the deteriorating patient is one of the emerging patient safety issues within the public health arena. It is recognised that serious adverse events such as unexpected death, cardiac arrest and unplanned admission to intensive care units are often preceded by changes in physiological observations. Use of RMDP principles and tools will assist clinicians to distinguish and document abnormal from normal progress in pregnancy and labour; guide them to refer to obstetricians in a timely and appropriate manner; and follow evidence based guidelines in their clinical practice.

The National Midwifery Guidelines for Consultation and Referral developed by the Australian College of Midwives have been approved for use as a statewide resource by the Deputy Director-General of the Policy, Strategy and Resourcing Division of QH. These guidelines offer consistent, efficient, timely and safe consultation and referral processes both between maternity care providers and with the woman receiving care.

To date, the Queensland Maternity and Neonatal Clinical Guidelines Program (conducted by QH) has developed and published 24 Queensland Maternity and Neonatal Clinical Guidelines and supplements as well as two operational frameworks. These include:

- Early onset group B streptococcal disease
- Intrapartum foetal surveillance
- Hypertensive disorders of pregnancy
- Obesity
- Vaginal birth after caesarean section
- Primary postpartum haemorrhage
- Venous thromboembolism prophylaxis
- Preterm labour
- Breastfeeding initiation
- Neonatal abstinence syndrome
- Hypoxic ischaemic encephalopathy
- Neonatal hypoglycaemia
- Neonatal resuscitation
- Neonatal jaundice
- Neonatal respiratory distress and the administration of Continuous Positive Airway Pressure

- Examination of the newborn
- Term small for gestational age baby
- Stillbirth care.

Recommendation 11 – ongoing professional training and development

All maternity units should schedule paid time for all staff and attending medical professionals to familiarise themselves with all polices, procedures and guidelines in place at the unit and for any changes to same. Understanding of these policies and guidelines should be formally assessed at least annually.

Response and action
Agreed in part and completed
Responsible agency: Queensland Health

Queensland Health's (QH) Statewide Maternity and Neonatal Clinical Network (see page 28) notes this recommendation.

Maternity staff are offered upon commencement of duty at a new service, the opportunity to complete orientation that includes time to familiarise themselves with policies, procedures and guidelines. In addition, and where possible, a facilitator or buddy is assigned for a period of time.

Each maternity service has their own, often multi-stranded communication methods of alerting staff to the implementation of new policies, procedures and guidelines. QH is endeavouring to standardise policies, procedures and guidelines, where possible, within their maternity facilities to promote evidence-based safe patient care and reduce inappropriate variation in clinical practice. The assessment of understanding of policies and guidelines is the responsibility of each individual service. In addition to standardised statewide policies, individual services will have local work instructions.

Recommendation 9 – policies and guidelines for maternity services

All maternity units should ensure there are clear guidelines and instructions as to when to refer to obstetricians.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health's (QH) Statewide Maternity and Neonatal Clinical Network (see page 28) agrees with this recommendation.

The National Midwifery Guidelines for Consultation and Referral, developed by the Australian College of Midwives, have been approved for use as a statewide resource by the Deputy Director-General of the Policy, Strategy and Resourcing Division of QH. These guidelines inform decision-making by midwives on both the care and advice provided to women and when consultation and referral to a medical practitioner is warranted throughout pregnancy, the antenatal period, during labour, birth and during the postnatal period.

Recommendation 10 – policies and guidelines for maternity services

All maternity units should have a paediatrician, or staff member capable of intubating a baby, available to be present:

- at all deliveries through meconium;
- where there is evidence of foetal distress in labour; or
- at any instrument delivery or caesarean section.

Response and action
Agreed in part and completed
Responsible agency: Queensland Health

Queensland Health's (QH) Statewide Maternity and Neonatal Clinical Network (see page 28) notes this recommendation.

QH's Clinical Services Capability Framework v 3.0 contains maternity and neonatal service modules, which articulate workforce requirements for medical, nursing, allied health and other personnel for the six service levels. Depending on the level of the service, different workforce requirements are specified. Not all hospital facilities have a designated maternity unit. In all service levels where there is a designated maternity unit, there is access to a medical practitioner to attend to an intubation if necessary. It is up to each facility to determine when escalation to a medical practitioner should occur.

Recommendation 13 – policies and guidelines for maternity services

That all hospital policies addressing monitoring include a plain language direction that draws attention to abnormal foetal heart

rate (FHR) patterns as outlined by RANZCOG, irrespective of whether a Doppler or CTG is being used. The policies should contain a plain language direction for specialists to be consulted if there is evidence of or any concern about whether there is an abnormal FHR pattern.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health's Statewide Maternity and Neonatal Clinical Network (see page 28) agrees with this recommendation.

Abnormal foetal heart rate (FHR) patterns would suggest possible foetal compromise. Queensland Health's intrapartum foetal surveillance clinical guideline supports clinical decision making and is consistent with the RANZCOG guidelines, outlining best practice in relation to:

- Use of FHR monitoring;
- Interpretation of continuous or intermittent FHR monitoring; and
- Management of suspected intrapartum foetal compromise, including directions on when to consult with obstetricians.

The clinical guideline describes signs of foetal compromise in plain language, defines normal FHR rhythms and directs for the referral of women with confirmed abnormal FHR patterns to an obstetrician.

Inquest into the death of Albert Edward Barrie

Mr Barrie died on the evening of 9 July 2009 from multiple injuries, in particular a damaged thoracic aorta, after being clipped by a motor vehicle when crossing Lions Creek Road outside the then Brothers Leagues Club in Wandal.

Coroner Hennessy delivered her findings on 10 May 2011.

Recommendation 3

That consideration be given by the Department of Transport to reducing the speed limit for Lion Creek Road to 50km in the area of the Club.

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

The part of Lion Creek Road where this accident occurred is not a State-controlled road. It is a local road within the care and control of the Rockhampton Regional Council.

The Rockhampton Regional Council has advised the Department of Transport and Main Roads that a road safety audit has been undertaken and that other works in this location have been undertaken to accord with a lower traffic speed limit for this area of road.

The Rockhampton Regional Council reports that a 50km per hour speed limit will be implemented in the second half of 2012 and associated works on Lion Creek Road, due for completion in late 2012, will accord with the revised 50km per hour speed limit.

Recommendation 4

That forensic crash investigations reports be prepared and considered by the Queensland Police Service in a timeframe which allows traffic charges to be laid within the legislative time limits.

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

Since the Rockhampton Coroner delivered her findings, Central Police Region has adopted new procedures to ensure forensic crash investigations are completed in a timely and professional manner.

All Forensic Crash Investigators submit a monthly Supplementary Form 1 to the Coroner for consideration as to the status of the investigations, in addition to all forensic crash investigation files being subject to a peer review conducted by a Senior Forensic Crash Officer (Sergeant). In conducting this peer review, the Senior Forensic Officer outlines any possible offences with suggested timeframes of investigations in order to reach a successful prosecution ensuring they are completed within the statute of limitations.

Since implementing these procedures, there has been no issue with the timeliness or professionalism of completed investigations.

The Central Police Region has assessed the need and benefit of implementing a permanent Forensic Crash Unit in Rockhampton. The Queensland Police Service's Strategic Workforce Planning Committee decided to increase Central Police Region resources with the implementation of a Forensic Crash Unit, including human resources, to ensure fatal and serious crashes are thoroughly investigated and reported in a timely manner. A Forensic Crash Unit has been established in Rockhampton and adequately resourced, comprising of two full-time officers. A suitable vehicle to be used by the Forensic Crash Unit in Rockhampton is currently being sourced and is the main priority in 2012/2013 financial year.

With all of the abovementioned policies implemented, forensic crash investigations will be dealt with expediently with offences being identified before the statue of limitations has expired.

Inquest into the death of Christopher Steven Bell

Mr Bell was found to have taken his own life by hanging himself in his cell at the Arthur Gorrie Correctional Centre on 18 March 2010 where he was being held in custody. Mr Bell had suffered from schizophrenia for several years although it was found that during his time in custody preceding his death, this mental illness was being adequately treated.

The State Coroner delivered his findings on 26 May 2011.

Comments – suicide resistant cells (pages 13-14)

This inquest has highlighted the inherent difficulty in trying to prevent prisoners taking their life by identifying those most likely to do so and providing them with special treatment including housing in suicide resistant cells. It seems even the best risk analysis tools are of limited value. This conclusion buttresses the recommendation of the Royal Commission into Aboriginal Deaths in Custody (RCIADC) that hanging points be eliminated from watch houses and prison cells. The then State Government accepted that recommendation and committed to implementing it. To the credit of all governments since, that has been achieved in relation to the police watch houses. However, Mr Bell's death and other deaths can be attributed in part to the failure of successive governments to fulfil that commitment by eliminating hanging points from correctional centre cells.

I acknowledge the evidence tendered in this and other inquests of the very substantial cost associated with implementing the RCIADC recommendation. I also acknowledge the prioritising of the demands on public finances is properly a matter for government. However, coroners are obliged to draw attention to the negative consequences of those decisions if they result in preventable deaths.

This inquest was told that at the Arthur Gorrie Correctional Centre currently, 20 years after the RCIADC, 43% of all cells still have exposed hanging points. As I understand their positions, the centre operators and Queensland Corrective Services acknowledge this creates an unmanageable risk - they can't accurately predict which of the numerous at risk prisoners might actually suicide and they can't house all at risk prisoners in

suicide resistant cells because there are too many such prisoners and too few such cells.

During the inquest, I was advised that further funding will soon be available to continue the process of building new suicide resistant cells and retro-fitting screens over bars in old cells. That of course is to be welcomed and those responsible for the relevant decisions deserve credit for them. However, as these improvements have been promised for 20 years and have still not been delivered, those decision makers and their predecessors must also share some responsibility for any deaths that occur between now and when the work is completed.

There is little more I can say to draw attention to the continuing risk.

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

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

As at 30 June 2012, 87% of prison cells in Queensland (a total of 3,522 cells) have suicide reduction measures in place.

Planning for the upgrade program to modify 112 cells at the Arthur Gorrie Correctional Centre in order to increase the number of suicide resistant cells, is underway with design and documentation completed in July 2012.

Funding of $16.793 million has been provided in 2012-13 for the Arthur Gorrie Correctional Centre cell upgrade program, which is expected to commence at the Arthur Gorrie Correctional Centre in late 2012 with completion expected in the 2014 calendar year.

Inquest into the deaths of Sanglin Chung, Moira Therese McGreevy, Glen Raymond McGreevy, Rachel Gai Purdy, Cory James Whitmore and Mark John Hamilton

Between September 2008 and January 2009, six people died in three separate vehicle collisions occurring within a 15 kilometre stretch of the Bruce Highway south of Gympie.

On 4 September 2008, Mark Hamilton lost control of his truck and it slid into the opposite lane of the Bruce Highway near the intersection with Carlson Road, colliding with Rachel Purdy and Cory Whitmore's sedan, killing them and their unborn child instantly.

On 25 January 2009 Sanglin Chung, a Korean national, died from head injuries after his northbound car drifted into the southbound lanes of the Bruce Highway and collided with an oncoming car.

On 30 January 2009 Mr and Mrs Glen and Moira McGreevy died from their injuries after their car lost control and collided with a truck travelling in the opposite direction on the Bruce Highway near Coles Creek.

A joint inquest was held into their deaths and on 8 June 2011, Coroner Baldwin delivered her findings.

Recommendation 1 – regarding the death of Sanglin Chung

It is recommended that the painted median strip project continue to effectively narrow the lanes to provide greater margin for error against the oncoming traffic and encourage a lower vehicle speed. Audio tactile marking devices installed on the centre lines are recommended to minimise the change of a lapse in concentration leading to vehicles crossing into the oncoming lane.

