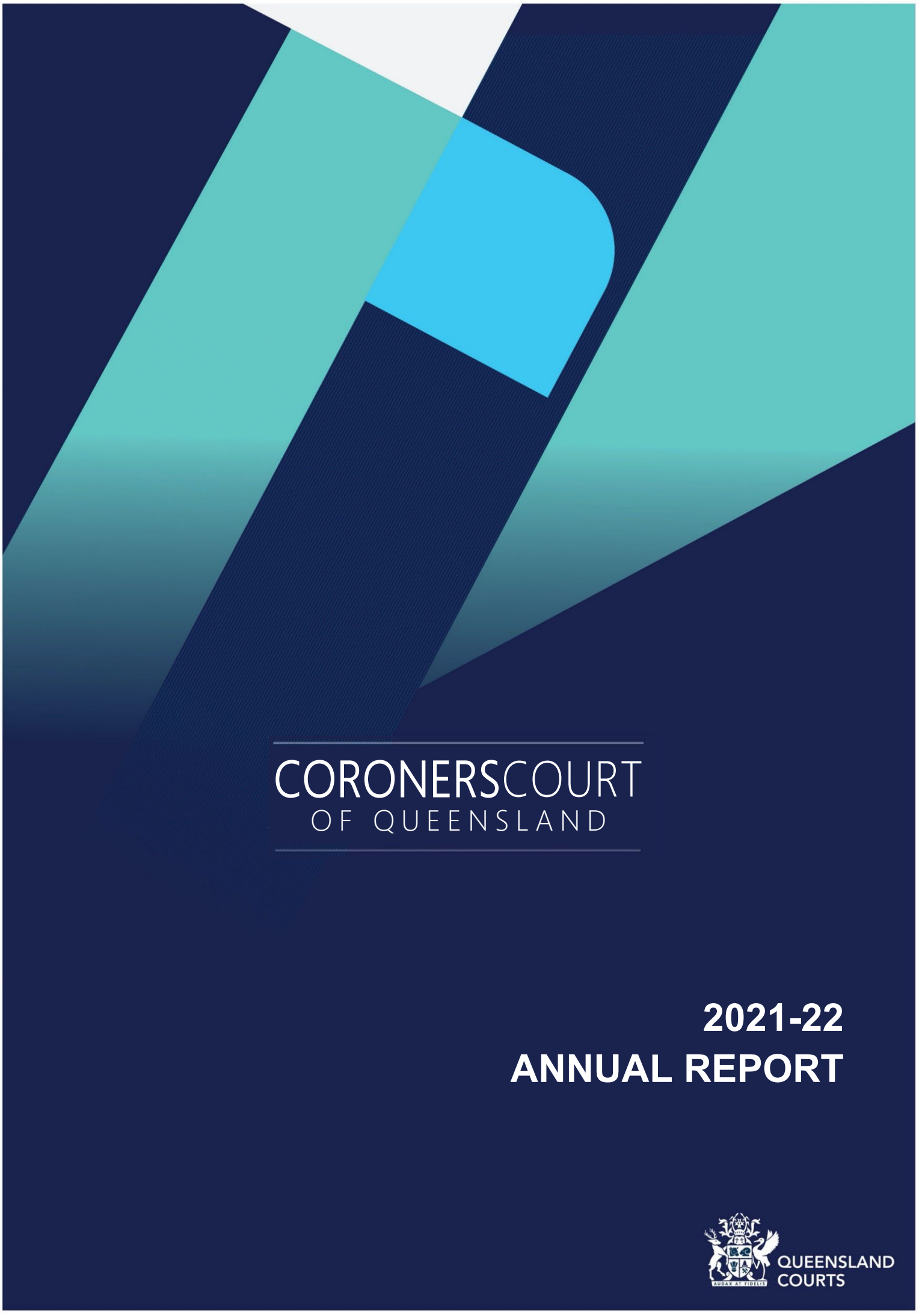


2021-22
ANNUAL REPORT

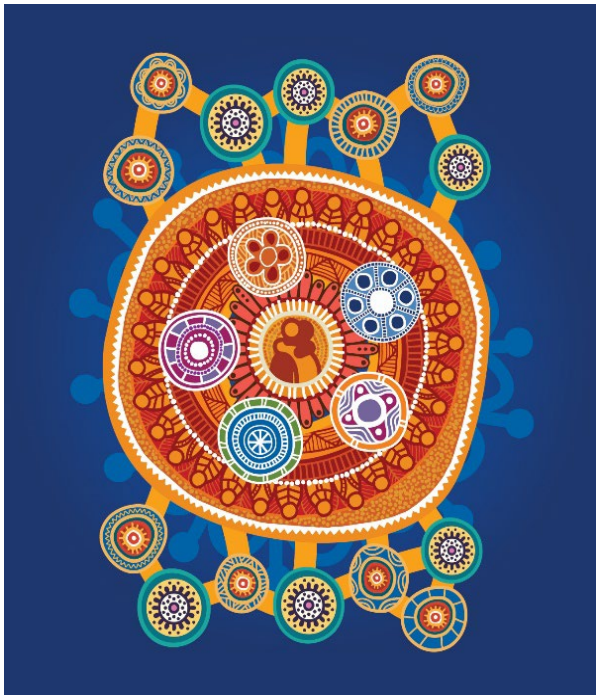
QUEENSLAND COURTS

The coronial system is underpinned by a shared understanding that society values and protects the life of every person.

We appreciate that each death brings sadness, disruption, and trauma to the families of those who are entrusted to our care.

When someone we love dies suddenly or in a way that is unexplained or unexpected, those feelings are magnified.

To the families and friends grieving the death of a loved one, we are ever mindful of your loss.



Acknowledgement of Country

The Coroners Court of Queensland acknowledges the Traditional Owners and Custodians of the lands across the State of Queensland. The Court pays respect to Elders past, present, and emerging. We value the culture, traditions and contributions that First Nations people have contributed to our communities, and recognise our collective responsibility as government, communities and individuals to ensure equality, recognition and advancement of First Nations Queenslanders in every aspect of our society.

13 October 2022

The Honourable Shannon Fentiman MP
Attorney-General and Minister for Justice
Minister for Women
and Minister for the Prevention of Domestic and Family Violence
GPO Box 149
BRISBANE QLD 4000

Dear Attorney-General

In accordance with section 77 of the *Coroners Act 2003*, I am pleased to present the Coroners Court of Queensland Annual Report for the year ended 30 June 2022.

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

During the reporting period the State Coroner's Guidelines were reviewed and updated in relation to *Chapter 6: Release of bodies for burial or cremation*, specifically directed at ensuring families are kept informed where further testing of remains is carried out in criminal proceedings under s590ASA of the Criminal Code.

The guidelines are publicly available at: https://www.courts.qld.gov.au/courts/coroners-court.

No directions were given during the reporting period under section 14 of the Act.

Yours sincerely

Terry Ryan
State Coroner

WARNING: Please be advised some content in this report may be distressing to readers. First Nations people are advised that this report contains the names of people who have passed away.

Purpose

The Coroners Court of Queensland Annual Report provides information about the Court's structure and operations as well as financial and non-financial performance measures for the period 1 July 2021 to 30 June 2022. The report has been prepared in accordance with the requirements of the *Coroners Act 2003*. This report is accessible online at: Publications Queensland Courts

Data

Please note: Content presented in this report was correct at the time of publication. Data provided is obtained from the Coroners Case Management System (CCMS).

CCMS is a "live" operational database in which records are updated as the status of coronial investigations change and/or input errors are detected and rectified. This constant updating and data verification may result in a slight variance of figures over time.

Enquiries

If you have any questions about this report, please contact:

Coroners Court of Queensland
GPO Box 1649
Brisbane QLD 4001
Telephone: (07) 3738 7050
Email: state.coroner@justice.qld.gov.au.

For further information about the Coroners Court of Queensland, please visit our website: Coroners Court | Queensland Courts.

Feedback

The Coroners Court of Queensland values your feedback on this report. Any comments can be provided through the *Get Involved* website: Your say | Queensland Government (getinvolved.qld.gov.au).

Interpreter

The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on telephone (07) 3738 7050 and we will arrange an interpreter to effectively communicate the report to you.

Contents

2021–22: IN REVIEW

Performance measures - cases

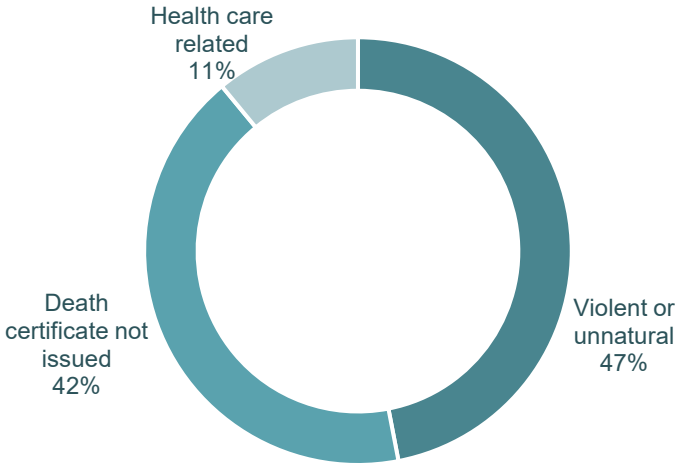
6,044 cases lodged

6,115 cases finalised

101.2% clearance rate

14.82% backlog indicator

Reportable Type

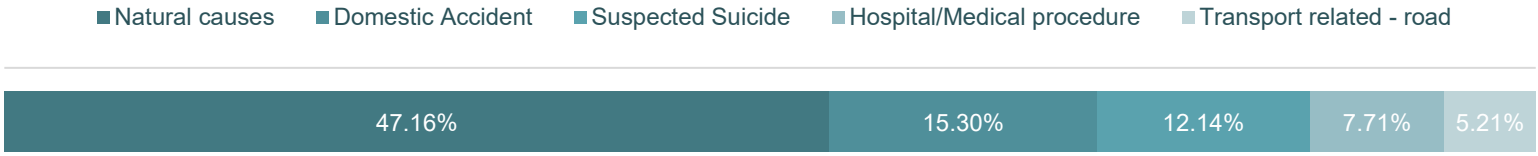


Timeframes

146 average days to finalise case

85.04% cases finalised in less than 12 months

Death Type



Inquests and Recommendations

27 inquests finalised

35 deaths investigated at inquest

5 joint inquests finalised

35 recommendations made

*Primary Reportable (refers to top three reported) and Death Type (refers to top five reported). The totals may be different from cases lodged as multiple can be selected.