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

In February 2008, the Department of Transport and Main Roads (former North Coast Hinterland District) undertook a project to develop and provide preliminary estimates for "interim safety improvements" that would reduce the crash rate and/or severity of crashes on the Bruce Highway between Cooroy to Curra.

One of the identified options was to provide a painted median strip to separate opposing traffic flows on the two-lane high speed rural sections between Cooroy interchange and the Wide Bay Highway intersection north of Gympie. The provision of audio-tactile line marking to supplement the existing painted lines was also identified.

On 16 March 2010, the Federal Minister for Infrastructure and Transport, the Honourable Anthony Albanese MP, announced a painted centre median strip (including audio tactile centre lines) as one of the first round of projects to receive funding allocations under the Government's $250 million Bruce Highway Safety Package.

Construction of the painted centre median strip, including audio tactile centre lines, was completed on 1 June 2011.

Recommendation 2 – regarding the deaths of Moira Therese McGreevy and Glen Raymond McGreevy

There can be little doubt, as was the case for Sanglin Chung, that the dual carriageway provides little margin for error especially given the high volume of traffic. However, unlike Mr Chung's vehicle, which appears to have crossed into the oncoming lane due to a lack of concentration, Mr McGreevy lost control of his vehicle due to a combination of factors. Thus, a widening of the width between oncoming traffic through painted centre median strips again would provide more margin for error in this high traffic zone. This would have the impact of slowing traffic to assist the accident rate in the case of error.

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

The painted centre median project detailed in the response to Recommendation 1 has provided a 1 metre separation of the opposing traffic flows. The existing lane widths have been narrowed from 3.5 metres to 3 metres to facilitate the separation.

Recommendation 3 – regarding the deaths of Rachel Gai Purdy, Cory James Whitmore and Mark John Hamilton

There can be no doubt that Mr Hamilton was unable to brake safely when the vehicle in front of him braked to account for the slowing traffic ahead of that vehicle. Mr Hamilton was on all accounts driving too close to stop safely when the need arose and this combined with the lack of weight in his truck and the wet conditions exacerbated the problem.

There can be little doubt that travelling too close to the vehicle in front is fraught with danger, especially on a road with a high volume of traffic. Legislation to mandate actual distances required between vehicles may assist to minimise the circumstances where braking in high traffic areas could lead to these tragedies.

Reducing the speed limit would also assist in reducing the distance required for stopping. The current speed limit of 90km/h is one step in this direction but a speed limit for wet and dry conditions, as in other jurisdictions, may also assist.

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

Section 126 of the *Transport Operations (Road Use Management – Road Rules) Regulation 2009* provides that a driver must drive a sufficient distance behind another vehicle so the driver can stop safely to avoid a collision. The rule does not specify any actual or timed distance.

The Department of Transport and Main Roads (DTMR) recommends that drivers use the time lapse formula for determining the gap between following vehicles. For dry conditions, a two-second following distance is recommended with a doubling of this distance for adverse weather conditions. The following distance for heavy vehicles is also recommended as being double the normal two-second gap applicable for cars. It is important to note that the time lapse formula provides a safe following distance at any speed. This is not the case with fixed distances. Were the department to legislate a fixed distance in metres for one vehicle following another, this would only be safe at one speed. It would be very cumbersome to legislate for a different distance for a range of different speeds.

Furthermore, DTMR is committed to retaining national consistency with regard to the road rules. The road rules legislation in all Australian states and territories is based on the Australian Road Rules model legislation administered by the National Transport Commission. At the 2008 Australian Road Rules Maintenance Group meeting, Queensland tabled a proposal to mandate a specific following distance. The proposal was not supported by any other jurisdiction. The main reason for the lack of support for the amendment was situations where it is virtually impossible to immediately establish the required following distance. For example, at busy merge situations a vehicle may have established a safe following distance but if another vehicle changes lanes into that gap then for a short while the safe following distance is removed and the driver would be in breach of the rule due to the actions of the driver of another vehicle. This is the case until the following vehicle can establish again a safe following distance behind the new vehicle in front.

In summary, about one in four crashes on the four lane section of the Bruce Highway from Brisbane to Cooroy occur in wet weather conditions compared to about one in three crashes on the two lane section from Cooroy to Gympie. While crashes in wet weather as a percentage of all crashes remains relatively stable over the past ten years, the total number of crashes is reducing significantly.

In 2009 there were 32 recorded crashes from Cooroy to Gympie and ten of these were wet, which equates to about one in three wet crashes. If there were two less wet crashes it would achieve a similar proportion to that of the four-lane section (about one in four). On these figures, the Cooroy to Gympie section has only a marginally poorer wet weather record than the section of highway to the south.

DTMR does not currently have any proposals to further reduce the speed limit below 90 km/h on the Cooroy to Curra section of the Bruce Highway or to introduce the practice of implementing dual dry/wet weather speed limits on Queensland's roads. Dual dry/wet weather speed limits would be difficult for road users to understand and apply in varying environmental conditions. It is considered that dual dry/wet weather speed limits would be extremely difficult for the Queensland Police Service to undertake effective enforcement of due to difficulties in establishing a clear definition of what constitutes wet weather and degree of road surface wetness, and establishing a widespread understanding and acceptance of that definition by Queensland's motoring public.

It is acknowledged that New South Wales has introduced a dual 100km/h (dry) / 90km/h (wet weather) speed limit demonstration project and TMR will watch with interest whether that project demonstrates sufficient road safety benefits in the future, in terms of a reduction in wet weather crashes.

Recommendation 4

It is recommended that until the highway upgrade is completed and a dual carriageway is available in both directions, the speed limit should remain reduced especially for wet weather conditions, the painted median strip project continue and the audio tactile devices be installed. I especially have regard to Mr Patane's evidence in this regard. These recommendations must be considered in the light of the current upgrade and the cost of the interim measures.

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

In 2008 as part of a targeted road safety initiative developed by the Department of Transport and Main Roads (at the time as the Department of Main Roads and Queensland Transport) and the Queensland Police Service an analysis was undertaken to identify ten of Queensland's worst performing road sections based on crash data, volumes of traffic and the road environment. An outcome of this analysis was a proposal to reduce the speed limit along the Bruce Highway between Cooroy and Curra. The proposal was approved and implemented in December 2008. The speed limit was reduced from 100km/h to 90km/h on the Bruce Highway between Cooroy and the Wide Bay Highway.

This speed limit reduction is an interim measure until the Cooroy to Curra highway upgrade project is completed. A time frame for completion of the whole upgrade project (including section C from Traveston Road to Keefton Road and section D from Keefton Road to Curra) has not yet been determined. The installation of a painted centre median strip and audio tactile line marking has been undertaken as a separate road safety project which was completed in June 2011.

The provision of variable speed limit signs on this section of highway is not considered practical or affordable. Safety messages are displayed on existing Variable Message Signs to raise driver awareness of important safety messages. One message used during wet weather is to "Drive Safe in Wet Conditions".

Inquest into the death of James Errol Tranby

Mr Tranby died on 17 December 2008 at the Townsville Hospital from the effects of necrotising fasciitis. Mr Tranby had been a prisoner at the Townsville Correctional Centre at the time of his death.

The State Coroner delivered his findings on 9 June 2011.

Recommendation 1

The facts of this case highlight the inadequacy of the current Queensland Corrective Services policy governing when a prisoner's nominated contact person should be advised the prisoner is to undergo a medical procedure. The sad consequences of a failure to do so in a timely manner, when a sudden death results should be avoided. Accordingly, I recommend Queensland Corrective Services review the policy to ensure as far as is possible that it accommodates the unexpected outcomes of relatively minor procedures and cases involving a progressive deterioration.

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

Queensland Corrective Services has amended the procedure "Transfer of Prisoner – Medical Procedure" to ensure the State Coroner's recommendation regarding notification of next of kin is addressed where a prisoner is admitted to an external medical facility. The procedure now includes the following:

> *"The general manager or nominee must consider the relevant security/escape related information and the prisoner's preference as to whether or not their nominated contact person is to be advised. Contact should then be made with the prisoner's primary contact on admission. Such notification should only be withheld where there are critical security/escape related concerns that cannot be appropriately managed."*

Notification may also be withheld where considered appropriate based on the prisoner's preference.

The amended procedure became effective statewide in November 2011.

Implementation of this recommendation was reviewed and endorsed by the Queensland Corrective Services' Incident Oversight Committee on 6 December 2011.

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

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

Coroner Lock delivered his findings on 24 June 2011.

Recommendation 2

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

Response and action
Agreed in part and under consideration
Responsible agency: Department of Housing and Public Works

The Department of Housing and Public Works (DHPW) has a policy for its social housing properties, which complies with the *Plumbing and Drainage Act 2003* and relevant standards. Since 1999, all new construction of social housing properties has included tempering valves to any pipe work that services bathrooms and en-suites.

DHPW is implementing this recommendation in a gradual process, through its recurring maintenance and refurbishment activities affecting sanitary plumbing outlets, such as during a bathroom upgrade, to include tempering mechanisms. However, the present regulatory requirements do not include tempering the kitchen and laundry outlets, or the undertaking of a blanket retrofit for hot water temperature control mechanisms. DPHW is reviewing its position to determine the most appropriate means for ensuring safety for its tenants.

A strategy to progress further implementation will be discussed with other Government agencies and key stakeholders to determine the most appropriate strategy as full implementation will not be consistent with the private residential sector and DPHW would need to seek additional funding for a retrofit program.

DPWH also notes that the latest version of Australian Standard 3500 referred to by the Coroner in his recommendations is dated 2003.

Recommendation 3

The Department of Infrastructure and Planning investigate and considers retrospective mandating of the Australian Standards in

respect to hot water tempering valves at point of sale and lease in a manner similar to that now adopted for smoke alarms, electrical safety switches and swimming pool fences.

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

The Department of Housing and Public Works (DHPW) has considered the recommendation and investigated the matter. DHPW found that the typical life of an electric hot water heater is about 12 years. As legislation requiring temperature limiting devices was introduced in 1998, it is likely that heaters installed before the introduction of the legislation will have either been, or are likely to be, replaced in the near future. As a result of the lifespan of water heaters, retrospectively mandating the Australian Standards may not be necessary as these older systems have been or soon will be phased out and replaced.

The Coroner's findings noted that the Queensland Injury Surveillance Unit had some concerns that temperature reduction was not required for all hot water outlets attached to a hot water system and that the Australian Standards for all new hot water installations are not retrospective.

DHPW has also found that it is common industry practice to install a temperature limiting device as near as practicable to the hot water system to ensure that all hot water outlets receive tempered water. This practice has arisen because a temperature limiting device needs to be easily accessible for maintenance (a requirement under AS/NZS 3500), however, this practice is not mandated.

Building Codes Queensland within DHPW will undertake further consultation with stakeholders on the implications of ensuring that a tempering device is in place on a hot water system at the time of lease or sale, irrespective of whether the system required a tempering device under the legislation that was in place at the time it was installed.

To ensure the Queensland plumbing industry is clear about the requirements for the use and location of tempering devices, DHPW has issued Newsflashes (456 and 478) regarding the current obligations of licensees when installing hot water systems. DHPW has also provided this information to the plumbing industry through an email alert.

Inquest into the death of Hossam Mohamed Elshazly

Dr Elshazly died on 17 January 2009 from multiple injuries after he fell from his bicycle and was run over by a truck's trailer at the roundabout intersection of the Captain Cook Highway and Trinity Beach Road near Cairns.

Coroner Priestly delivered his findings on 29 June 2011.

Recommendation 1

That DMR establish a program to review the current design standards that are relevant to cyclist safety and to develop guidelines to assist traffic engineers and managers in assessing the need for, and when to retrofit, treatment options (risk mitigation measures) to existing infrastructure. The safety implications of changes to standards should be risk assessed and the treatment options costed.

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

The Department of Transport and Main Roads (DTMR), like other road authorities across Australia, has adopted the Austroads (Association of Australian and New Zealand Road transport and traffic authorities) guides as the primary road design reference. However, some Queensland design references exist to supplement the Austroads guides. Currently there is some disparity across Austroads jurisdictions on the level of cyclist provision at roundabouts. Some transport authorities in other states and territories believe that bicycle lanes through roundabouts as presented in the current Austroads Guide to Road Design are not safe and that cyclists should be excluded from roundabouts or be forced to integrate with traffic (similar to the Trinity Beach roundabout at the time of Mr Elshazly's accident).

In order to resolve these disparities Austroads has commissioned Project NS1722 "Treatments for Bicycles at Roundabouts" which aims to:

- develop criteria for when bicycle lanes should be included on roundabouts;
- understand whether and how cyclists use marked cycle lanes in roundabouts; and
- investigate whether the current roundabout design could be amended to better slow motor vehicles to improve the safety of bicyclists and pedestrians.

DTMR's Safer Roads Unit is actively contributing to this project in order to ensure that changes to Austroads guidance accounts for the safety of all road users and that the cycling safety assessment criteria is applicable to both existing and new projects.

This project will inform subsequent national design guidelines. It is expected this project will assist traffic engineers and managers in assessing roundabout retrofit options to improve cycling safety. The NS1722 project is scheduled to be completed in the second half of 2012.

Once the NS1722 project is complete, DTMR's Safer Roads Unit will develop a guideline to incorporate into the Transport and Road Use Management manual for use until amendments to the Austroads guides and Queensland Road Planning and Design Manual are finalised.

A review of vulnerable road user crash history at roundabouts in Queensland, as well as relevant international guides and research, has been undertaken as a basis for guideline development. A summary of this review was presented at the 2012 Engineering Technology Forum on 30 August 2012. The accident in which Mr Elshazly died was incorporated as a case study in the presentation. The audience of the conference included representatives from local and state road authorities, consultancies and academics.

Recommendation 2

That the guidelines so developed be disseminated to the regions to assist traffic engineers in assessing and prioritising locations on their road network for cost/risk effective retrofitting to current standards. Regional traffic engineers and managers can then allocate available funding to the highest priorities as well as apply for further funding if the level of risk supports that application.

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

The Traffic and Road Use Management manual guideline developed in response to Recommendation 1 will be disseminated for peer review within the Department of Transport and Main Roads (DTMR). The guideline will require endorsement by the Traffic Management and Practices Committee which includes representation from DTMR and councils. The bicycle planning and design training courses delivered by DTMR's Safer Roads Unit to designers, engineers and planners will incorporate new content related to safety assessment guidance.

A statewide project facilitating road infrastructure managers in DTMR's regions to assess and prioritise cycling safety improvements was completed in June 2011. This project assessed and prioritised locations on the state-controlled road network for retrofit of dedicated cyclist safety improvements.

The bicycle safety projects which were identified through this project were incorporated into a cycling safety works program for delivery between the 2011-12 and 2014-15 financial years with a statewide funding allocation of $9.4 million. This cycling safety works program (Element 12) includes roundabout safety improvement projects in Brisbane, Bundaberg, Cairns, Gold Coast, Mackay, Rockhampton and Townsville. The cycling safety works program is the funding vehicle for the investigation and delivery of cyclist specific safety improvements. Other programs or projects may also incorporate cyclist safety improvements as part of a wider scope of works.

The cycling safety works program and all other departmental works programs are currently under review with future funding allocations to be determined.

Recommendation 3

Further, DMR should explore whether there exists an opportunity to incorporate into Netrisk a module that would allow its key functionality to apply to the state of infrastructure with safety implications for cyclists and to prioritise the need for retrofitting as between particular locations.

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

Austroads, the Association of Australian and New Zealand Road transport and traffic authorities, has commissioned the Australian Road Research Board to complete Project ST1571, the Australian National Risk Assessment Model. This project is developing a tool that is similar to but more advanced than NetRisk, the current risk assessment tool used by the Department of Transport and Main Roads (DTMR). It is expected that this newly designed tool will replace NetRisk and other assessment models such as AusRAP as the standard risk assessment tool used by transport bodies throughout Australia.

Technically, the Australian National Risk Assessment Model is being based on the International Road Assessment Program. The International Road Assessment Program model has the functionality to assess separately the risk from infrastructure to cars, motorcyclists, cyclists and pedestrians. This is because it was initially designed for use in developing countries where there is much greater road use by, and deaths and serious injuries associated with, vulnerable road users. However, the Australian National Risk Assessment Model will differ significantly from the International Road Assessment Program in that it will have the capability to combine the infrastructure rating with reported crash data to give one overall measure of risk. The Australian model will also have a somewhat different reporting

approach to the International Road Assessment Program so as to be more applicable to Australian conditions.

The Australian National Risk Assessment Model project is undertaking further investigation and development of a Pedestrian Road Protection Score, a Motorcyclist Road Protection Score and a Cyclist Road Protection Score based on available evidence suitable for Australian conditions.

Program development and trials under Project ST1571 are expected to be completed in the second half of 2012. DTMR will continue to contribute to Project ST1571 and work towards Road Protection Scores for vulnerable road users being included in the Australian National Risk Assessment Model.

Inquest into the death of Bela Heidrich

On 28 February 2008, Bela Heidrich, a newborn infant, died at the Rockhampton Hospital from mechanical asphyxiation as a consequence of overlaying. Bela's mother, exhausted after a long and difficult labour, fell asleep while breastfeeding unsupervised and Bela was accidentally smothered by her mother's breast.

Coroner Hennessy delivered her findings on 29 June 2011.

Recommendation 1

That all Queensland Health facilities that provide birthing services be provided with a summary of events in relation to the three deaths that have occurred in similar circumstances to ensure staff are aware of the potential dangers of bed-sharing.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health (QH) accepts this recommendation.

On 3 September 2010, a Patient Safety Notice was distributed to all QH facilities on the subject of "Safe Infant Care in Queensland Health Facilities". The notice was issued subsequent to the Patient Safety and Quality Improvement Service (PSQ) becoming aware of at least three deaths of babies (including Bela) in similar circumstances being investigated by the Coroner and the patient safety concerns associated with these cases. The PSQ identified that there was an urgent need to communicate the circumstances of these deaths and the risks involved with mothers and babies sharing sleep surfaces, and in particular where the mother is regarded as "high risk" as described by certain evidence-based risk factors. A mother's risk factors include being a smoker; having consumed alcohol or taken drugs which alter consciousness or cause drowsiness; and being tired.

Once QH has completed all corrective actions in response to the Heidrich coronial recommendations, it will re-issue the Patient Safety Notice to all QH Hospital and Health Services with this additional information

Recommendation 2

That all Queensland Health facilities that provide birthing services have a specific policy that covers the topics of co-sleeping and bed-sharing. These policies should be easily understood by staff and clearly match the level of supervision to patient needs.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health (QH) accepts this recommendation.

QH does not support mothers and infants sharing a sleep surface in its facilities, unless while breastfeeding.

The QH Primary Community and Extended Care Branch has developed the QH Safe Infant Sleeping Policy 2012 and supporting documents: the Safe Infant Sleeping Implementation Standard; and the Co-sleeping and Bed-sharing Implementation Standard. The new policy was developed following a review of QH's evidence-based Safe Infant Care to Reduce the Risk of Sudden Unexpected Deaths in Infancy (SUDI) Policy Statement and Guidelines 2008 (the 2008 Guidelines).

The review of the 2008 Guidelines highlighted a number of areas for improvement including better consultation and promotion of key safe infant sleeping and co-sleeping/bed-sharing messages, improved availability of parent education and staff training opportunities, and greater clarity around the roles and responsibilities for implementing the policy.

The revised policy includes requirements for QH to perform regular risk assessments of mother's consciousness before feeding and adjust the level of supervision required based on clinical judgment. Staff are then required to document this activity within the Statewide Maternity Clinical Pathway. A Statewide Clinical Pathway is a standardised, evidence-based multidisciplinary management plan, which identifies an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a homogenous patient group. There are pathways for neonatal care, caesarean births and vaginal births. Staff are also required to document risk assessment activity in the baby and mother's medical record. As part of their reporting requirements QH facilities must annually audit compliance and variations in practice against the statewide standardised clinical pathway using the statewide standardised audit tool.

Recommendation 3

That Queensland Health considers whether the existing policy should require the following steps be taken before breastfeeding lying down occurs:

a) that a risk assessment be conducted to consider the condition of the mother, in particular that she is lucid and awake and that this is noted in the patient's medical records;

b) that the mother be given some information about the dangers of falling asleep and be provided with a buzzer to be able to contact staff in the event she becomes tired, the baby has stopped feeding or is unsettled; and

c) that a determination be made about the level of supervision required and this be noted in the patient's medical records.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health (QH) accepts this recommendation in part.

Maternal risk assessment post partum is a component of the maternity clinical pathways (management plan), which guide clinical practice and are available statewide. The observations section of the maternal clinical pathway includes provision to note the mother's level of consciousness.

QH has implemented strategies to improve assessment of mothers' level of consciousness and risk of falling asleep and to ensure a buzzer is within the mother's reach should she identify the need to alert staff to her tiredness, an unsettled baby or other concerns.

In addition to the work undertaken to update the 2008 Policy and Guideline and associated resources a suite of tools has been developed to manage a range of risks to mothers and babies during pregnancy, early labour, the intrapartum phase, birthing, and the post partum phase. This suite of tools is available on the QH website. A memorandum was sent to all districts in January 2012 informing them of the tools' availability.

Skin to skin contact and the initiation of breastfeeding is often undertaken shortly after delivery when the baby's transition to extra uterine life is underway. Neonatal observations conducted during this time would enable clinicians to determine the level of supervision required for the mother. Neonatal observations during the baby's transition to extra uterine life are included in the Neonatal Clinical Pathway. These documents were reviewed by the Clinical Pathways and System Design Team (CPSDT) in consultation with clinicians in 2011.

The QH Safe Infant Sleeping Policy 2012 provides that determining the level of supervision required for breastfeeding lying down is a clinical decision based on risk, protective and other relevant factors. Therefore, the policy cannot specify the level of supervision required as this is a clinical decision that must be based on each patient's individual needs which can change rapidly. The policy states that the mother must be awake and lucid at any time when co-sharing sleeping surfaces with their baby.

Recommendation 4

That every prospective parent in Queensland be provided with specific information both orally and in written form in relation to SIDS/SUDI, bed-sharing (with specific reference to breastfeeding lying down), co-sleeping and the risks and dangers associated with each and steps that can be taken to bed-share and/or co-sleep more safely. This information should be provided during the antenatal period, at hospital prior/during the first feed and during the postnatal period prior to discharge.

Response and action
Agreed and completed
Responsible agency: Queensland Health

All maternity services in Queensland have implemented the Pregnancy Health Record (PHR). The PHR is a standardised record of the woman's antenatal care that is held by the woman and completed by the clinician. Sudden Unexpected Deaths in Infancy (SUDI) information is provided in the mother's section of the PHR. The PHR is designed to be filled in by 34 weeks gestation, including the "awareness statement" signed by the mother and primary maternity carer/s.

A review of the Neonatal Clinical Pathway (the clinical guidelines for newborn babies in hospital) was completed in November 2011. The review bolstered the SUDI, bed sharing and co-sleeping information within the pathway.

Also in November 2011, the Statewide Maternity and Neonatal Clinical Network distributed to all Queensland Health maternity services the "Keeping Babies Safe – A Message for Parents" poster. This poster is currently in use at the Royal Brisbane Women's Hospital and Logan Hospital and serves as a cognitive aid for parents and staff regarding supervision level, co-sleeping and bed sharing education and reinforces prompts contained within the statewide PHR, Intrapartum Record (a standardised clinical record completed by clinician during labour) and the maternal and neonatal clinical pathways.