State Coroner's Overview

I am pleased to present the Annual Report on the operation of the *Coroners Act 2003* for the financial year 2021-22.

The coronavirus pandemic continued to affect the work of the court. As a consequence of the increase in the number of COVID-19 deaths in the community, more deaths of this nature flowed through to the court, reported as potential health care-related deaths, or deaths where medical practitioners were not in a position to issue a cause of death certificate.

Despite the record number of deaths reported, the court was able to maintain a clearance rate over 100% for the fourth consecutive year. The court was also able to reduce the average number of days taken to finalise cases from 169 to 144. Despite the significant increase in lodgements the court's backlog indicator only marginally increased to 14.82%. Over half of the cases in the backlog are awaiting criminal proceedings or are the subject of an inquest. The overall number of cases pending declined by 2.85%.

Any consideration of the backlog must take into account that the number of deaths reported to the court has continued to increase. The number of deaths reported in 2021-22 (6044) was 27% higher than in 2012-13 (4762). However, the number of judicial officers allocated to the court has not increased at the same rate. The number of full-time coroners has not increased since the appointment of the Central Coroner in August 2012.

In addition, while clearance rates are one measure of court performance, they do not reflect the complexity of the work involved in finalising matters or the quality of coronial investigations. The increase in the number of deaths reported has arguably also contributed to a reduction in the number of inquests held. For example, in 2012-13 there were 66 inquests finalised compared to 27 in 2021-22. This reflects the reduced capacity of coroners to undertake more detailed work as they respond to increasing numbers of complex cases.

I am grateful for the allocation of additional resources to the court. This has included temporary funding for an additional coroner in the last two budgets to support the investigation of domestic and family violence related deaths. Additional registry staff have also been funded to respond to the increasing number of apparent natural cause and health care related deaths reported to the court. However, consideration should be given to undertaking a benchmarking exercise with comparable jurisdictions to develop a sustainable resourcing model for the court.

The work of the Coronial System Board lost some momentum during 2021-22 due to the departure of key personnel and the redirection of agency resources to the COVID-19 response. I anticipate that during 2022-23 the Board will finalise a Coronial System Backlog Reduction Strategy and the Coronial System Family Engagement Strategy.

I thank Deputy State Coroner Jane Bentley for her support during over two years in that role to April 2022. In addition to managing a busy investigations load, Magistrate Bentley assisted with the administration of the coronial system as Chair of the Coronial System Coordination Group. She also had carriage of several high profile inquests which increased community awareness of coercive control in domestic violence relationships and recommended enhanced police responses to those matters.

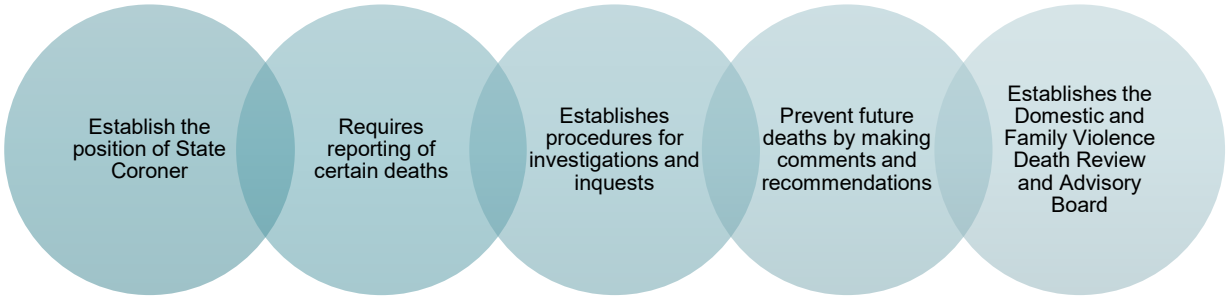
I also extend my thanks to my fellow coroners, the coronial registrars, and the dedicated and skilled legal and administrative staff of the court, led by the Director of the Coroners Court, Raelene Speers. Together with our partner agencies including the Coronial Support Unit in the Queensland Police Service and Queensland Health Forensic and Scientific Services, their contributions are critical to the work of the Queensland Coronial System in providing independent, family centred and timely death investigations.

Our Court

The Coroners Court of Queensland (CCQ) provides Queenslanders with a consistent and coordinated system to investigate deaths that are sudden or unexpected or occur in custody, police operations, or in care.

Our jurisdiction

Not all deaths that occur in Queensland are reportable; only those considered to warrant scrutiny by virtue of the nature of the incident that triggered the death or due to the deceased person's particular vulnerability are reportable and investigated. Coroners and registrars are responsible for determining whether a death referred is reportable or not. Queensland's coronial jurisdiction operates in accordance with the functions outlined the *Coroners Act 2003* (Coroners Act). Broadly, the Coroners Act provides for a coronial system and other purposes as represented below:



Our purpose

Once a death is reported the process of investigating the circumstances of the death commences. Coroners are required to establish (if possible) who the deceased person was, when, where, and how they died, and the medical cause of the death. A coronial investigation is an independent, impartial, open, and transparent inquisitorial process. The investigation provides answers to families and informs the community about death prevention. It is not the role of a coroner to find people guilty of criminal or civil offences.

Our commitment

Where an inquest is held coroners consider whether the death may have been preventable. Coroners can make comments and recommendations about systemic or policy or procedural changes that could contribute to improvements in public health and safety, or the administration of justice, or prevent or reduce similar deaths in future. Coroners are prohibited from making a finding that someone be held criminally or civilly liable for a death.

Our Vision:

Coronial services that partner to deliver independent, family-centred, and timely investigations

Our interconnected system

The coronial jurisdiction is multidisciplinary supported by our two key partner agencies that each has specialist skills and expertise applying at different stages in the coronial process. Coronial services operate as an interconnected and interdependent system.

Coroners Court (CCQ)

The CCQ sits within the Magistrates Courts Service and supports the State Coroner's statutory function to administer and manage a coordinated state-wide coronial system in Queensland. The CCQ provides registry, administrative and legal support to coroners and registrars across the State. The CCQ is also a central point of contact for families about coronial matters. We aim to deliver family-focused services and are always working towards improving how we engage and support bereaved families, our stakeholders, and our coroners. The CCQ also administers the burials assistance scheme and manages government undertaker contracts for burial assistance coronial conveyance services.

Queensland Police Service (QPS)

QPS officers attend the scene of the death and obtain information from family, friends and witnesses and assist during a coronial investigation. Management of coronial processes on a state-wide basis within the QPS is coordinated by the Coronial Support Unit (CSU). CSU officers are co-located within most CCQ offices and at the Coopers Plains mortuary, where they attend autopsies and liaise with forensic pathologists and mortuary staff. The Disaster Victim Identification Squad is also part of the CSU and are responsible for the removal and identification of deceased persons from mass fatalities, air, and natural disasters.

Queensland Health (QH)

QH Forensic and Scientific Services (QHFSS) provide coronial mortuary, forensic pathology and toxicology and coronial nursing services for cases delivered out of the QHFSS complex in Brisbane. Coronial autopsies are performed in QHFSS mortuaries which are located in Brisbane (Coopers Plains), Gold Coast University Hospital, Toowoomba Hospital, Rockhampton Hospital, Townsville Hospital and Cairns Hospital.

Coronial Family Services, also based in Brisbane provide information and counselling support to relatives of deceased, work through objections to autopsies, organ and tissue retention and inform families of postmortem examination findings.

Forensic Medicine Officers (FMO) within the Clinical Forensic Medicine Unit (CFMU) based in Brisbane provide independent clinical advisory services, including toxicology interpretation, expert opinions and advice about issues requiring further investigation. The Gold Coast Forensic Medicine Team based in Southport assists the Southeastern Coroner as the CFMU does.

Our Coroners

Queensland has seven specialist coroners located across the State in Southport, Brisbane, Mackay, and Cairns.

State Coroner – Terry Ryan

State Coroner Terry Ryan was appointed as a magistrate and as State Coroner in July 2013. After being admitted as a solicitor in 1991, he worked in private practice before returning to the Queensland Government where he commenced his career in 1984 as a social worker in the fields of child protection and youth justice. Magistrate Ryan holds a Bachelor of Social Work, Bachelor of Laws (Hons), Master of Laws and a Graduate Diploma in Legal Practice.

In the period 2001 to 2010 Magistrate Ryan served as the Director of the Strategic Policy Unit and Assistant Director-General, Strategic Policy, Legal and Executive Services in the Department of Justice and Attorney-General (DJAG). From 2010 up until his commencement with the Coroners Court, Magistrate Ryan was the Deputy Director-General of DJAG. Magistrate Ryan is the Chair of the Domestic and Family Violence Death Review and Advisory Board. He is also the current President of the Asia-Pacific Coroners Society.

Deputy State Coroner and Southeastern Coroner – Jane Bentley

Magistrate Bentley commenced her legal career at Legal Aid Queensland (formerly known as the Public Defenders Office. She holds a Bachelor of Laws (Honours). In 1994 she was admitted as a barrister of the Supreme Court. From 1996 to 1999 Magistrate Bentley worked within the QPS as a legal officer before commencing with the National Crime Authority up until 2001. In April 2010 Magistrate Bentley was appointed to the Magistrates Court of Queensland and held the position of Northern Coroner within the Coroners Court in the period 2013 to 2014. On 20 March 2020 she was appointed as the Deputy State Coroner. In April 2022 Magistrate Bentley resigned as Deputy State Coroner and returned to the general magistracy in Southport.

Deputy State Coroner – Stephanie Gallagher

Magistrate Gallagher was appointed as a Magistrate on 29 July 2021 and commenced in the role of Brisbane Coroner on 2 August 2021. On 23 May 2022, Magistrate Gallagher was appointed to the role of Deputy State Coroner. Magistrate Gallagher has more than 30 years' experience as a solicitor and barrister with specialisation in the regulation of the health professions, medical and health-related litigation and policy, mediations, guardianship matters, special health matters and coronial inquiries. She was Chair of the Queensland Interim Medical Board in Queensland (QMING) for approximately one year, the chair of the Professional Standards Committee of the Nursing Council for 7 years and sat on the Boards of St Andrew's War Memorial and QEII Hospitals. She also sat as a member of Institutional Ethics Committees at tertiary hospitals for more than 15 years. Magistrate Gallagher is an Adjunct Associate Professor in the School of Applied Psychology at Griffith University.

Brisbane Coroner – Christine Clements

Prior to commencing in the Magistrates Court of Queensland, Magistrate Clements was responsible for the Bundaberg Legal Aid Office and worked as a barrister and solicitor in private practice in South Australia since her admission in 1980. Magistrate Clements was appointed as magistrate in 2000 and has worked exclusively in the coronial jurisdiction since 2002 when she was appointed as a coroner. Magistrate Clements was the inaugural Deputy State Coroner, holding the position from 2003 for 10 years. In December 2013 Magistrate Clements was appointed as a Brisbane Coroner.

Brisbane Coroner - Don MacKenzie

Don MacKenzie has worked within the Criminal Justice System for over 30 years, commencing as a law clerk in the Public Defenders Office in 1990. He holds a Master of Laws, a Bachelor of Arts and a Graduate Diploma of Military Justice. He was admitted as a Barrister in 1993, spending 5 years working for the Legal Aid Office and 14 years at the Office of the Director of Public Prosecutions (Qld), rising to the positions of Senior Crown Prosecutor then Consultant Crown Prosecutor. In 2008, Don MacKenzie joined the private Bar, practising as a member of More Chambers in Brisbane. Mr MacKenzie estimates that he has prosecuted or defended well over 800 jury trials (including dozens of murder trials), has appeared on hundreds of Court of Appeal matters and as sole counsel in the High Court of Australia. He is also an officer in the Royal Australian Navy with the Inspector-General Australian Defence Force and held the statutory appointment as the Chairman, Public Records Review Committee of Queensland before his appointment as a Magistrate in 2017 and Coroner in 2019. He has regularly appeared as a guest lecturer on criminal law and evidence for the Queensland Law Society and at the University of Queensland and is the senior editor of the Thomson's loose-leaf publication Summary Offences Queensland.

Northern Coroner – Nerida Wilson

Magistrate Wilson was appointed as a Magistrate in 2015 and instated as the Northern Coroner for Queensland in 2017. Magistrate Wilson is based in Cairns. Magistrate Wilson served as an Australian Federal Police Officer from 1987 until 1995 thereafter completing her degree and practising as a solicitor. She was called to the Bar in 2008 until her appointment as a Magistrate. Magistrate Wilson was conferred the Queensland Regional Woman Lawyer of the Year award by the Women Lawyers Association of Queensland in 2013. Magistrate Wilson was one of 45 women lawyers selected from across Australia to participate in the "Trailblazing Women and the Law" oral history project now archived in the National Library of Australia.

Southeastern Coroner – Carol Lee

Magistrate Lee was appointed as the Southeastern Coroner on 23 May 2022 and is based in Southport. Magistrate Lee has had extensive experience representing parties at coronial investigations and inquests. Magistrate Lee holds a Bachelor of Laws degree after having obtained qualifications as a registered nurse; Magistrate Lee has extensive clinical experience in the Queensland public hospital system and the multifaceted environment in which the health sector operates. Magistrate Lee has held a number of senior positions including special counsel, partner, and consultant in a number of leading law firms, where she specialised in the field of health law. Magistrate Lee has also served as a legal member of the Queensland Mental Health Review Tribunal, the Chiropractors and Osteopaths Board of Queensland, the West Moreton Human Research and Ethics Committee, General Practice Training Queensland and Acting Ordinary Member of the Queensland Civil and Administrative Tribunal. Magistrate Lee has also undertaken nationally accredited mediation training and has been awarded Best Lawyer status in the fields of Health and Aged Care and Medical Negligence for the past 10 years.

Central Coroner – David O'Connell

In 1991 Magistrate O'Connell was admitted as a solicitor of the Supreme Court of Queensland and in 1994 to the High Court of Australia. He holds a Bachelor of Laws, Graduate Diploma in Taxation and Master of Business Administration. Magistrate O'Connell was appointed to the Magistrates Court of Queensland and to the position of Central Coroner in August 2012. Magistrate O'Connell is based in Mackay.

Brisbane Coroner – Christine Roney

Magistrate Roney is a long serving Magistrate who has worked in a number of Brisbane and suburban courts, Longreach and the Southport Courts. Previously she has also been commissioned as a member of QCAT, a commissioner at the Industrial Commission and is a former Chair of the Veterinary Surgeons Disciplinary Tribunal. During 2021-22, the Chief Magistrate continued to allocate Magistrate Roney to work in the coronial jurisdiction on a part-time basis.

Our Registrars

The Coronial Registrars based in Brisbane triage deaths from an apparent natural cause, review potentially reportable deaths and provide telephone advice to clinicians about whether to issue a cause of death certificate. The registrars operate under a delegation from the State Coroner to manage these matters.

Coronial Registrar – Ainslie Kirkegaard

Ainslie Kirkegaard is the inaugural Coronial Registrar of the Coroners Court of Queensland. This is a unique judicial registrar role designed to triage deaths reported daily across Queensland. Ainslie has held this role since early 2012 and previously held the positions of Counsel Assisting the Deputy State Coroner and Director, Office of the State Coroner. Ainslie became a part of the Queensland coronial system in 2008, bringing more than 15 years' experience in policy and legislation development in the health, education, and justice portfolios, with specialist expertise in coronial and health regulatory law and policy. Having been appointed as an Acting Magistrate since April 2015, Ainslie now also relieves as coroner when required.

Coronial Registrar – Jessica Lambert

Jessica Lambert was appointed as Coronial Registrar on 16 September 2021. Prior to her appointment as Coronial Registrar, Jessica held the quasi-judicial appointments of Supreme and District Court Corporations Registrar and Deputy Admiralty Marshal. Admitted as a Legal Practitioner since 2006, she has held various positions at the State ODPP and within QUT Law School. Jessica is currently a Member appointed to multiple committees including FSS Human Ethics and QLS Dispute Resolution & Government Lawyers Committees. Her civil expertise sees her as a co-author of Thomson Reuters Publication Queensland Civil Procedure while her interest in broader social issues is reflected in her pro bono work at Refugee and Immigration Legal Service. As QLS Nationally Accredited Mediator, Jessica is also an inaugural Member of the Commonwealth Department of Health's National Sports Tribunal and the Commonwealth Games Nomination and Selection Disputes Panel.

Our Governance and Structure

Under the leadership of Director, Ms Raelene Speers, the **CCQ employed 65 team members** as of 30 June 2022. The Court is comprised of positions ranging from the Administrative Officer (AO) level to the Senior Officer (SO) level, as well as staff in the Professional Officer (PO) stream. Members of the CCQ are aligned to one of five streams which are each led by a senior manager (either AO8, PO6 or SO).

Business Services: Supports the corporate governance and operation of the Court through finance, information technology, data collation, communications, information release, human resources, burials assistance and contract management functions.

Operations: Eight team-based coronial teams who work closely with coroners and registrars and liaise with families and other stakeholders to case manage coronial investigations and progress matters to inquest. There are three Coronial Support Coordinators who provide management support based on regional location and/or team.

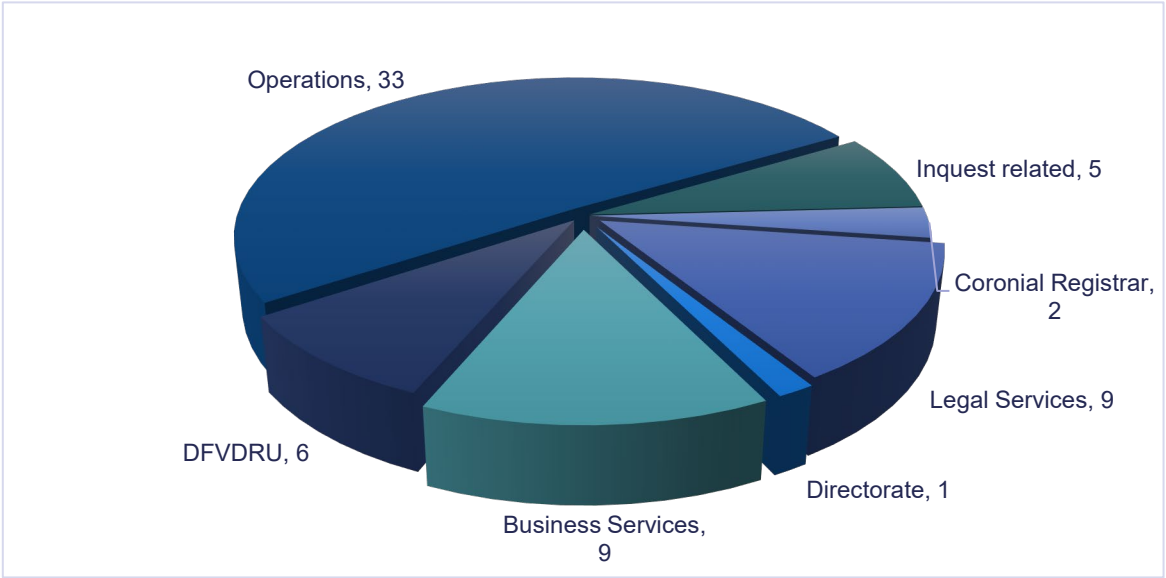
Domestic and Family Violence Death Review Unit: Provides specialist advice and assistance to coroners in their investigation of domestic and family violence related homicides and suicides as well as deaths of children who were known to the child protection system prior to the death. The unit also provides secretariat support to the Domestic and Family Violence Death Review and Advisory Board.

Legal Services: In-house lawyers (known as counsel assisting) assist coroners in their investigations by providing legal advice on case files, preparing matters for inquest, as well as appearing as counsel assisting at inquests.

Directorate: Comprises of the Director of the CCQ responsible for the strategic leadership, governance and accountability of the registry and the Executive Support Officer who supports both the Director and State Coroner.