Recommendation 5

That further consideration be given to framing the various levels of supervision referred to in the breastfeeding policy to ensure consistent approaches by nursing staff, and that training occur on new information.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health (QH) has considered this recommendation

The QH Safe Infant Sleeping Policy 2012 provides that determining the level of supervision required for breastfeeding lying down is a clinical decision based on risk, protective and other relevant factors. Therefore, the policy cannot specify the level of supervision required as this is a clinical decision that must be based on each patient's individual needs which can change rapidly. The policy states that the mother must be awake and lucid at any time when co-sharing sleeping surfaces with their baby.

Recommendation 6

That Queensland Health give consideration to adopting the procedure used by the Mater Mothers' Hospital, Brisbane, where the medical notes accurately record bed-sharing, the location of the baby and the infant's activity.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health (QH) accepts this recommendation.

QH stakeholders were consulted and agreed the Mater Mothers' Hospital form is a good tool and its content would be worth implementing statewide. Elements of the Mater Mothers' Hospital form have been incorporated into the statewide maternal clinical pathways (a standardised, evidence-based multidisciplinary management plan, which identifies an appropriate sequence of clinical interventions, timeframes, milestones and expected outcomes for a particular patient group), which are in use across QH maternity services.

Recommendation 7

That Queensland Health conduct further examination into the appropriateness of student midwives and endorsed midwives both being required to work a full case load. Consideration should be given to ensuring appropriate time is set aside for the supervision and training of the student midwife in the ward.

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

Queensland Health (QH) accepts the Coroner's recommendation that a further examination/review of the post graduate student midwife clinical placement framework is required, with particular reference to caseload, supervision and training capacity. The Nursing and Midwifery Office Queensland will be responsible for this body of work.

Currently, QH employs Nurse Educators and Clinical Facilitators who provide support for midwives and student midwives. Postgraduate student midwives work in an evidence based practice partnership model with a qualified midwife where the registered nurse-student midwife shares the partnership workload with the midwife. The midwife delegates workload activities to the registered nurse-student midwife based on the knowledge, skills and abilities of the student midwife

However, there is an expectation that the student midwife, as a registered nurse also, has skills including, but not limited to:

- observation of vital signs;
- medications;
- basic life support;
- risk assessment skills; and
- workload management skills.

The review of the post graduate student midwife clinical placement framework will involve extensive consultation with clinical placement providers and industry partners. The review is due for completion in April 2013 and the implementation of any recommendations arising from the review will be considered by the District Directors of the Nursing and Midwifery Advisory Committee.

Recommendation 8

That Rockhampton Hospital ensures that all recommendations of the Root Cause Analysis have been implemented.

Response and action
Agreed and completed
Responsible agency: Queensland Health

The Rockhampton Base Hospital accepts and has completed this recommendation.

Recommendation 9

That Queensland Health ensures that the Root Cause Analysis process includes providing feedback to staff involved in the incident being investigated.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health (QH) accepts this recommendation.

The QH *Clinical Incident Management Policy including Root Cause Analysis and Open Disclosure* (CIMP – formerly the Clinical Incident Management Implementation Standard), the *Health Services Act (Qld) 1991* and the *Health Services Regulation 2002* governs the process of conducting a Root Cause Analysis (RCA).

The CIMP describes the overarching framework for clinical incident management within QH, including the process of conducting an RCA for events resulting in death or likely permanent harm, which is not reasonably expected as an outcome of healthcare. The CIMP refers specifically to ensuring feedback on the RCA is given to the personnel who reported the clinical incident. All RCA forms were updated in 2011 to provide for feedback being given to the reporter and staff involved in the incident and review process. This has been added into the RCA training course for new RCA trainees.

In addition to the CIMP, QH in May 2011 developed a Safety and Quality report. Upon completion of the RCA these reports can now be generated electronically which will assist in giving feedback to staff who were involved in the incident that was being investigated. Patient Safety Officers (PSO) are responsible for ensuring that staff who were interviewed during a RCA process are made aware that they may request a copy of the Safety and Quality Report at the time of interview. This responsibility was communicated to PSO staff in December 2011.

Recommendation 10

That Queensland Health ensure that a full record is kept of staff attending a MET call.

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

The Patient Safety and Quality Improvement Service will facilitate implementation of this recommendation via work carried out by the Recognition and Management of the Deteriorating Patient (RMDP) team.

The RMDP team has included this coronial recommendation in the statewide RMDP Guidelines, which has been endorsed by the statewide RMDP Reference Group. The statewide RMDP Guidelines are scheduled for release in late 2012.

Recommendation 11

That Queensland Health ensure steps are taken to ensure medical records in all Queensland Health facilities accurately reflect the date and time of the assessment, and where an assessment is conducted at some period earlier than when the notes are later made, that this be noted.

It is recommended that consideration be given to Dr Wakefield's opinion that rather than retraining staff on this issue, records be amended so staff are required to record the time the entry is made in the medical records and the time the actual assessment/measurements etc took place.

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

Queensland Health (QH) accepts the first part of this recommendation.

The current practice within QH for the writing of clinical notes is to write the date and time the note or assessment is written. According to the Clinical Documentation Information Booklet 2005, if notes are written up at a later time it is preferable to record the date and time the note is written, while making it clear in the notes that the time of the event being written about is estimated.

Some Health Service Districts currently have policies and/or procedures to ensure that entries made in the medical record have the date and time the note is written. They also identify that retrospective documentation must include the date and time an entry is made with reference to the date and time the event actually occurred.

Consideration has been given to Dr Wakefield's opinion that rather than retraining staff on this issue, record templates be amended so staff are required to record the time the entry is made in the medical records and the time the actual assessment/measurements etc. took place.

There are over 6000 different clinical forms in use across the wide range of clinical services in Queensland Health. Hospital and Health Services are able to develop their own forms so there would need to be a change in the formatting of forms at the local level. Furthermore, Dr Wakefield's suggestion would still require training for staff. Hence, it would not be practical or cost-effective at this stage to implement Dr Wakefield's recommendation.

A draft statewide policy outlining how to document in a medical record has been developed. Further consultation is required in accordance with the new model for developing policies and/or Health Service Directives. It is anticipated that this policy will be finalised in early 2013.

As local policies have been developed by some Health Service Districts supporting how to document in a medical record, these documents will provide the groundwork for the statewide policy.

Recommendation 12

That Queensland Health ensures that the Patient Safety Officer in each Health Service District be responsible for a regular assessment of the clocks in the facility to ensure they are checked and synchronised.

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

Queensland Health (QH) does not support this recommendation.

The Coroner's identification that accurate references to time must be available where a time critical process occurs is noted. However, while it may be argued that all aspects of health care are time critical, the proposed recommendation to periodically synchronise clocks is not sustainable throughout a hospital or all hospitals in Queensland.

In a time critical process, internal clocks within equipment, such as cardiotocography and electrocardiograph machines, are important and should be synchronised and accurate. Queensland Health considers that where time is not critical to a process there is no necessity to synchronise clocks.

Inquest into the death of Gitanjali

On 31 October 2010, Gitanjali, a young Indian women studying and living in Australia, died at the Royal Brisbane Hospital from severe burns that resulted from an act of self-immolation.

Coroner Lock delivered his findings on 15 July 2011.

Recommendation 1

It is recommended that the establishment of a Donor Skin Bank and Skin Culture Laboratory in Queensland be progressed as soon as possible. It is noted these facilities have been approved by the Queensland State Government and are waiting final regulatory approval by the Therapeutic Goods Administration and it is recommended that this final hurdle be overcome expeditiously.

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

Skin grafts are the most effective way to treat people with severe burns. Ideally these grafts will be taken from unburnt parts of the patient's own body. Unfortunately, some people do not have enough of their own skin left for this to happen. In these cases, skin grafts from a donor are vital. Skin Banks are responsible for retrieving and distributing skin tissue. The Queensland Skin Bank was issued with a Therapeutic Goods Administration licence to "Process, store on site and release for supply, Human Tissue – Skin" on 7 July 2011. Production has commenced in a limited capacity and is expected to expand as the service becomes more established and donations increase.

The Queensland Skin Culture Centre is in the process of being established in the Burns Unit area at the Royal Brisbane and Women's Hospital. The Centre will produce cultured skin for more severe burn injuries. The Queensland Skin Culture Centre requires the refurbishment of the Burns Unit laboratory to ensure it meets the stringent requirements for Therapeutic Goods Administration licensing. This is a complicated project from a mechanical perspective and as such will cost more than the original funding that was approved in 2007. The Royal Brisbane and Women's Hospital has sent a brief to the Deputy Director General of the Health Planning and Infrastructure Division through the Metro North Health Service District to request funding approval to tender and contract this final proposal.

Once the laboratory refurbishment is complete there will be an estimated 12 month period of clinical and operational validation before the application for a Therapeutic Goods Administration manufacturing licence and the commencement of the skin culture service. This licensing is anticipated to occur in 2013.

Inquest into the death of Saxon Phillip Bird

Mr Bird died on 19 March 2010 after drowning at the Australian Surf Life Saving Championships at Kurrawa Beach. He was knocked unconscious by a stray surf ski while competing and drowned in the rough surf.

The State Coroner delivered his findings on 2 August 2011.

Recommendation 3

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

Response and action
Under consideration
Responsible agency: Queensland Police Service

The Queensland Police Service (QPS) requested clarification from the State Coroner on the term 'large surf life saving events'. The State Coroner defined a large surf life saving event as 'being one where it is big enough for the Queensland Police Service to believe it needs to have a presence'.

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

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

The QPS is still considering this recommendation but as a provisional response the QPS supports the provision of at least one water police officer trained to Assistant SARMC or SARMC level (of which there are 70 such officers available across the State) at the State and National Surf Life Saving Titles (each held once a year), and with a Regional SARMC, if not attending the event, to be on call at all times during the event. QPS is currently consulting further with each Region and/or Command with a view to identifying support or non-support of the Coroner's recommendation. The result will be presented to the QPS Senior Executive for a final decision in early 2013.

Inquest into the death of Adrian Elliott Jones

Mr Jones died on 8 April 2006 at Nambour Hospital from multiple injuries he sustained earlier that day when he lost control of his motorcycle and collided with a station wagon on the Yandina Bli Bli Road at Maroochy River.

Coroner Callaghan delivered her findings on 24 August 2011.

Comments, paragraphs 84-86 of findings

"It was not appropriate for Senior Constable Church to prepare the statement, email it in an incomplete form to another police officer who happened to be the husband of the witness and ask that officer, who had an interest in the outcome of the investigation (his father was the driver of the other vehicle involved), to settle it. Constable Michael Miley Junior should have refused to settle the statement. Church should have requested Kathryn Miley to write out her own statement in her own words and have her have that statement witnessed.

I do not accept that the behaviours of Michael Miley Junior and Church were deliberately and intentionally misleading … a copy of this decision will be forwarded to the Queensland Police Service for them to take up this matter with Church and Michael Miley Junior."

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

Arising out of this coronial inquest, the Ethical Standards Command (ESC) within the Queensland Police Service (QPS) commenced a discipline investigation. The investigation identified failings by Senior Constable Church and Senior Sergeant Miley in terms of compliance with the QPS Operational Procedures Manual and Code of Conduct. The investigation concluded there are insufficient grounds to take any criminal or disciplinary action against Senior Constable Church and Senior Sergeant Miley.

Having regard to the spirit and intention of the new police complaints and discipline system, the QPS recommended the failings can be adequately addressed through managerial action. On 13 January 2012, these recommendations were endorsed by the Crime and Misconduct Commission and on 25 January 2012 the management action and investigation was finalised by the QPS.

Inquest into the death of Carl Antony Grillo

Mr Grillo died on 16 September 2009 after his life support was turned off, following two days in a coma at the Royal Brisbane and Women's Hospital. Mr Grillo originally lost consciousness after being chased and detained by police officers two days prior to his death.