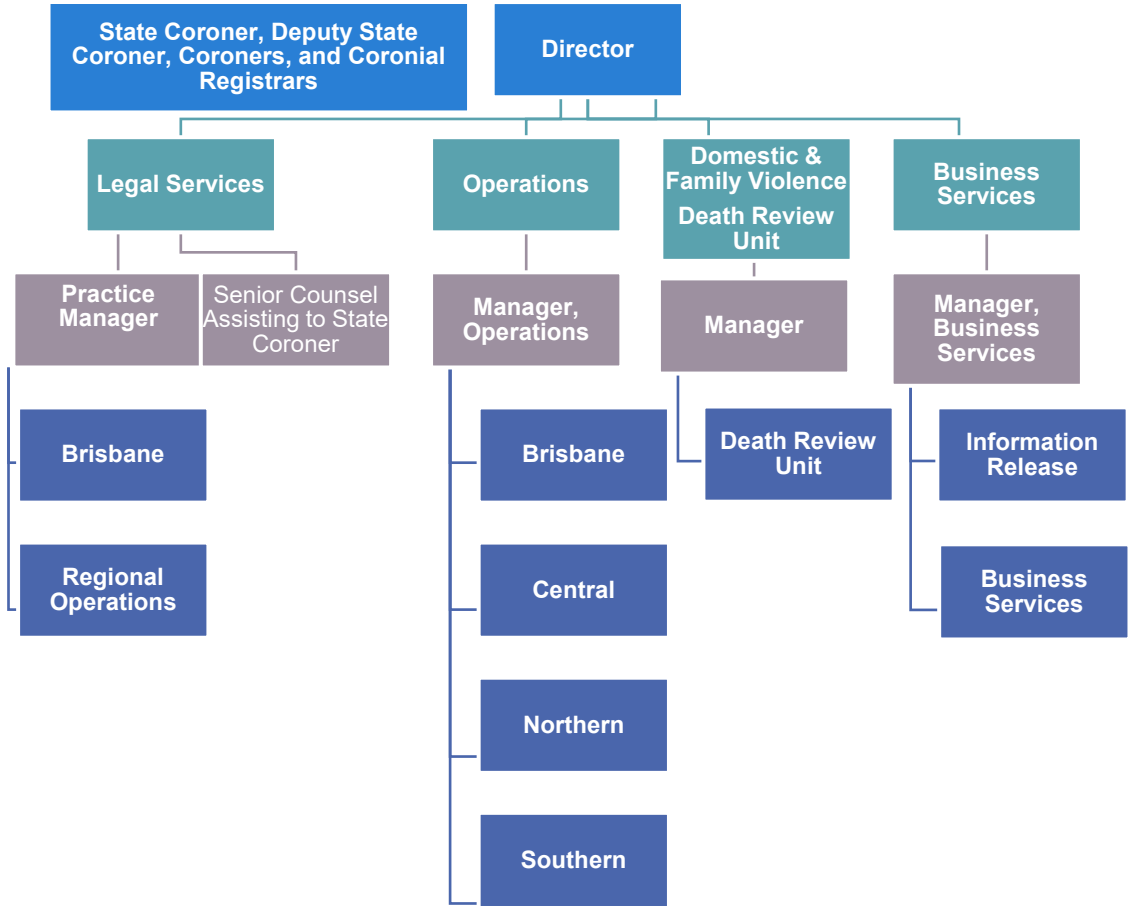
The figures depicted in the workplace profile chart do not reflect funded or actual full-time equivalent (FTE) positions allocated to the court. During the reporting period the **CCQ only funded 49.81 FTE positions** with the remainder of positions managed by temporary funding and those allocated as part of the government budget outcomes, for 'inquest related' purposes, namely the Whiskey Au Go Go and Clarke/Baxter matters. The two coronial registrar positions while captured in the establishment are not managed by the registry and report directly to the State Coroner.

Figure 1 – Workforce profile



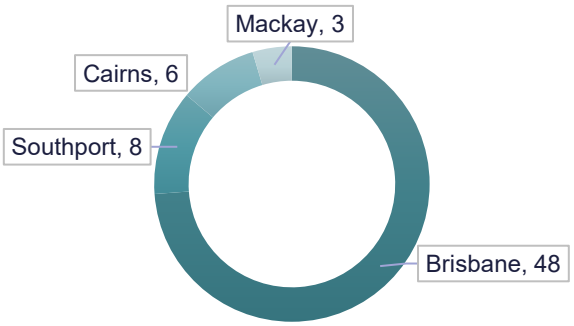
Senior Leadership Team: consisting of the Director and a senior manager from each stream, meets regularly to raise and examine any issues arising within the investigative and business functions of the Court; reviews court policies and procedures to ensure continued effectiveness; identifies training and professional development needs of court staff; discusses workload issues and progresses major projects. The Senior Leadership organisational structure is depicted below.

Figure 2 – Senior Leadership organisational structure



Registry profile: Court employees are located within one of four regional registry locations, either in Brisbane, Southport, Mackay or Cairns and work in a team-based structure to support coronial investigations and/or the administrative functions of the Court.

Figure 3 – Workforce registry location



Reforming our coronial system

Over the past three reporting periods the coronial system has been responding to the challenges and recommendations identified in the Queensland Audit Office (QAO) report[1]. The audit assessed the performance of the three key agencies involved in delivering coronial services and the support provided by these agencies to coroners and families. The audit report identified the coronial system is complex and under stress and highlighted reforms to improve the system. The report has been instructive in focusing improvements on priority areas to deliver real change, resulting in better coronial system coordination between partner agencies and sustainability.

Coronial Services System Delivery Framework 2021-2025

A key sustainability action has been the development of the Coronial Services System Delivery Framework 2021- 2025[2] (the Framework). This is an important system planning document, providing a strategic framework for multidisciplinary coronial services delivery to ensure family focus, sustainability, and performance. The framework released in September 2021 was developed through a series of strategic conversations and cross-agency workshops and explains the partnership approach that underpins the coronial system and sets out its vision, purpose, and partnership principles. The Framework provides the overarching strategic charter for agencies delivering coronial services with its aim of facilitating a co-ordinated system putting families at its centre.

Coronial System Board

The establishment of the Coronial System Board (the Board) in July 2021 was another step forward in the transformation of Queensland's coronial system through greater coordination and planning to deliver family centred services. Chaired by the State Coroner, membership consists of senior leaders from the DJAG, QH, and the QPS and met three times during the reporting period. The Board provides strategic direction, enhance partner collaboration, innovation, and performance, and will drive implementation priority actions within the Coronial Services Delivery Framework over the next five years with the Coronial System Coordination Group.

Coronial System Coordination Group

In August 2021 the Coronial System Coordination Group (the Group) met for the first time. Chaired by the Deputy State Coroner, with membership is from senior departmental officers from partner agencies, it will operationalise the Board's priorities to deliver improved services to families and the community.

The main focus of the Group is to implement priority actions that extend on the current reforms and complete the open audit office recommendations. **The achievements and priorities for the Group during the 2021-22 period included:**

- Achievement of full automation of the Form 1 – police report of a death to a coroner – *to achieve efficiencies in death reporting through integration of agency IT systems.*

- Implement phase one of the QH led *Regional Coronial Services Plan* – to optimise opportunities for enhancing coronial services across regional Queensland – *to achieve sustainable autopsy services in Far North Queensland, strengthen arrangements to enable more preliminary examinations to be performed in regional areas (with fewer deceased transfers) and better access to coronial counselling and regional support.*

[1] Delivering Coronial Services – Report 6: 2018-19 - https://www.qao.qld.gov.au/reports-resources/delivering-coronial-services
[2] Coronial Services Delivery Framework - https://www.courts.qld.gov.au/__data/assets/pdf_file/0003/692301/ccq-delivery-framework-2021-2025.pdf

- Embed permanency of Apparent Natural Causes (ANC) death triaging including the development of interagency business process maps. A final draft circulated for endorsement by partner agencies during the period – *to inform and achieve improved oversight and quality assurance of death reporting, appropriate issuing of cause of death certificates, reduce the number of not-reportable deaths entering the coronial system by joint-agency triage*

- Build on initial planning to enhance reporting and triaging of health care related deaths – *including guidelines, protocols, roles, responsibilities, and timeframes*

- A draft Coronial System Backlog Reduction Strategy 2022-25 - formalise a backlog strategy based on collaborative interagency approaches to reduce the number of pending cases – *to achieve efficient and effective death investigations, a shared responsibility for system performance and monitoring and data to understand the case profile of backlog matters to identify strategies to address particular investigations. A target of 10% has been set for cases older than 24 months in 2022-2023 financial year.*

- Development of a draft Coronial System Family Engagement Strategy which focuses on strengthening family engagement in coronial services through adopting a family centred, culturally appropriate, trauma aware approach to service delivery - *to achieve timely and compassionate family notifications and death scene investigations and strengthened family liaison*

Investment in coronial services

Government has supported and invested in coronial services over the last few years to support reform and renewal activities and to progress domestic and family violence death investigations.

As part of the 2021-22 Budget, the Department of Justice and Attorney-General was allocated recurrent funding of $2.776 M and permanent FTE for seven positions and one temporary FTE in the Coroners Court

Specifically, this investment to deliver a more effective, efficient and sustainable coronial system included:

- $1.011 M of recurrent funding and seven permanent FTE for the Coroners Court of Queensland to maintain reform improvements, and to support case management practices to continue strengthening Queensland's coronial system, including:
    - $0.381 M recurrent funding and three permanent FTEs for the establishment of the second coronial registrar team; and
    - $0.630 M recurrent funding and four permanent FTEs to continue strengthened case management functions.
- $0.143 M and one temporary FTE to continue the enhanced contract management of government undertakers, with the department to report back to government at the end of reporting period for an evaluation of the role
- $1.422 M (one-off funding) to support the investigation and inquest into the deaths of Hannah Clarke and her three children
- $0.200 M (one-off funding) for the Coroners Court of Queensland to develop material for staff about building resilience and managing vicarious trauma (carried over into the next reporting period).

Farewell to Magistrate Bentley

During the reporting period, Magistrate Jane Bentley announced her resignation from the position of Deputy State Coroner and returned to the general magistracy in Southport.

Magistrate Bentley first commenced with the Coroners Court in 2012 where she held the Northern Coroner position until December 2014. As Northern Coroner Magistrate Bentley finalised over 1,460 investigations. Of note during this period was the inquest into the death of a woman at Granite Gorge in North Queensland. A decision not to prosecute under the Work Health and Safety Act 2011 was made by the Office of Fair and Safe Work Queensland. During the inquest Magistrate Bentley directed an employee of that Office to answer a question relating to the decision not to prosecute, which was challenged by their legal representatives. The principle established by this case was that a coroner's powers under s 46(1) of the *Coroners Act 2003* are not qualified by some general prohibition upon an investigation of or comment on a decision whether to prosecute someone in connection with the death being investigated[3].

The recommendations made as a result of Magistrate Bentley's inquest into the suspected death Jay Brogden resulted in changes in the way the Queensland Police Service managed missing person files, in particular timeframes for reporting missing persons and scheduled audits of all files held by the Missing Persons Unit to ensure those over 12 months or more have been referred.