While no single factor was found to be the predominant cause of Mr Grillo's death, the confluence of physical exertion after being chased on foot by police officers, the lateral vascular neck restraint position he was restrained in and his high amphetamine toxicity levels, when viewed against his pre-existing heart disease, were found to have contributed to the cardiac arrest that ultimately caused hypoxic brain injury and precipitated his death.

The State Coroner delivered his findings on 7 September 2011.

Comments, page 13

I am satisfied that Mr Grillo's death became far more likely when he decided to flee from police, wrestled with Senior Constable Jakes, was restrained by that officer and Mr Ward and was then handcuffed and placed in a position that was likely to have further impeded respiration at least to some extent.

I am also satisfied though that the officers were entitled to pursue Mr Grillo and that the force used to detain him was appropriately necessary...

In his report, Inspector Hobbs notes that the QPS Operational Skills and Tactics Program Committee are reviewing the use of the Lateral Vascular Neck Restraint (LVNR). The inquest heard that this review concerned confusion arising from the classification of this restraint as "lethal". I agree that different wording, while continuing to express the significant risks involved, may be appropriate.

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

The Queensland Police Service (QPS) Operational Skills and Tactics (OST) Committee continually review all teaching practises and content delivered to all police across the State. The OST Committee have drafted amendments for inclusion in the QPS Operational Procedures Manual which addresses the difference between the Lateral Vascular Neck Restraint (LVNR) and the neck restraint hold, identifying

clearly that the neck restraint hold is considered to be a lethal use of force and police should not use neck restraint holds unless exceptional circumstances exist. Additionally, police officers are required by QPS policy to attend OST training, which provides training for LNVR.

The draft amendments are currently being reviewed by the Crime and Misconduct Commission prior to approval by the QPS.

It is anticipated that the proposed amendments, once approved, will be incorporated into the QPS Operational Procedures Manual in late 2012.

Inquest into the death of John Clive Anderson

Mr Anderson died on 7 June 2009 at the Princess Alexandra Hospital after suffering a heart attack, which was precipitated by infective endocarditis.

At the time of his death, Mr Anderson was an inmate at the Arthur Gorrie Correctional Centre and while his treating general practitioner did raise the possibility of infective endocarditis in his referral to the Princess Alexandra Hospital, this was not acted upon in a timely enough manner to effectively treat the infection.

The Deputy State Coroner delivered her findings on 20 September 2011.

Comment 1, page 10

There is evidence the prisoner population is at elevated risk of a (still) very rare but potentially fatal disease of infective endocarditis. This has regard to the higher incidence of intravenous drug usage, possible poorer dentition exposing prisoners to a risk of transmission of infection within the bloodstream via infection in the teeth or in the course of dental treatment, as well as the generally poorer overall health status of prisoner population.

Comment 2, page 11

Treating general practitioners of prisoners should be mindful of the possibility of this condition and seek prompt specialist review according to their clinical judgement upon identifying significant symptoms.

Response and action
Agreed and completed
Responsible agency: Queensland Health

To raise awareness of this issue amongst correctional centre staff (including visiting medical officers and other clinical staff), the Queensland Health (QH) Patient Safety and Quality Improvement Service has forwarded the findings from this inquest to:

- Offender Health Services, within QH;
- Arthur Gorrie Correctional Centre;
- Borallon Correctional Centre; and
- Metro South Health Service District, within QH.

However, this issue extends beyond the corrections environment into the general population. To raise the awareness of general practitioners of this issue, the QH Patient Safety and Quality Improvement Service has forwarded the findings of this inquest to The Royal Australian College of General Practitioners.

Comment 3, page 11

It is interesting to note the impression from the general practitioners' perspective was they expected the appropriate response to a suspicion of infective endocarditis by a general practitioner was quite high. An urgent referral to a specialist was called for. But the evidence in this inquest from Dr Scott of the General Medicine Unit suggests a specialist performing a triage role, on receipt of the referral and without examining the patient, might not accept a prima facie suspicion of a serious condition recorded by a general practitioner unless there was other significant information supporting the possible diagnosis.

With the acknowledged benefit of hindsight, perhaps specialists might also consider contacting the referring practitioner to discuss a referral where the risk to the patient of not acting is serious and the patient is a prisoner with elevated risks.

Response and action
Agreed and completed
Responsible agency: Queensland Health

This issue extends beyond the corrections environment into the general population. To raise the awareness of general practitioners of this issue, the Queensland Health (QH) Patient Safety and Quality Improvement Service has forwarded the findings of this inquest to the Royal Australian College of General Practitioners (RACGP).

The issue of specialists contacting the referring practitioner has been referred to the QH Metro South Health Service District which manages the Security Inpatient Unit. The Security Inpatient Unit provides holistic and efficient 12 bed inpatient and outpatient services to Queensland Corrective Services clients within a secure safe environment. It is the only facility of its kind in Queensland.

Comment 4, page 11

Where consideration of security delays the advice of a specialist appointment back to the referring doctor and prisoner until

(typically) the day before the specialist appointment, the referring doctor should be mindful to proactively ensure the patient's referral has been considered by the relevant specialty. The referring doctor should be mindful of the risk in any delay, particularly when a diagnosis has not been confirmed but has potential for serious detriment to the patient's health.

Response and action
Agreed and completed
Responsible agency: Queensland Health

To raise awareness of correction centres staff (including visiting medical officers and other clinical staff) of this issue, the Queensland Health (QH) Patient Safety and Quality Improvement Service has forwarded the findings from this inquest to Offender Health Services, the Arthur Gorrie Correctional Centre and the Borallon Correctional Centre.

Inquest into the death of Matthew Maurice Tiers

Mr Tiers died on 14 May 2010 at Rockhampton Hospital from multiple organ failure that was precipitated by sepsis. Mr Tiers had begun a period of incarceration at the Capricornia Correctional Centre a week before his death. While the State Coroner found the health care he received there was adequate, he expressed concerns regarding the management of his alcohol withdrawal.

The State Coroner delivered his findings on 29 September 2011.

Recommendation 1

As detailed earlier, the management of Mr Tiers' withdrawal from alcohol was somewhat ad hoc. The literature is replete with studies indicating that symptom triggered protocols that involve the use of a standardised alcohol withdrawal scale to direct the administration of medication have superior outcomes. Accordingly, I recommend Offender Health Services review its policies to ensure they are most appropriate for dealing with such a prevalent problem among its patient population.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Offender Health Services have reviewed and re-drafted their alcohol withdrawal guidelines. This has included consultation with the Queensland Health Forensic Medicine Unit and the Metro North Health Service District's Alcohol, Tobacco and Other Drugs Service. The revised guidelines include a standardised alcohol withdrawal scale.

Inquest into the death of Ryan Charles Saunders

Ryan Saunders died on 26 September 2007 at Rockhampton Base Hospital from toxic shock syndrome precipitated by a Group A Streptococcal infection which probably originated in his throat. Ryan's condition deteriorated after those treating him at the Rockhampton Base Hospital failed to detect and respond to the infection in a sufficiently timely manner. Ryan was nearly three years old when he died.

The State Coroner delivered his findings on 7 October 2011.

Comments, page 28-30

"When considering what improvements might be recommended as a result of the events leading to Ryan's death I have benefited from having regard to the 16 recommendations made by the Health Quality and Complaints Commission (HQCC). Although most of them would not have resulted in a different outcome for Ryan, I am satisfied each of them is an appropriate response to the problematic systemic issues brought into focus by Ryan's case...

"Dr John Wakefield, the Director of the Queensland Health and Patient Safety and Quality Improvement Service ... told the inquest that 13 of the 16 recommendations had been implemented in full. Dr Wakefield gave evidence ... that the remaining three recommendations ... are very close to finalisation. Those recommendations are numbers 3, 7 and 8."

> *HQCC recommendation 3 – for Queensland Health to advise when the forced CRP (C-reactive protein) reporting tool has been implemented statewide.*
>
> *HQCC recommendation 7 – for Queensland Health to consider developing and implementing an early warning observation system for use in all Queensland Health paediatric facilities and by the Paediatric Emergency Team.*
>
> *HQCC recommendation 8 – that Queensland Health implement an escalation procedure for pathology reports and consider the merits of an automated pathology alert system which automatically signals and notifies the relevant clinician of any significant variance in results.*

"Recommendations 3 and 8… are near completion and will seemingly result in best practice when it comes to the way in which doctors in Queensland hospitals order pathology tests and how they are notified of critical pathology results.

"Recommendation 7 could in fact be said to have been fulfilled as ... the department has in fact developed such a system - the Children's Early Warning Tool (CEWT) - and has trialled it in a number of hospitals including Rockhampton... I am satisfied that the research and effort put into the development of the CEWT system is a satisfactory response."

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

In order for the forced CRP (C-reactive protein) reporting tool to be implemented as per HQCC recommendation 3, two capabilities are required: firstly, the capacity to audit the review of pathology results must be in effect; and secondly an electronic order entry system with decision support must be in place.

The capability to audit the review of pathology results is provided by electronic results databases, specifically AUSCARE Results Verification (silver) and the ERIC system.

Regarding implementation of an electronic order entry system with decision support, Queensland Health (QH) is currently in contract negotiations with potential integrated electronic medical record (ieMR) suppliers regarding specifications including a decision support system.

The first (of four) implementation stage of the ieMR is scheduled to be completed for 60% of QH business by December 2012. Orders and results reporting modules are planned to be included in stage two, scheduled for 2013. At present, funding has been allocated to roll out to a limited number of hospitals. The variation in the dates in the roll out of ieMR has been due to progress in contractual negotiations.

In response to HQCC recommendation 8, QH has implemented an escalation procedure for pathology reports and considered the merits of an automated pathology alert system. All QH clinicians currently have access to the QH Laboratory Information System which currently provides real time result reports as soon as they are available.

Inquest into the death of Gregory Stephen Bonanno

Mr Bonanno died on the evening of 1 June 2010 from multiple injuries he sustained after the vehicle he was driving left the Gin Gin - Mount Perry Road, collided with trees and was incinerated. There were no witnesses to the accident but Coroner Hennessy found that a causal factor in the accident was a lack of adequate signage that reduced the speed limit and alerted drivers to the possibility of loose gravel after re-surfacing works were completed earlier that day on the section of road where Mr Bonanno lost control. Potential speeding on the part of Mr Bonanno could also have been a contributing factor.

Coroner Hennessy delivered her findings on 11 October 2011.

Recommendation 1

That the Department of Transport and Main Roads give serious consideration to including in the Manual of Uniform Traffic Control Devices (MUTCD) training and information on the parts of the Main Roads Technical Standard (MRTS) that contain regulation of signage controls.

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

The Manual of Uniform Traffic Control Devices (MUTCD) contains the design of, and the methods, standards and procedures in relation to every sign, signal, marking, light or device, installed on a road. Part 3 - "Works on Roads" of the MUTCD is currently being revised. The Main Roads Technical Standard MRTS02 (Provisions for Traffic) is the relevant technical standard regulating road signage controls and it will be referenced in the revised version of the MUTCD. Consequently, details and guidance on the selection and signage of speed limits to be used during bitumen surfacing works will be specifically included in the MUTCD.

The revision of Part 3 of the MUTCD is expected to be complete by December 2012. When the MUTCD revision is complete, detail concerning speed limits to be used during bitumen surfacing works will be included in the traffic management training course curriculum.

Recommendation 2

That the Department of Transport and Main Roads give serious consideration to the inclusion of guidelines in the Manual of Uniform Traffic Control Devices (MUTCD) in relation to the conduct of risk assessments for road works in order to ensure

that a consistent and sufficiently rigorous process is followed in the interests of public safety.