The court welcomed Magistrate Bentley back to Coroners Court in March 2020 when she was appointed Deputy State Coroner. In June 2020, Magistrate Bentley finalised the child death inquest of Mason Lee who was 22 months old when he died from injuries severe abuse and neglect. The inquest was held to inform Mason's family and the public how his death occurred and to make recommendations to prevent this type of death from ever happening in future. The Queensland Government's response to the recommendations made by Magistrate Bentley regarding Mason's death were tabled in Parliament on 17 June 2020 and were noted as all being 'accepted.

Following further inquests into suspected deaths, notably Monique Clubb and Tiahleigh Palmer saw further improvements in the way missing person investigations are conducted. Changes as a result of these inquests included clarification of who is responsible for carrying out an investigation and amendments to police operational procedural manuals specifically in relation missing children under the age of 13 years being automatically deemed high risk missing persons.

While Magistrate Bentley presided over a number of high-profile inquests during her time as Deputy State Coroner, she was also instrumental in driving systemwide reforms as a result of the QAO report and was an unwavering support to the registry in developing efficiencies and striving towards excellence in performance. Magistrate Bentleys contribution in this regard were through her commitment to the Coronial System Coordination Group as Chair, as the CCQ Legal Governance Group member and her ongoing engagement with QH and QPS to oversee system reform and provide advice.

Magistrate Bentley's commitment to families in ensuring they were well supported, and investigations were finalised in a timely manner was also at the forefront of her work in the coronial jurisdiction. As Deputy State Coroner, she finalised 693 investigations and over 2000 during both her periods with the court. Towards the end of her tenure as Deputy State Coroner, Magistrate Bentley presided over the high-profile domestic and family violence deaths of Hannah Clarke and her three children and Ms Doreen Langham. The hearings for these matters received nationwide media attention with both inquests examining the appropriateness of responses to any contact by the women with police, domestic violence, and counselling services prior to their deaths. Magistrate Bentley made a number of recommendations directed at the Queensland Government and Queensland Police Service in particular. A summary of those cases follows.

Public interest inquests: Domestic and Family Violence

Addressing Domestic and Family Violence ('DFV') is a matter of great public interest and coronial inquests involving intimate partner homicide have drawn attention to the horrific nature of intimate partner violence and the insidious and far-reaching consequences of acts of DFV in the Queensland community.

The *'Not Now, Not Ever: Putting an End to DFV in Qld report',* released in 2015, included recommendations aimed at improving police officers' understanding of the dynamics of DFV and strengthening options for perpetrator accountability. The report recommended improvements to the criminal investigation and prosecution of perpetrators of DFV; achieving a more pro-active investigation and protection policy; ensuring that arrest is prioritised where a risk assessment indicates the action is appropriate; and improving governance, supervision, and training of police officers in relation to DFV.

In the **inquest into the death of Doreen Gail Langham and Gary Matthew Hely**, the then Deputy State Coroner (Jane Bentley) noted that the circumstances of Ms Langham's death indicated that the QPS had been unable to date, to implement the recommendations arising from the *Not Now, Not Ever report*.

The Domestic and Family Violence Death Review and Advisory Board (DFVDRAB), chaired by the State Coroner, is responsible for the systemic review of DFV deaths in Qld. The establishment of the board was a key recommendation from the "Not Now, Not Ever" report. The Board's functions include analysing data and applying research to identify patterns, trends and risk factors relating to DFV deaths in Qld, conducting research to prevent these types of deaths, writing reports to identify key lessons and elements of good practice in preventing DFV deaths in Qld, making recommendations to the minister about improving legislation, policies, practices, services, training, resources and communication to prevent or reduce the likelihood of DFV deaths in Qld.

The *Women's Safety and Justice Taskforce report* released in 2022 contained 89 recommendations. The Qld government agreed to implement all recommendations. Following the Taskforce, the Independent Commission of Inquiry into QPS responses to DFV commenced and ran for four months. At the time of writing, the findings of the inquiry were not yet available.

In the Inquest into the death of **Hannah Ashlie Clarke, Aaliyah Anne Baxter, Laianah Grace Baxter, Trey Rowan Charles Baxter, and Rowan Charles Baxter**, the Qld Police Union of Employees and the Commissioner of Police acknowledged that the QPS does not have all the answers and that all levels of government, non-government organisations, businesses and the community needed to work together to identify and deliver sustainable, long term and culturally appropriate solutions to DFV.

Doreen Gail Langham and Gary Matthew Hely

Magistrate Jane Bentley – 27 June 2022

Circumstances of the death

Ms Langham and Mr Hely commenced their relationship in 2018, in early 2019 they moved to Queensland. On 9 February 2021, Ms Langham attended the Beenleigh Magistrates Court and applied for a DVO noting that the couple had been together three years, separated about three weeks ago, but were still living together, Mr Hely had threatened to kill her, he sent multiple harassing and inappropriate texts each day, he exhibited aggressive behaviour when she blocked him on social media and changed her phone number, he had taken photos of her whilst she slept in her bedroom, he had been going through her personal items and she feared for her safety.

The matter was listed for an urgent application. The Magistrate made a temporary protection order ('TPO') and noted that Mr Hely was "erratic" and "extremely unstable". The TPO contained conditions which prohibited Mr Hely from remaining at Ms Langham's home, going to within 100 metres of Ms Langham's place of work or home, locating or contacting Ms Langham by any means whatsoever, going to within 100 metres of Ms Langham when she was at any place, using the internet to communicate with or publish comments about Ms Langham. The matter was adjourned for Mr Hely to be served with the application. Police were not aware of the Magistrates comments. At that time private DVO applications were not reviewed by police.

On 11 February 2021, Mr Hely was served with the TPO and stated that he had moved out. He appeared to be very agreeable and reasonable. He said he was shocked as there had never been any violence and she had never had to fear for her safety. He said he loved Ms Langham but he would walk away.

Despite Ms Langham reporting multiple breaches of the TPO to police (commencing from 14 February 2021) and being visibly upset and fearful when she did so, Mr Hely continued to offend and police responses to Ms Langham's reports of ongoing DFV by Mr Hely overlooked issues of the frequency of offending, stalking behaviours, separation and previous indicators of high risk of lethality. There was also a failure by police to differentiate between breaches of the TPO and criminal offences that could have been categorised with the circumstance of aggravation – as domestic violence offences. *A timeline of possible points of intervention in the lead up to the fatal event is contained in the Coroners findings at Annexure B.*

About 2:30pm on 21 February 2021, Mr Hely went to Ms Langham's home. Ms Langham called police at 9:21pm. At that time, Mr Hely was at the front of the unit. He was at the rear of the unit when police attended some four hours later. Mr Hely waited at the rear for police to attend and leave, then waited for two more hours before he gained entry to Ms Langham's unit. It was likely that Mr Hely entered the back yard of Ms Langham's unit around midnight. It is unclear how he gained access to the unit, however the Coroner found that Ms Langham did not consent to him entering her unit.

Once inside, Mr Hely struggled with Ms Langham during which time she sustained an injury to her spleen. Mr Hely sustained injuries to his neck and chest. It is possible that he inflicted those injuries himself. He doused Ms Langham with petrol and possibly himself. He may have poured petrol around the unit. He then ignited the fire in the loungeroom. Ms Langham and Mr Hely were alive and conscious when the fire started although Ms Langham died very soon after the fire began. Mr Hely died as a result of the effects of the fire.

The Inquest

The inquest took place in Southport from 7 to 11 March 2022, with 24 witnesses called to give evidence. The issues at inquest were:

- *The findings required by s45(2) of the Coroners Act 2003.*
- *The adequacy of the QPS response to Ms Langham.*
- *The extent and adequacy of responses to Ms Langham by DFV services.*
- *The extent and adequacy of responses to Mr Hely by DFV services and the QPS.*

- *Whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.*

The Domestic and Family Violence Death Review Unit ('DFVDRU') noted that the relationship between Mr Hely and Ms Langham was characterised by coercive control by Mr Hely, including him going through Ms Langham's phone, being present when she was Facetiming friends and family, isolating her from friends and family, refusing to speak to her to control her behaviour, sending multiple texts and becoming increasingly abusive if she didn't respond, coming into her room and taking photos of her without her consent, threatening to release intimate photos of her on the internet if she left him, threats of suicide when she wanted to end the relationship, coerced sex, destroying property and personal items, physical assaults – punching her in the head and biting her, threats to kill, breaking into her house.

He had also demonstrated a similar pattern of coercive control in previous relationships including threats to kill, threats to rape, threats to suicide, assault and threats to harm, coerced sex, verbal abuse, non-lethal strangulation, stalking, harassment and intimidation, isolating from family and friends, breaking into homes, leaving flowers, pet abuse, taking intimate photos without consent, love-bombing e.g. engaged to both previous partners within six months and setting fire to a house.

In this case the DFVDRU identified that 20 of the 39 lethality indicators were present including, history of DFV in the relationship, prior threats to kill the victim, prior suicide threats by perpetrator, prior attempts to isolate the victim, controlled most or all of the victim's daily activities, prior forced sexual acts/or assaults during sex, prior destruction or deprivation of the victim's property, choked/strangled victim in the past, perpetrator was abused and/or exposed to domestic and family violence as a child, escalation of violence, obsessive behaviour displayed by perpetrator, extreme minimisation and/denial of spousal assault history, actual or pending separation, depression – in the opinion of family/friends/acquaintances – perpetrator, depression – professionally diagnosed, failure to comply with authority – perpetrator, after risk assessment, perpetrator had access to victim, sexual jealousy – perpetrator, misogynistic attitudes – perpetrator, victim's intuitive sense of fear of perpetrator.

The DFVDRU found that there were multiple potential points of intervention in which the service response could have been strengthened, prior to Ms Langham's death The DFVDRU recognised that this homicide-suicide occurred within a region where an integrated service response, high-risk team and specialist DFV court were operating, all of which are intended to enhance the way services collaborate to keep victims safe and hold perpetrators to account. Despite this there was minimal evidence of services working together, recognising the swift escalation in risk or responding effectively to Ms Langham's multiple attempts at seeking help. The Magistrate identified the high risk of harm but that failed to prompt any further consideration by agencies of the need for a better response.