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

Austroads have prepared a report *Implementing National Best Practice for Traffic Control at Road Work Sites: Risk Management, Auditing and Field Operations*. This document provides advice in the areas of risk management, compliance, safety inspections, road safety auditing and practical field operation techniques. It is not known when the document will be published. When published, the document will be referenced in the Manual of Uniform Traffic Control Devices (MUTCD), Part 3 of which deals with "Works on Roads" and is currently being revised. The revision is expected to be complete by December 2012.

These guidelines and procedures specific to road works and traffic control will provide a tailored approach to risk assessment that can be applied consistently across work sites rather than leaving it to the responsible person(s) to adopt their own risk assessment methodology.

Inquest into the death of an unnamed prisoner

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

The deceased was being held in pre-trial custody and it became apparent that he realised in the days before his death that he faced a realistic prospect of "putting his wife through a traumatic trial and/or spending many years in prison". However, nothing in his behaviour indicated to his family or the mental health professionals who were treating him that he was at risk of self-harm. The State Coroner found that overall the quality of mental health care given to the deceased while in custody was of a high standard.

However, concerns were raised regarding the level of contact the deceased was allowed to have with his wife while in custody and the manner in which his family were notified of his death.

The State Coroner delivered his findings on 14 October 2011.

Recommendation 1

While recognising the genuine public interest in the publication of information about deaths in custody, this must be balanced against the distress that can be caused to those close to the deceased if they first hear of the death via the news media.

Accordingly, I recommend QCS media section policies be amended to stipulate that before a media release is issued in relation to such an event, the responsible officer establish whether the deceased prisoner's contact person and next of kin have been advised of the death. If not, no information that is likely to enable those persons to identify the deceased prisoner should be included in a media release until all reasonable efforts to do so have been undertaken.

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

Queensland Corrective Services' (QCS) media policy and procedure directs that offenders who die in custody are not named unless there is a significant community interest or public benefit in doing so. In this circumstance the offender's name would only be released after the next of kin had been notified (or after all reasonable steps had been undertaken to notify the next of kin).

As a result of the Coroner's recommendation, this direction was reinforced via memorandum to General Managers on 29 February 2012 instructing the General Managers to confirm upon request by QCS' media officers or duty executive that an offender's next of kin has been informed before details are officially released.

The Death in Custody procedure has been amended to include a new section, 5.3, which relevantly states that:

> "the Director of the Office of the Commissioner, Queensland Corrective Services (Queensland Corrective Services Media) is responsible for establishing with the appropriate General Manager or duty executive if next of kin have been informed before releasing information to the media. If the next of kin have not been informed, no information that is likely to enable those persons to identify the deceased prisoner should be released to the media. A notification to the media about a death in custody may only be made by the Director of the Office of the Commissioner".

The amended procedure was published on 19 April 2012.

The implementation of this recommendation was reviewed by the QCS' Incident Oversight Committee on 10 July 2012 and it was determined that the recommendation has been implemented.

Recommendation 2

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

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

Queensland Corrective Services (QCS) has commenced a review of its policies.

The Commissioner, QCS, wrote to the Commissioner of the Queensland Police Service (QPS) on 1 June 2012 seeking advice regarding the availability of

information relating to current Domestic Violence Orders and associated conditions for a personal visitor when criminal history checks are undertaken.

The Commissioner, QPS, responded on 21 September 2012. QCS is in the process of considering the Commissioner's response to determine how it will respond to the recommendation.

Inquest into the deaths of Grace Ann Hornby, Jessica Lee Hornby, Denise Ann Mansel and Anthony Paul Thomson

On 8 May 2009, Denise Ann Mansell, her granddaughters Grace Ann and Jessica Lee Hornby and Anthony Paul Thomson all died of multiple injuries sustained in a two-car accident at the intersection of Blackall Street and the Nambour Connection Road at Woombye. Ms Mansell's car, containing her two granddaughters was turning right into Blackall Street from the Nambour Connection Road when it collided with Mr Thomson's car, which was travelling in the opposite direction on the Nambour Connection Road.

From the evidence presented at the inquest, the Coroner found that the inadequate illumination of Mr Thomson's headlights and the excessive speed at which he approached the intersection were contributing factors in the collision. The inquest heard that it would be unreasonable to have expected Ms Mansell to be able to avoid the collision given these factors. The Coroner also found that Mr Thomson could have been affected by the side effects of excessive doses of prescribed and unprescribed medications that were present in his system at the time of the accident. However, the medications that Mr Thomson had been prescribed were found to be appropriate for his various medical conditions and would not have adversely affected his ability to drive when taken in the prescribed amounts. Mr Thomson's doctors were found to have taken appropriate action to ensure this occurred.

Coroner Callaghan delivered her findings on 20 October 2011.

Recommendation 1

The Department of Transport and Main Roads should continue to review the intersection of the Nambour Connection Road and Blackall Street with a view to considering whether traffic lights ought to be installed at the intersection or whether the medium ought to be closed.

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

A number of detailed internal and independent investigations were undertaken as part of the Department of Transport and Main Roads' (DTMR) review and analysis of this crash. An overarching report was compiled drawing upon these investigations, which included recommendations to consider potential safety improvements at the intersection.

Acting on this report, DTMR completed a $1.2 million road safety project to encourage lower speeds through the intersection. This included lowering the speed limit, installing a Woombye village sign, electronic speed warning signs and new line markings.

Vehicle speeds through the intersection were monitored for six months from 1 January 2011 with a view to installing traffic signals. An important consideration for the proposed installation of traffic signals is prevailing vehicle speeds and the ability of drivers to respond safely to changing signals. If vehicle speeds meet the required speed criteria for traffic signals in this road environment, the installation of traffic signals would be viable. This speed monitoring indicated that vehicles were still travelling at speeds in excess of the requirements to safely install traffic signals.

Following the completion of the speed monitoring trial, additional investigations were undertaken to identify what further measures could be implemented to reduce traffic speeds. DTMR will install a fixed speed camera at the intersection of Nambour Connection Road and Blackall Street by the end of 2012. A high-friction surface treatment will also be installed to create a change in the road environment so that motorists approaching the intersection will notice a change in environment and reduce their speed if necessary.

A further six month speed monitoring period will take place to assess the impact of the fixed speed camera on influencing the speeds. Traffic signals will be considered if the fixed speed camera can reduce the speed of vehicles travelling on the approach to the intersection.

Inquest into the death of Sheldon Douglas Currie

Mr Currie died on 20 February 2010 at the Princess Alexandra Hospital from hypoglycaemic hypoxic-ischaemic encephalopathy caused by acute liver disease after his hepatitis B and C infections unexpectedly worsened. At the time of his death, Mr Currie was on remand at the Arthur Gorrie Correctional Centre.

The State Coroner delivered his findings on 3 November 2011.

Recommendation 1

I recommend Offender Health Services review the availability of treatment for prisoners infected with viral Hepatitis to ensure reasonable endeavours are being made to contain the spread of this notifiable condition by treating its carriers while they are in custody.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Queensland Health (QH) has reviewed the availability of treatment for prisoners infected with viral hepatitis to: contain the spread of this notifiable condition by treating its carriers while they are in custody; and to develop a definitive response to this recommendation.

For correctional facilities, QH's Communicable Diseases Branch has developed and implemented the *Protocol for the Management of Viral Hepatitis in Offender Health Services*. The protocol addresses diagnosis, management and antiviral therapy. The process of diagnosing prisoners with hepatitis will include screening, blood work up and taking a good medical history. The management of prisoners diagnosed with hepatitis will include harm minimisation (decreased use of alcohol and other drugs illegally obtained while in prison, ensuring an appropriate diet and exercise program), vaccination, counselling, education, monitoring and ensuring their mental health issues are addressed. Antiviral therapy will be determined on an individual basis. Additionally, if an offender tests positive for hepatitis B or C, the protocol will require that these offenders routinely be offered a hepatitis A vaccination.

The protocol has been published on the QH website and is being recommended to become a QH – Director-General Directive as of 1 July 2013.

Comment 1 – medical records

It became apparent during the course of the inquest that the keeping of medical records at the Arthur Gorrie Correctional Centre was seriously substandard. Some attempt was made to

suggest this was an aberration peculiar to this case. Neither I nor the Chief Inspector's investigators accepted that. I am however satisfied the operators of Arthur Gorrie Correctional Centre are constructively seized of the issue.

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

In response to the Queensland Corrective Services' (QCS) Chief Inspector's recommendation for GEO Group Australia Pty Ltd (GEO) (responsible for privately managing and operating Arthur Gorrie Correctional Centre) to institute a process to ensure that appropriate record keeping is undertaken in the Medical Unit, including a process to ensure proper tracking of medical files, GEO introduced a colour coded record system in 2010. This system involved:

- designating a colour code for different health services functions and occupational groups;
- establishing a colour coded tracking card system for situations where a file is removed and returned from and to the Medical Unit secure compactus; and
- oversight by the Health Services Manager.

The QCS' Incident Oversight Committee approved GEO's implementation of the Chief Inspector's recommendation in October 2010.

Comment 2 - communication

As a result of concerns, Correctional Services Officer Hayat had information relevant to the assessment of Mr Currie when he went to the medical centre on 15 February which was not conveyed to the medical staff who reviewed him. The Chief Inspector's report recommended a review of the procedures for the provision of information from custodial staff to health staff in such situations. I have been advised by Queensland Corrective Services this has been implemented by GEO and that Queensland Corrective Services is currently in the process of ensuring it is implemented statewide.

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

The Chief Inspector's recommendation was implemented by GEO Group Australia Pty Ltd in October 2011.

Queensland Corrective Services (QCS) amended the Prisoner Management procedure to ensure that the process of facilitating communication with health staff is implemented. The procedure which governs what process officers are required to follow, states at section 3(h) that "During day to day interaction, if a custodial officer observes that a prisoner is presenting with apparent or expressed significant health concerns, an immediate referral should be made to the health centre outlining any concerns." Section 8.2(h) also requires that case notes on the Integrated Offender Management System must be entered in the circumstances outlined in section 3(h).

The procedure was published and implemented statewide in February 2012.

The QCS' Incident Oversight Committee considered the implementation of the Chief Inspector's recommendation to be complete on 11 August 2012.

Comment 3 – Indigenous liaison

While the Chief Inspector's report did not make any finding that cultural competency contributed to lack of appropriate care for Mr Currie, it did recommend that GEO implement a process for ensuring greater involvement of the Indigenous counsellors in the management of the health care of Indigenous prisoners. This has happened at GEO and Queensland Corrective Services is in the process of ensuring it happens statewide.

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

The Chief Inspector's recommendation was implemented by GEO Group Australia Pty Ltd in October 2010.

Offender Health Services (OHS) within Queensland Health was advised by Queensland Corrective Services (QCS) in December 2010 that Cultural Liaison Officers are available in all correctional centres to assist medical staff in the management of Indigenous offenders. Nursing Unit Managers statewide have been advised by OHS that these officers are available. General Managers at all correctional facilities statewide were also advised in December 2010 that Cultural Liaison Officers must be made available upon request from OHS.

The QCS' Incident Oversight Committee considered the implementation of the Chief Inspector's recommendation as complete in January 2011.

The Coroner's comment from November 2011 that QCS is in the process of ensuring greater statewide involvement by Indigenous counsellors in the management of the health care of Indigenous prisoners had been addressed prior to the handing down of the inquest findings.

Inquest into the deaths of Gregory McClellan, Yan Sun, Shengqi Chen and Dominic Chen

On 1 September 2007, Gregory McClellan, his wife Yang Sun, their friend Shengqi Chen and his twelve-year-old son Dominic Chen all died after the boat they were all travelling in collided with and was run over by another boat, the Four Winns, in Moreton Bay. Mr McLelland and Mr Chen both succumbed quickly to the multiple injuries they suffered while Ms Sun and Dominic both drowned. Wei Chen, Mr Chen's wife and Dominic's mother, was the only survivor from their boat.

Neither Mr McClellan nor the 16-year-old driver of the Four Winns took any evasive action to avoid the accident as no one from either boat saw the other vessel approaching until a few seconds before the impact.

The Deputy State Coroner delivered her findings on 25 November 2011.

Comment 1 – Boats on converging courses

I do not consider that any change in existing legislation about any of these matters is called for but given the evidence of the driver of the Four Winns, a renewed emphasis in training could be beneficial. I suggest it is important to emphasise, particularly to inexperienced boat operators, the true requirement of keeping a proper lookout. It is not satisfied by simple compliance with the give way to the right rule (more properly described as the boat on a portside course gives way to the boat on a starboard course, sometimes described as "the golden rule"). It is not satisfied by cursory observations to the left-hand/portside. It requires constant careful assessment of the total surrounds and adjustment of the manner of driving, taking into account those observations. In addition, training should emphasise the importance of reducing speed in circumstances of reduced visibility.

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

Maritime Safety Queensland has upgraded the content of the BoatSafe course. The BoatSafe course must be completed by all candidates for a Recreational Marine Driver Licence. The new BoatSafe course includes a night and electronic navigation training video that must be viewed by all candidates in order to be eligible for a Recreational Marine Driver Licence. The training video was sent to BoatSafe Training Operations in March 2012 for implementation by 30 June 2012.

The night and electronic navigation training video emphasise the requirement under the International Regulations for Preventing Collisions at Sea (published by

International Maritime Organisations) for every boat driver to maintain a proper lookout. Rule number five of the International Regulations for Preventing Collisions at Sea provides that "every vessel shall at all times maintain proper lookout by sight and hearing as well as by all available means appropriate in the prevailing circumstances and conditions so as to make a full appraisal of the situation and of the risk of collision.

Comment 2 – Licence changes

Wei Chen passionately submitted the age of eligibility for operation of a boat as large as the Four Winns should be increased. The McLellan family joined in this submission. I consider the recent changes of boat licensing which require a higher standard of boat skill operation for new licence holders of large recreational boats will improve the safe operation of these craft. I consider the best approach is to require demonstrated higher levels of skill, rather than a rule about minimum age requirements...

I note the licensing regime for driving a motor vehicle which provides a sequence of licences with various restrictions being lifted over time.... Motor bike riders likewise must commence at a lower capacity machine before progressing over time to a higher capacity bike...

I would therefore suggest that Maritime Safety Queensland consider a similar scheme. This should require a demonstration of prescribed skills for particular classes of vessels, but also a progression of licensing at minimum intervals of time to enable the applicant to gain experience and maturity in developing those skills over time. The effect of such a scheme would necessarily increase the age at which a person could apply for a licence for a higher powered vessel. I do not consider the coroner is best equipped to suggest time intervals between applying for types of licences or the range of vessel capacity.

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

Maritime Safety Queensland is considering the implementation of a tiered licence system.

Under this system, applicants for a Recreational Marine Driver Licence who are less than 18 years old (an applicant must be at least 16 years old) would only be permitted to obtain a licence to drive recreational boats less than 12 metres in length. They would be required to successfully complete the standard BoatSafe training course to obtain this licence. Upon successful completion of the course they would be issued with a limited recreational marine driver licence (for boats less than 12 metres).

New licence applicants wanting to operate larger recreational boats would need to be 18 years or older, complete additional training and have held a limited licence for at least 12 months before upgrading to an open recreational marine driver licence.

Existing holders of a Recreational Marine Driver Licence (issued prior to 1 January 2013) would continue to be permitted to operate a recreational boat of any size without further training.

An analysis of the data on the age of marine licence holders and their involvement in marine incidents over the past two decades indicates that younger licence holders are not proportionally over-represented in marine safety incidents. This is in contrast to the rate of involvement of young drivers in road traffic incidents.

Comment 3

Of course wearing personal flotation devices will save lives when people are thrown into the water unexpectedly. The current deliberate policy of Maritime Safety encourages the use of personal flotation devices and continues the education and safety programs giving this message to the public. This strategy should be continued and education and training programs be properly resourced. Maritime Safety should continue to actively review the circumstances of boating fatalities and consider the incidence of deaths that can be attributed to a failure to wear them. Any consideration of legislative change requiring mandatory wearing of flotation devices must also consider providing capacity for public education and awareness and capacity to enforce such law change.

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

As noted by the Deputy State Coroner in her comment, Maritime Safety Queensland (MSQ) maintains a continual safety education program. One element of the program is an annual summer boating safety campaign that coincides with the peak boating season in Queensland and targets all recreational boat users. The aim of the campaign is to create awareness of safe boating practices and to encourage safe boating behaviours.

Based on an analysis of marine incidents, the safety campaign for the 2011-2012 summer boating season had the over-arching theme of: 'You're The Skipper, You're Responsible'. There were three stages to the campaign, with each stage focusing on a different boating safety message. The messages were based around the correct use, maintenance and servicing of life jackets including: wearing a life jacket whenever there is a heightened risk; keeping a proper lookout including slowing down in reduced visibility; and, responsible drinking behaviour.

MSQ will continue to implement its safety education programs each year.

It is the policy and practice of MSQ when investigating a fatal marine incident, to establish the extent to which personal flotation devices were, or were not, used by those involved. Consideration is given to the extent to which a death may be attributed to a failure to wear a personal flotation device. The outcomes of these considerations are reported each year to Parliament and the public in the report *Marine Incidents in Queensland*.

MSQ is not currently considering any legislative change in relation to the mandatory wearing of personal flotation devices. However, should this be reviewed in the future, consideration will be given to providing capacity for public education and awareness and capacity to enforce such law change.

Inquest into the death of Tracey Lee Inglis

Ms Inglis died on 17 or 18 September 2010 in her cell at the Townsville Women's Correctional Centre from blood loss resulting from self-inflicted wounds. Ms Inglis had a history of depression and suicidal ideation, which was exacerbated by chronic pain she suffered as the result of other physical injuries. The State Coroner regrettably found that Ms Inglis had intended to end her life and that the insufficient pain relief administered to Ms Inglis during this most recent period of incarceration was probably a factor in her decision.

The State Coroner delivered his findings on 9 December 2011.

Recommendation 1

To maximise the likelihood of the Initial Risk and Needs Analysis (IRNA) form gathering reliable information, prisoners should be explicitly asked whether they identify with any ethnic group and if so, whether they would like a person from that ethnic group to be present during the assessment. Similarly, prisoners should always be offered the option of having the assessment undertaken by a counsellor of either gender. I recommend QCS consider mandating such policies be implemented in all correctional centres.

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

Queensland Corrective Services (QCS) has commenced consultation with relevant internal and external stakeholders, including multicultural language service providers, to assess implementation of this recommendation and determine the impact on service delivery. In addition, QCS is reviewing the operational practice guideline to ensure the appropriate identification, referral and management of vulnerable groups.

QCS has completed an examination of available research, including consultation with internal and external stakeholders, regarding gender matching for assessments and whether doing so supports disclosure of personal information by prisoners in a correctional environment. QCS is expected to make a determination on whether, and to what extent, this recommendation will be implemented in late 2012

Recommendation 2

In view of the lengthy and unnecessary interruption of the deceased's prescribed medication after her incarceration, I

recommend Queensland Health urgently develop guidelines to assist visiting medical officers engaged by Offender Health Services to make appropriate judgements concerning continuity of care for newly received prisoners and implement procedures that ensure verification of existing prescriptions occurs in a timely fashion.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Offender Health Services have drafted and disseminated continuity of care guidelines following review by key stakeholders.

Recommendation 3

In view of the inadequate pain management provided to the deceased in this case and the paucity of guidelines available to Offender Health Services staff on how to respond to chronic pain, a disproportionately common complaint among their patient population, I recommend that Queensland Health urgently develop guidelines to assist visiting medical officers engaged by Offender Health Services make appropriate judgements concerning the assessment and treatment of the condition.

Response and action
Agreed and completed
Responsible agency: Queensland Health

Offender Health Services have drafted and disseminated pain management guidelines following review by key stakeholders.

Recommendation 4

In view of the generally poor health and vulnerability of prisoners, I recommend that QCS require all prison operators to make information about the role and function of the Health Quality and Complaints Commission readily available to prisoners and allow free telephone calls to the agency.

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

Information about the role and function of the Health Quality and Complaints Commission (HQCC) was distributed to all General Managers in February 2012, including posters and brochures for display, with the request that centres provide this information to offenders. On 30 January 2012, Queensland Corrective Services (QCS) also approved the distribution of this information to offenders through the Prisoners' Legal Service Inc, throughout February 2012.

Effective February 2012, the HQCC telephone number was added to the 'Common Auto Dial List' of telephone numbers available to offenders free of charge. These lists are situated next to the telephones available for use by offenders.

QCS updated the prisoner induction program to ensure prisoners are advised during the induction program that they may make a complaint about a health service to the HQCC. The Prisoner Induction Procedure (which outlines the prisoner induction program) and Prisoner Information Booklet have also been updated to include information relating to the HQCC, and were published on 24 May 2012.

Implementation of this recommendation was reviewed by the QCS' Incident Oversight Committee on 10 July 2012 and it was determined that the recommendation has been implemented.

Inquest into the death of Graham Robert Tait

Mr Tait died on the evening of 21 March 2007 from electrocution after coming into contact with live low voltage powerlines that had fallen to the ground in a vacant lot behind his home in Narragon Beach. The inquest examined how the powerlines came to be on the ground, the response of the electricity providers and the Electrical Safety Office and Workplace Health and Safety investigations into Mr Tait's death.

The coroner made recommendations directed to the following business units within the Department of Justice and Attorney-General (DJAG):

- Workplace Health and Safety Queensland (WHSQ);
- Electrical Safety Office (ESO); and
- Fair Safe Work Queensland (FSWQ).

WHSQ assists Queensland business to improve work health and safety outcomes. WHSQ conducts a range of education and awareness strategies and enforces work health and safety laws.

The ESO has primary responsibility for the delivery of electrical safety services in Queensland. The ESO develops and enforces standards of electrical safety across industry and the community.

FSWQ coordinates the work of the ESO and WHSQ with regards to shared legislative and enforcement programs.

Coroner Brassington delivered her findings on 9 December 2011.

Recommendation 1, page 36, paragraph 136

Accordingly, with a view to minimising the significant safety risks posed by live fallen LV conductors, I recommend that the Office of Fair and Safe Work Queensland progress legislative amendments to mandate the reporting to the ESO of all incidents in which LV conductors fall to the ground and remain energised.

Response and action
Under consideration
Responsible agency: Department of Justice and Attorney-General

The Electrical Safety Office in the Department of Justice and Attorney-General has developed a proposal for regulatory amendment of Part 12 of the *Electrical Safety Regulation 2002* (the Regulation) that would require distribution entities to report annually on incidents in which low voltage (LV) conductors fall to the ground and remain energised. Occasions resulting a mass failure (for example, a cyclone) would be excluded from this requirement. This proposal would serve to improve the

information available to the regulator in relation to identifying any trends relating to an electricity network's operation and performance that may affect safety.

This proposal is being considered as part of the ten year review of the Regulation required by the *Statutory Instruments Act 1992*. This will be subject to Ministerial approval and the associated Regulatory Assessment Statement and cost benefit analysis. The RAS is proposed for release for public comment in late 2012, with the ten year review of the Regulation due for completion in 2013.

Recommendation 2 (page 40)

While Ergon has addressed this issue, Counsel assisting has submitted a recommendation should be made addressed to other electrical entities to review their scripting in these circumstances with a view to implementing similar changes... I accept this submission.

I recommend that electrical entities review their call centre scripting to include a specific warning reminding callers where there is a total or partial loss of supply, brown out or other emergency, one cause of that situation may be fallen powerlines and fallen or hanging power lines should be treated as live.