The Evidence

Evidence was provided by first responders, witnesses, and experts. Notably Professor Kerry Carrington gave evidence. Over the last three decades she has been established as a world leading expert on gender violence and its prevention. Her team has undertaken a world first study on how Women's Police Stations in Argentina respond to and prevent gender violence and what Australia can learn to improve its policing response to gender violence. Professor Carrington's assessment of the police response:

'No one officer or team took responsibility for Ms Langham's case. Vital information was not passed on, diluted, misunderstood, went missing, not followed up or fell through the cracks of so many different QPS officers and communication systems. There were so many errors, mistakes and lost opportunities in this case to respond effectively to potentially lethal DV that leads me to conclude these short-comings are systemic, structural and institutional, and not attributable to the failings of any single individual police officer. In fact, some QPS police were set up to fail being given no or insufficient background of the history of the matter'.

Findings and Comments

The Coroner found that there were numerous missed opportunities for police to respond to Mr Healy's escalating behaviours and overall, the response of the QPS to Ms Langham's complaints and contacts regarding Mr Hely was inadequate and police officers failed to protect her and prevent her death. It is possible that, had every complaint been dealt with in accordance with relevant duties and obligations, Mr Hely would not have killed Ms Langham or himself. The response Ms Langham received in response to her concerns fell far short of basic expectations.

The poor response by numerous officers indicates a serious lack of training and consequently, understanding, of the complex nature of DV by police officers generally but particularly frontline officers. This is concerning as reviews of DV matters by specialist DV police can only be based on the records made by frontline officers. If those records are deficient, reviews are ineffective. Further, there is a lack of any specialist training for those police officers that the QPS considers specialist DV officers such as those who work in the VPU who are given responsibility for training and mentoring frontline officers. The seriousness of Ms Langham's complaints and her risk of lethality were not recognised by the DV specialist police who reviewed her complaints. Some reviews which should have been undertaken were not due to a lack of police staffing. Police officers failed to take even the most basic steps to investigate Ms Langham's complaints or ascertain the risk Mr Hely posed to her. Had one of the numerous officers with whom she had contact looked at CrimTrac on their QLiTE device they would have realised that Ms Langham was at great risk. Unfortunately, this information was not available to Ms Langham so she was unable to assess that risk for herself. It was the duty of the police officers to make themselves aware of Hely's past serious history of DV, particularly since Ms Langham alerted police officers to that history.

The Coroner found the greatest systemic failure is that every police officer dealt with each complaint in isolation and without checking the police database for relevant information. A holistic investigative approach would have revealed that Mr Hely had concerning DV history interstate and that the frequency and severity of his behaviour was escalating. I accept that none of those officers acted out of malice and their inadequate response was the result of inadequate training and acute understaffing in the Logan District coupled with an increasing demand for services. I accept that the pandemic greatly affected training and staffing within the QPS at that time. I accept that each of the police officers involved with Ms Langham and Mr Hely have been impacted by their deaths and regret any failings and that this inquest views their conduct in hindsight and in light of the tragic outcome.

Recommendations

The Coroner noted that the Commissioner of Police had indicated an intention to commence a 12 month pilot program to embed QPS domestic and family violence specialist officers into the Brisbane DFV Service at South Brisbane and the Domestic Violence Action Centre at Ipswich.

The Coroner further noted that the inquest had revealed the need for urgent reforms to address the inadequate response of the QPS to victims of DFV and recommended as a matter of urgency:

- The Qld Government provide funding for the QPS to trial a specialist victim-centred police station specifically designed to deliver an integrated response for victims of DFV, staffed by suitably qualified multidisciplinary teams which include police officers with specialist DFV training, DFV workers, social workers and legal advisors in the Logan District.
- The Qld Government provide funding for an appropriately qualified and experienced DFV specialist social worker to be embedded at the front counter of every police station in Logan District for a trial period of 12 months.
- OPM 9.3.1 be amended to state that officers "must" view a person's interstate record for every DFV matter.

Finally, the Coroner recommended that the QPS should consider requiring officers serving TPOs and DVOs to provide perpetrators with information about counselling and support, parenting and mediation, housing and legal assistance by way of a document such as the "Information for Respondents" document provided to respondents to DVOs by the Caxton Legal Centre.

Hannah Ashlie Clarke, Aaliyah Anne Baxter, Laianah Grace Baxter, Trey Rowan Charles Baxter, and Rowan Charles Baxter

Southport Coroner, Jane Bentley (Deputy State Coroner) – 29 June 2022

Circumstances of the deaths

On the morning of 19 February 2020, Rowan Baxter killed his wife, Hannah Clarke and their three children, Aaliyah, Laianah and Trey, by dousing them with petrol and setting them alight in their car. Rowan Baxter also killed himself. At the time of their deaths Hannah Clarke and the children were living with her parents at Camp Hill as Hannah Clarke had recently separated from Rowan Baxter. There was a Domestic Violence Protection Order ('DVO') and Hannah Clarke felt protected and reassured by that order. Hannah Clarke met Rowan Baxter when she was 20 years old and he was 31 years old, they married in October 2012. They operated a gym together. Many people in the community believed that Hannah Clarke and Rowan Baxter had a happy family and relationship.

The Inquest

The inquest took place in Southport from 21 to 31 March 2022. Police, first responders, friends, family and various expert witnesses were called. The sense of tragedy, loss and inherent grief in this matter was evident in the testimonies of the 35 witnesses.

The issues at inquest were:

1. *The findings required by s45(2) of the Coroners Act 2003.*
2. *The nature and extent of any contact by Hannah Clarke with DFV services or counselling prior to 19 February 2020.*
3. *The nature and extent of any contact by Rowan Baxter with DFV services or counselling prior to 19 February 2020.*
4. *The appropriateness of responses to any contact by Hannah Clarke and/or Rowan Baxter with DFV services and the QPS prior to 19 February 2020.*

The DFVDRU review found that 29 of 39 DFV lethality indicators were identifiable in this case in the relationship between Hannah Clarke and Rowan Baxter.

The lethality indicators present in this case included: history of violence outside the home by perpetrator, history of domestic and family violence in the relationship, prior threats to kill the victim, prior assault with a weapon, prior suicide threats by perpetrator, prior attempts to isolate the victim, perpetrator controlled most or all of the victim's daily activities, prior hostage taking and/or forcible confinement, prior forced sexual acts/or assaults during sex, child custody or access disputes, prior destruction or deprivation of the victim's property, prior assault on victim while pregnant, choked/strangled victim in the past perpetrator was abused and/or exposed to domestic and family violence as a child, escalation of violence, obsessive behaviour displayed by perpetrator, perpetrator unemployed, extreme minimisation and/denial of spousal assault history, actual or pending separation, depression – in the opinion of family/friends/acquaintances (perpetrator), depression – professionally diagnosed (perpetrator), new partner in victim's life (as perceived by Rowan Baxter), failure to comply with authority, after risk assessment, perpetrator had access to victim, sexual jealousy (perpetrator), misogynistic attitudes (perpetrator), age disparity of couple, victim's intuitive sense of fear of perpetrator, perpetrator threatened and/or harmed children.

Findings and Comments

The Coroner found that the actions of Rowan Baxter were premediated, and that he had forced his way into the vehicle with his family, as Hannah Clarke was leaving her parents' house, to take their children to school. Rowan Baxter had with him, a container of petrol, a knife and a lighter. Rowan actively hindered people who attempted to help Hannah Clarke and the children, before killing himself.

The Coroner found it unlikely that any further actions of police, friends, or family members could have prevented Rowan Baxter from killing his family. He was not mentally ill. He was a master of manipulation. Any efforts Rowan Baxter made to seek counselling were designed by him, to assist him

in further manipulating and controlling Hannah Clarke and her children and disrupting the processes of the DVO and Family Court process. He manipulated doctors and psychologists. When Rowan Baxter realised he had lost control over Hannah Clarke, he killed her and their children.

The Coroner found that the actions of the first responders on scene were professional in the face of horrendous circumstances. The actions of Senior Constable Angus Skaines were highly commendable in the face of such tragedy, as were the actions of Senior Constable Kent who supported Hannah Clarke in an effort to assist Hannah Clarke in recognising the signs of DFV within her relationship with Rowan Baxter.

The Coroner found there were missed opportunities to hold Rowan Baxter to account, for example he was not charged and put on bail for the breach of the DVO and the assault occasioning bodily harm but rather, given a notice to appear for the breach and a common assault. However, overall, Hannah Clarke was dealt with appropriately by the police with whom she had contact.

The Coroner found that: *'since 2017 there had been inadequate training provided to police officers considering that DFV accounts for up to half of their work. Although QPS has introduced new roles of DV Co-ordinators and a policy of auditing DV incidents, it is uncertain how effective these new roles can be when the officers are auditing information input by front line officers who are not adequately trained to obtain relevant information. I can only conclude that police officers are under-trained in relation to DV. "Specialist" DV police officers may, in fact, have had no training other than the minimal amount provided to all police officers. The majority of front-line police officers who are dealing with DV constantly and who are responsible for assessing risk and gathering the information on which the "specialist" officers audit their decisions had, at the time of this inquest, received one online "refresher" training program in the last five years. I am satisfied that Mr Leavers is an expert in how DV incidents are impacting police officers and its effect on policing in Qld. I agree with him that immediate comprehensive training is urgently required to bring all police officers up to date with amendments to DV legislation and the latest studies in relation to identification and policing of DV and that annual refresher training is then required. Acting Inspector Martain said that the "gold standard" of policing would be a multi-disciplinary team of police, social workers, child safety workers etc who could properly assess the risk of harm to victims of DV including children. Mr Leavers agreed that a multidisciplinary team approach to DV is required'.*

The coroner found that there is a significant lack of counselling, programmes and support for perpetrators of DFV. However, even if it had been available in this matter, Rowan Baxter was not interested in wholistically engaging with such supports, other than to further his own manipulation and self-serving behaviours. There was a failure by all agencies to recognise the extreme risk of lethality, and the risk of intimate partner homicide that results from separation in a coercive controlling relationship. Finally, the Coroner found that there was no real assessment of harm to the children by QPS or Child Safety, other than Hannah Clarke was able to care for them.

Recommendations

The Coroner recommended that:

1. The Qld Government fund QPS to provide a five-day face to face DFV training program for all specialist DFV police officers as a matter of urgency.
2. The QPS include in the annual Operational Skills Training a face-to-face module on DFV which is mandatory for all officers.
3. The Qld Government provide funding to trial a multi-disciplinary specialist DFV police station for a period of 12 months (preferably in the Logan or Kirwan district which have the highest numbers of DFV incidents) and the station includes at least the following:

    a. Specialist DFV police officer/s including a detective to investigate criminal offences,
    b. specialist DFV support worker,
    c. a child safety officer from Department of Child Safety to assess risk of harm to children of families impacted by DFV,

d. an employee from Qld Department of Housing to provide advice and assistance on accommodation for victims,
e. an employee from Qld Health to assess mental health, drug and alcohol issues and the wellbeing of children,
f. a lawyer to provide legal advice to police and victims.