Response and action
Agreed and completed
Responsible agency: Energex Pty Ltd, via the Department of Energy and Water Supply

Energex call centre scripting has been reviewed and currently callers to the 131962 Emergency line will hear the following message:

> *"This is the Energex electricity emergency service. If you have a life threatening emergency, please call triple zero NOW. If you are reporting powerlines down or a dangerous situation hold the line. Please be aware that any fallen or overhanging power lines could still be live - stay well way until Energex arrives. Your call will be recorded for safety purposes."*

Callers to the 136262 loss of supply IVR (Interactive Voice Response) will hear the following message before proceeding:

> *"Thank you for calling Energex. Your power problem could be associated with fallen or hanging power lines which could still be live. For safety reasons, please keep well clear of them until Energex arrives."*

Callers to 131253 who choose to report wires down or loss of power supply are transferred to the loss of supply IVR where again they will hear:

> *"Thank you for calling Energex. Your power problem could be associated with fallen or hanging power lines which could still be live. For safety reasons, please keep well clear of them until Energex arrives."*

Recommendation 3 (page 41)

"At this time, there was no specific guidance to guide the control room personnel to deal with electrocution. In hindsight, a decision to shut down the feeder could have been made sooner…. However, it would not be fair to those in the control room to criticise their actions. I am satisfied they acted diligently and professionally... any delay in de-energisation did not contribute to Mr Tait's death. Immediate de-energisation by ERGON upon receiving notification of the electrocution would not have saved Mr Tait.

Notwithstanding this finding, it is entirely appropriate that ERGON has moved to ensure decisions to de-energise lines are made in a timely manner in similar situations... These new procedures and processes for managing wires down have become fully operational in Ergon since August 2011... The guideline now provides for immediate de-energisation where urgent rescue or imminent threat is involved. I accept Counsel Assisting's submission that a recommendation should be made to all electricity entities to institute similar policies.

I recommend that electricity entities review and, if necessary, develop and document procedures to guide control centre staff and field crews to deal with emergency situations involving downed live wires, including de-energisation policies where urgent rescue and/or imminent threat is involved.

Response and action
Agreed and completed
Responsible agency: Energex Pty Ltd, via the Department of Energy and Water Supply

Energex's Network Control has reviewed their process as well as the worker response component.

For incidents associated with fallen wires, section 6.1 of the Energex Operating Practices Manual (OPM) includes clear instructions directing trained staff to remotely trip 11,000 Volt feeders and to de-energise any live wires in order to ensure public safety and/or to facilitate rescue by emergency services personnel.

The Energex Control Room has direct communication links with all Emergency Services and has remote control of all Energex network 11,000 Volt feeder circuit breakers, and will not hesitate to take appropriate actions in the interests of public safety. This will occur as soon as sufficient information has been collated in order to take such action (e.g. live wires down at an accident scene, outside a school, etc.)

Following the inquest into the death of Mr Tait, Energex has not undertaken any material change to its policy in the area involving the field staff response process that is associated with the inquest findings. There has been one change to the field reporting process which is not associated with the findings from this inquest. Previously, field personnel undertaking a task who inadvertently stumbled on unreported fallen overhead electricity wires ('wires down') that were not associated with their task at hand, reported the incidence to the Energex Central Dispatch Centre. However, field staff now contact the Emergency Line Operators in Energex's Contact Centre. Field staff inadvertently locating unreported 'wires down' is quite common in storm situations where Energex could have many field crew units in numerous areas. There are many unreported fallen wires, some of which are located during repairs to other lines that have already been reported. The emergency line operators are skilled and equipped to deal with the reporting duties associated with these newly located fallen wires and as a result, the repair work is completed much sooner without disrupting other dispatch staff from their specific duties.

This change in reporting procedures has not been implemented in the Energex OPM as the manual assumes that details such as reporting procedures are stipulated in documented Work Instructions, which are distributed to applicable personnel such as field staff and Control Centre staff.

Recommendation 4 (page 49)

I recommend that the Queensland Police Service, Office of Fair and Safe Work Queensland and electricity entities consult and develop a shared understanding of their respective priorities and procedures to enhance the process of scene preservation and the identification and collection of evidence at fatal incidents involving electrical supply networks.

I also recommend that the Queensland Police Service, Work Health and Safety Queensland and the Electrical Safety Office continue education of their personnel about the importance of early initial contact and consultation between their agencies to promote effective investigation.

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

A Memorandum of Understanding (MOU) between Workplace Health and Safety Queensland (WHSQ) within the Department of Justice and Attorney-General and the Queensland Police Service (QPS) was finalised in August 2011.

The MOU identifies the respective roles, responsibilities and obligations of QPS officers and Fair and Safe Work Queensland (FSWQ) officers in relation to reporting and investigation of, and attendance at, workplace incidents and electrical incidents. The MOU includes information sharing between WHSQ, the Electrical Safety Office (ESO) and the QPS when conducting enquiries or investigations into the same matter.

The MOU also includes provisions regarding effective scene preservation. These provisions align with protocols that have been established within FSWQ to ensure adequate advice is provided to anyone who is said to hold an obligation under the *Workplace Health and Safety Act 1995* (such as an employer, worker, supplier etc) about scene preservation following a fatality at a workplace. Advice regarding scene preservation is an element of the work done nationally to achieve consistent triaging of incident notification and workplace health and safety complaints. The national incident notification and complaint triaging model was implemented in Queensland in January 2012.

Education Training Command within the QPS has also been advised of the coronial recommendation and is continuing to review and provide relevant training regarding electrical incidents to police recruits, as well as providing ongoing education of sworn police officers through updated education books.

The QPS' Operational Procedures Manual (OPM) has been reviewed with the only amendment to be made is reference to the MOU. The OPM is currently being updated and is expected to be published in late 2012.

Upon publication of the OPM, the QPS Forensic Services Branch will be provided with a copy of the MOU. Additionally, the QPS will provide WHSQ with a copy of section 8.5.6 of the OPM, 'Workplace or electrical incidents causing or likely to

cause grievous bodily harm or death'. WHSQ will consider this with a view to adapting WHSQ training manuals.

Comment (page 49)

"The witnesses from OFSWQ… should be commended for their frankness and assistance to the Inquest… they all impressed as anxious to use the lessons learned in this matter to improve the response of their agencies in the future with a view to preventing deaths in similar circumstances. With a view to assisting that process, I make the following recommendations focussed on assisting their current review of the investigation of Type 1 electrical incidents."

Recommendation 5a (page 50)

I recommend that OFSWQ include in their review consideration of reassessing lead agency allocation of an electrical incident to the ESO when that incident occurs in a 'workplace' or non-domestic premises but does not involve work-related activity.

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

In May 2011, at the request of Workplace Health and Safety Queensland (WHSQ) and the Electrical Safety Office (ESO), Fair and Safe Work Queensland (FSWQ) commenced a review of its responsibility for investigation of electrical incidents. The objective of the review was to consider the responsibilities of each of the agencies for investigating workplace deaths and serious incidents caused directly by electricity or originating from electricity.

Changes have been made to the 'Operational Policy for the Investigation of Electrical Incidents by WHSQ and the ESO' which provides investigation allocation criteria to determine which agency will be responsible for leading the investigation and management of the matter. These changes include the ESO being the responsible agency for incidents that occur at a place or non-domestic premises but does not involve a work activity. The amended procedure came into effect in September 2012.

Recommendation 5b (page 50)

I recommend that OFSWQ include in their review consideration of including in the operational policy a requirement for a broader focus of investigations confined not simply to whether a breach has occurred but whether there are broader preventative measures that might be recommended.

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

This incident occurred prior to the implementation of the Workplace Investigations Governance Group. This group was established in 2009 to contribute to more effective outcomes from enforcement activity, particularly investigations. This process enables Fair and Safe Work Queensland (FSWQ) to contribute constructively to coronial investigations, and allows FSWQ to consider related programs already implemented or organisational actions being taken to address key issues identified from an investigation. The Workplace Investigations Governance Group considers each fatality investigation with a view to identifying and implementing actions to prevent or minimise similar incidents in the future.

Further, in 2009 Workplace Health and Safety Queensland (WHSQ) implemented the Incident Cause Analysis Method which is a causal analysis system that effectively and efficiently supports investigatory and regulatory processes. This method identifies all contributing factors to an incident and uses practical tools for examining incident causes with a focus on systematic health, safety and environmental deficiencies.

In 2010, the Electrical Safety Office (ESO) initiated a Fatality Review Committee to look at the probable cause of suspected electrical fatalities in the workplace and the community generally. This committee has now considered a number of fatalities and made numerous recommendations to the ESO regarding additional educational, legislative and compliance activities which may serve to prevent such fatalities from occurring in the future. The committee's reports have been forwarded to various coroners for their consideration and the implementation of recommendations in these reports is monitored by the committee.

Recommendation 5c (page 50)

I recommend that OFSWQ include in their review clarification of how investigators should consider and verify investigative reports completed by other agencies (including electrical entities), including how investigators can access independent advice.

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

Workplace Health and Safety Queensland and the Electrical Safety Office support this recommendation and have convened a working group to research the methods engaged by other regulatory agencies, both within Queensland and interstate for the use of report prepared by other agencies and accessing independent advice during investigations.

It is envisaged that this process will be completed by the end of 2012.

Recommendation 5d (page 50)

I recommend that OFSWQ include in their review consideration to improving documentation of investigations including the basis on which decisions are made.

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

Workplace Health and Safety Queensland (WHSQ) is currently conducting an independent review, the 'Investigations Review Project' with a view to effectively positioning its resources and processes and ensuring that WHSQ inspectors are best placed to respond to the investigative requirements under the *Work Health and Safety Act 2011*. The adequacy of WHSQ's current investigation documentation is being considered as a part of this project. This includes a working group that is examining the current investigation templates as well as documentation, case management and decision making processes utilised by WHSQ when conducting investigations. This working group will consult with the Electrical Safety Office with a view to implementing standard processes and templates across the agencies.

The established working group has commenced implementing changes from this review. It is anticipated that all changes will be effected by the end of 2012.

Recommendation 5e (page 50)

I recommend that OFSWQ include in their review consideration of ways to improve collaboration between ESO and WHSQ, including assessing whether organisational culture may impede that collaboration.

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

Both Workplace Health and Safety Queensland and the Electrical Safety Office are committed to enhancing collaboration between the agencies. The 'Operational Policy for the Investigation of Electrical Incidents by Workplace Health and Safety Queensland and the Electrical Safety Office' has been amended to support this recommendation.

Recommendations profiled in the *Queensland Government's Response to Coronial Recommendations 2010*

The following recommendations appeared in the *Queensland Government's response to coronial recommendations 2010*. 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 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 delivered her 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 partially completed
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.

In response to Vehicle Operations Management within the Department of Transport and Main Roads request, the National Transport Commission has included issues concerning lighting glare associated with delineation for oversized loads being on the Commission's forward research work program.

Any changes to heavy vehicle lighting will have to be agreed to by all state and territory vehicle standards jurisdictions.

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 Centre 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 his findings on 9 July 2010.

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 Corrective Services Investigation Unit officers with the proviso that any information provided cannot be used against them in criminal or disciplinary proceedings.

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

On 11 July 2011, the Department of Community Safety referred to the Queensland Police Service (QPS) the issue of whether to enhance powers under the *Police Powers and Responsibilities Act 2000* to compel prisoners or corrective services officers to provide self-incriminating information to the QPS' Corrective Services Investigation Unit investigators during coronial investigations.

In June 2012, the QPS declined to seek an extension of existing powers. Therefore, Queensland Corrective Services will consider amending the *Corrective Services Act 2006* (the Act) to address this recommendation as a part of its statutory review. The review of the Act is expected to be finalised by August 2013.

Please note: This publication was produced prior to the current government.