4. The Qld Government provide funding for men's behaviour change programs, both in prisons and in the communities, as a matter of urgency.

Our Achievements

State Coroner's Guidelines – s14 of the Coroners Act

One of the State Coroner's functions is to issue guidelines[4] about the investigation of deaths and other matters under the Coroners Act. These guidelines are issued with the objective of ensuring best practice in the coronial system and the State Coroner must consult with the Chief Magistrate before issuing any guidelines or amendments to guidelines.

During the reporting period, Chapter 6 which deals with the release of bodies for burial or cremation was updated to reflect amendments to the Criminal Code contained in the *Evidence and Other Legislation Amendment Act 2022*.

The amendments were implemented in response to recommendations made at the inquest into the death of Daniel Morcombe. The inquest examined circumstances in which the prosecution and defence failed to reach agreement on the identity of the deceased, which resulted in the remains being held for an extended period before they were returned to Daniel's family for burial. One of the recommendations made by the State Coroner at the close of the inquest was that a time limit should be imposed on testing of the remains for the purpose of the criminal proceeding.

Insertion of s 590ASA into the Code ensures a time limit is imposed on the testing of human remains where the prosecution and defence fail to reach agreement on the identity of the deceased. The revision of the guidelines in chapter 6 – Release of bodies for burial or cremation, will ensure families are informed where further testing of remains is carried out in criminal proceedings.

Courts Services Queensland Awards

On 24 November 2021 the annual CSQ Staff Awards were held with over 60 nominations across the Magistrates Court. The CCQ were nominated in a number of categories with an individual win for Patrice Bensted in the *Customer Focus* category, the Registrar Support Team receiving a highly commended *Performance* Award and Stephen Galler, highly commended in the *Behind-the-Scenes* category.

Justice Services Divisional Excellence Awards

On 5 May 2022, CCQ teams and individual were finalists in the Justice Services Divisional Awards. The CCQ received three individual nominations and one team nomination in the categories of *Customer Focus, Innovation* and *Partnerships* and won or were highly commended in all categories nominated.

- *Winner for Customer Focus*, Rin Shimada (Operations)
- *Winner for Innovation*, Carmel-Lee Skinner (Business Services)
- *Winner for Partnerships*, Susan Beattie (DFVDRU)
- *Highly Commended for Partnerships*, CCQ For You

DJAG Staff Excellence Awards

On 29 June 2022, CCQ continued to represent their work and commitment to the court with wins at the 2022 DJAG Staff Excellence Awards held at Parliament House. Rin Shimada won the *Customer Focus* award for her work as the dedicated case manager in the historical and complex, Whiskey Au Go inquest and Susan Beattie won the *Partnership* award for her work in maintaining key partnerships to reduce and prevent domestic and family violence.

[4] The State Coroner's Guidelines can be accessed at: https://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/resources-and-legislation

Communication and Corporate branding

In September 2021 the Court finalised its corporate branding which is reflected for the first time in this annual report. Branding includes correspondence templates, signature blocks and pull-down banners for display in our court registries. Connected to these works includes the progression of the Coroners Court of Queensland standalone website which will be finalised in the 2022-23 reporting period.

Form 1 – Police Report of a Death to a Coroner project

The Operations Team within the court continued work with DJAG Information Technology Services and the Queensland Police Service to progress the automatic deployment of Form 1 police reports of a death to the coroner to the courts dedicated case management system, CCMS. Previously Form 1 were emailed to the court and manually registered. From October 2021 the Form 1 integration project was realised and sees Form 1 reports automatically transfer into CCMS for registration by the team. Further works continue in the Form 1 space to improve the quality of data and timeliness of referral to coroners.

CCQ For You

The Court's training and development working group, CCQ For You fully embedded itself during the reporting period and continued monthly information sessions. Fifteen in-house, partner and external agencies presentations to coroners, court staff and coronial partner agencies about their work and how it intersects with the coronial jurisdiction, were delivered. The sessions provide invaluable opportunity for the court to better understand the practises of other agencies and how the court can work better together to progress coronial investigations and improve interaction with and support to families.

Some of the agencies the court heard form during the reporting period included, the Missing Persons Unit, the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships, Maritime Safety, QPS Search and Rescue, the Department of Child Safety, the Koori Engagement Unit in the Victorian Coroners Court, the Clinical Forensic Medicine Unit and QHFSS Coronial Family Services.

CCQ For Fun

CCQ for Fun is a staff-run social group developed in 2021 to focus on staff wellbeing. CCQ for Fun assists in the prevention of vicarious trauma and aids in the wellbeing of staff by building connectedness and strong relationships across the court. CCQ for Fun organises activities to bring cheer and playfulness into the workplace.

During the reporting period CCQ for Fun celebrated International Women's Day by holding a high tea set in a gallery of famous women with accompanying summaries of their achievements. The event included group singing, positive affirmations, lots of home baked goodies and of course good humour.

The group supported Share the Dignity, a women's charity that works to make an on-the-ground difference to those experiencing period poverty, homelessness, or fleeing domestic violence. CCQ for Fun also organised bake offs, lucky dips, wall of pets, Christmas decorating competition, mindfulness colouring and a variety of raffles. All these activities enable staff to participate in activities outside of business as usual, connect across teams, network, and simply enjoy themselves.

CCQ For Wellness - *Vicarious Trauma Prevention Strategy Project*

Due to the nature of the work the Court recognises that vicarious trauma is a significant risk factor within the organisation and has had a renewed focus on mitigating and managing vicarious trauma. The court is working towards developing a 'wellness program' which will be a targeted long-term strategy for managing vicarious trauma for CCQ employees and engaged an external provider who specalises in health and wellbeing in the workplace to assist.

The court is working towards changes and process improvements to reduce the risk of vicarious trauma and received one-off funding of $0.200 M in the 2021-22 Budget (of which $0.149 M was carried over

to the 2023-23 Budget to fund ongoing project engagements) to develop material for staff about building resilience and managing vicarious trauma.

Initial works have included introductory sessions with all court teams, 'deep dives' with individual team members (including on-site visits where able) to provide staff with an opportunity to give honest and open feedback about their experience working in the Coroners Court, as well as suggestions on how to improve the workplace, desktop reviews of policies, procedures, and training already in place regarding vicarious trauma and an exploration of barriers to a VT program being successful in the court.

A final report due to be provided in the next reporting period will be reviewed by the Leadership Team to identify themes and priority areas to improve moving forward.

Workplace improvements

In response to the Working for Queensland Employee Opinion Survey in 2021 which captures the experience of a Queensland public servant, the CCQ engaged an external consultant to undertake a psychological safety assessment to better understand the survey results. Court staff were asked to participate in a survey to identify areas of improvement to be prioritised which found 'communication' and 'wellbeing' the top themes.

In May 2022 the Court released a CCQ Governance and Communication flowchart to demonstrate the achievements made in embedding consistent, targeted, and relevant communication across the court. The guiding chart outlines, regular communication channels, communication tools and overarching court roadmaps, action plans and frameworks. In August 2021 the court also reinvigorated a regular Director newsletter of events, achievements, project updates and team acknowledgments to improve information flow through the court. Initiatives will continue to progress across other priority themes in the coming years.

COVID-19 and the 2022 flooding event

Despite the continuation of COVID-19 pandemic and flooding that occurred in South-East Queensland in February 2022, the CCQ were well equipped to work remotely to continue to finalise findings, focused on the backlog of cases, and achieved clearances rates above 100 per cent for a fourth year in a row.

The Court acknowledges the engagement, professionalism and efforts displayed by staff in response to the COVID-19 pandemic compounded by the flooding event which left many staff unable to leave their homes and access the court.

The Court continued to review and update its COVID-19 guidelines for the management of inquests in line with practice directions from the Chief Magistrate and advice from the Chief Health Office. With the opening of State borders in December QR codes were established for court rooms and registries to assist Queensland Health with contact tracing if required. The court also updated its information sheet on when a COVID-19 death is reportable to the coroner[5].

Cultural capability

The court commenced working towards a practice direction for the investigation of deaths in custody with a particular focus on convening inquests in a culturally appropriate manner. The court has observed Welcome to Country and Acknowledgment of Country during a number of inquests convened during the period, conducted community visits on Country and acknowledges the importance of referencing First Nations people by their 'skin name'. A new position to commence in the next reporting period, Manager, Cultural Capability will enhance the ability of the court to effectively support families, as well as coroners and the Domestic and Family Violence Death Review Advisory Board in their investigation and review of deaths of First Nations people experience of domestic and family violence. The position will provide training to all coroners and court team members and provide expert advice and assistance for relevant reportable deaths.

[5] When does a COVID-19 death need to be reported to the coroner (courts.qld.gov.au)

Asia Pacific Coroners Society (APCS) conference

Queensland was scheduled to host the APCS[6] conference in 2020, which after a challenging few years navigating the Coronavirus pandemic was postponed to 2021 and again to 2022. The conference is scheduled to take place in the next reporting period in November on the Gold Coast.

During this reporting period the court recommenced preparations for the conference, scheduling keynote, guest, and panel speakers, promoting the conference and arranging social events. The conference is a three-day program of approximately 30 speakers with a full social program, intended for anyone involved in or associated with the coronial jurisdiction.

[6] https://www.ivvy.com.au/event/APCSC2021/program-and-speakers.html

Coronial Performance

The performance measures for the coronial jurisdiction align with the national benchmarking standards outlined in the Report on Government Services. Coronial performance is measured by reference to a clearance rate and a backlog indicator.

Clearance rates

During 2021–22, a total of **6,044 deaths were reported to the CCQ for investigation**. This represents the highest volume of deaths lodged with the court in its history. The percentage increase in lodgements is also the highest since the 2015-16 reporting period where the court saw 5,287 or a 6.54% in lodgements from the previous year.

Despite an **increase of 330 (or 5.78%) in lodgements from the previous year the court finalised 6,115 cases,** achieving a **clearance rate of 101.2%**. This is the **fourth consecutive year the CCQ accomplished a clearance rate above 100%** meaning more cases were finalised than were lodged.

Table 1 – Performance figures from 2015–2022

Year	Cases lodged	Percent change	Cases finalised	Clearance rate	Backlog	Inquests Finalised[7]
2021-22	**6,044**	**5.78%**	**6,115**	**101.2%**	**14.82%**	**27**
2020–21	5,714	1.47%	5,845	102.29%	14.18%	26
2019–20	5,631	-2.86%	5,744	102.02%	14.81%	28
2018–19	5,797	-0.26%	5,860	101.09%	17.58%	29
2017–18	5,812	4.02%	5,618	96.66%	18.43%	52
2016-17	5,587	5.67%	5,014	89.7%	16.6%	30
2015-16	5,287	6.54%	5,313	100.5%	13.6%	49

The Court receives reports of deaths state-wide which are reported into the four main registry locations for management either by a coroner or coronial registrar. The figures below account for all deaths reported to the court by regional reporting location of death.

Table 2: Statewide performance figures[8]

Deaths reported by coronial region	Brisbane	Northern	Central	Southeastern
Number of deaths reported for investigation	3,854	704	697	789
Number of coronial cases finalised	3864	766	660	825
Number of coronial cases pending	1332	409	321	219
Coronial cases pending - *Greater than 24 months old*	202	64	35	37

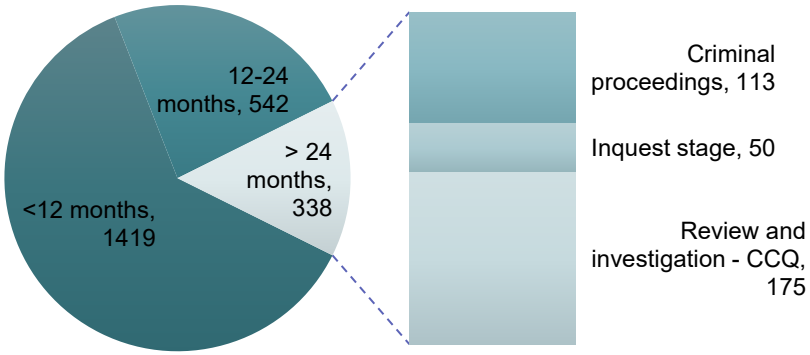
[7] Figure refers to inquests finalised, not the number of deaths investigated at inquest. Multiple deaths can be heard conjointly.
[8] These figures represent the numbers recorded within the particular region the death was reported i.e., the State Coroner, Deputy State Coroner and Coronial Registrars can receive reports of deaths state-wide.

Backlog indicator and pending cases

Coroners are aware that delays in finalising coronial matters can cause unnecessary distress for families. However, the finalisation of a coronial investigation can be dependent on other agencies completing their investigative processes such as the completion of autopsy, toxicology and police reports, or the Court may be required to await the outcome of criminal proceedings. The court has continued its focus on the backlog indicator (cases more than 24 months old) with strategies involving both partner agencies, the QPS and QH carried out.

Despite the growth in lodgements the courts backlog indicator percentage only marginally increased from the previous reporting year (from 14.18% to 14.82%). While the backlog percentage indicator slightly increased on the previous year, the **overall number of cases pending declined from the previous reporting period, 2,281 down from 2,348 (or 2.85%) in 2020-21**. Of the total **2,281 lodgements pending**, 1,419 were less than 12 months old, 524 between 12 and 24 months and **338 cases were pending more than two years.**

Figure 4 – Backlog indicator breakdown



Of the **338 cases pending, 113 of those were matters awaiting criminal proceeding outcomes**. In those circumstances coroners are prevented pursuant to s29(2) of the Coroners Act to hold or continue an inquest where a person is charged with an offence in relation to a death, however, can continue their investigation. Additionally, **50 of the 338 pending cases were at inquest stage** (part heard, adjourned for further hearing or for findings), with the **remaining 175 either under review by a coroner or counsel assisting, awaiting police, autopsy, or other investigative material to progress**.

Not reportable matters

Many matters reported to the Court are found to be not reportable within the terms of the Coroners Act, or reportable but not requiring autopsy or further investigation. Of the deaths finalised during 2021-22, **2,603 were found to be not reportable** within the meaning of section 8(3) of the Coroners Act. These matters are included in the Court's lodgement figures as significant work is involved in determining whether these matters are reportable or whether a death certificate can be authorised. This work can involve reviewing medical records, discussing the death with treating clinicians and family members, and obtaining advice from the CFMU.

Review applications

The State Coroner has a review function under the Act in respect of decisions about whether a death is reportable, whether an inquest should be held and whether an inquest or non-inquest investigation should be reopened. During the reporting period, the State Coroner **received 32 applications** in this regard and **finalised 31 matters** of this nature.

Reportable death types

Section 8(3) of the Coroners Act defines the deaths reportable to the court for investigation. The categories of those deaths and the corresponding figure reported to the court are noted in the following table.

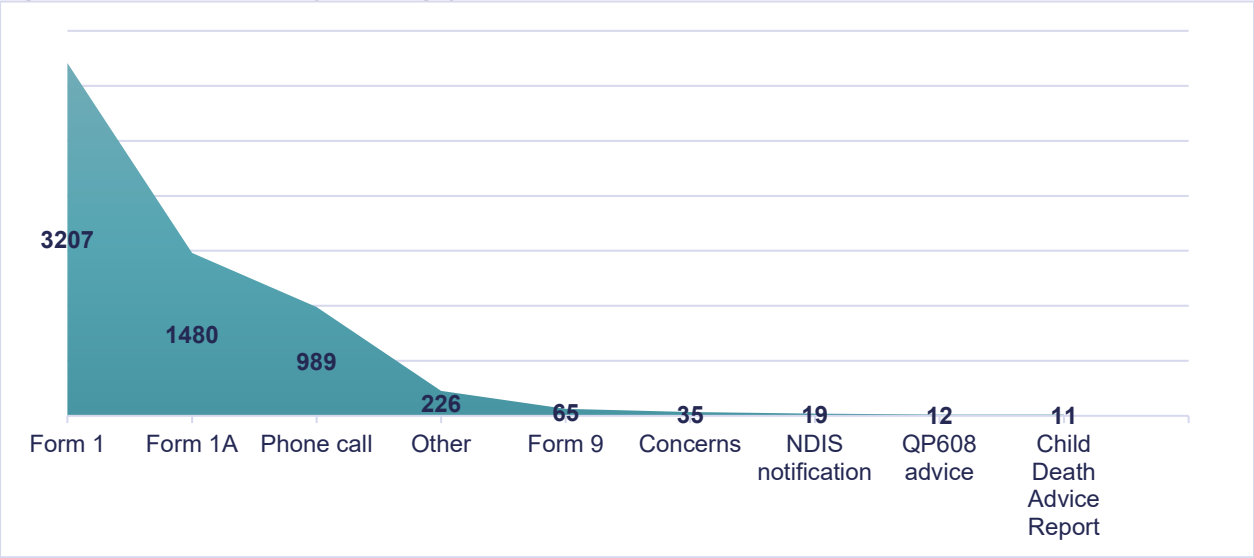
Table 3: Deaths reported statewide by type[9]

Category of death	TOTAL
Suspected death (missing person)	12
Death in custody	**16**
Death as a result of police operation	**3**
Death in care	**109**
Health care related death	**649**
Suspicious circumstances	**22**
Violent or unnatural	**2775**
Death certificate not issued and not likely to issue	**2485**
Unknown persons	**6**

How deaths are reported

The Court receives reports of death by police (Form 1) or by medical practitioners (Form 1A). The Court also receives 'Other' reports of deaths for review and investigation, which can include phone calls from medical practitioners, funeral directors, or aged care facilities, directly from family who may have concerns, missing person reports/advice, child death advice/ notifications directly from the NDIS.

Figure 5: Deaths reported by initiating type of report



[9] The total *Reportable Type* may be different from *the total number of cases lodged*, as multiple *Reportable Types* may be selected on a case in the CCMS.

Coronial Registrars

The Coronial Registrars use a multidisciplinary approach to:

- **investigate apparent natural causes deaths reported by police** (via Form 1) because a death certificate has not been issued and is unlikely to be issued;
- **review deaths reported directly by medical practitioners** via Form 1A who seek advice about whether a death is reportable or seeking authority to issue a cause of death certificate; and
- **provide telephone advice to clinicians** who seek advice about the reportability of the death before they issue a cause of death certificate. This provides an opportunity to filter out not-reportable deaths and to triage reportable deaths where a cause of death certificate may be authorised under section 12(2)(b) of the Coroners Act.

While the Form 1A process is primarily a triage mechanism aimed at diverting reportable deaths from unnecessary autopsy, it too is driven by the underlying general prevention object of the Coroners Act. The Coronial Registrars manage this reporting pathway with an eye to proactively identifying opportunities to improve patient safety and inform quality improvement in the health care sector.

In practice, most of the deaths reported by Form 1A resolve with the Coronial Registrar authorising the issue of a cause of death certificate under section 12(2)(b) of the Act without further coronial investigation. This is because there is sufficient clinical information to support the treating doctor's cause of death diagnosis without a coronial autopsy, and the Coronial Registrar is satisfied there were no significant outcome changing issues requiring a full coronial investigation.

Not infrequently the Coronial Registrar's investigation will identify clinical management issues that, while not significantly outcome changing for an individual deceased person, are issues the Coronial Registrar considers may benefit from clinical review by the care provider with a view to improving patient safety and health care quality. It has been the Coronial Registrars' routine practice to refer these matters formally to the relevant care provider with a recommendation for formal internal clinical review for this purpose. Where relevant, the Coronial Registrars have also notified agencies including the Aged Care Quality & Safety Commission and the National Disability Insurance Scheme Quality & Standards Commission of issues warranting regulatory review rather than coronial investigation.

This is done with the family's knowledge and the care provider is encouraged to engage directly with the family as part of any subsequent local clinical review process. While the coronial investigation is finalised once the Coronial Registrar authorises the issue of the cause of death certificate in these cases and care providers are under no legal obligation to share internal review outcomes with the Coronial Registrar, it has been our experience that most care providers are very responsive to these notifications and keen to share the outcomes of their internal reviews with both families and the Coronial Registrars.

It has been heartening to see many positive changes made in response to issues identified by the Coronial Registrars through the Form 1A triage process which, while not meeting the threshold for a full coronial investigation, have been examined and acted on by care providers across the health, aged care, and disability sectors to make timely changes to improve patient and client outcomes.

The Coronial Registrar's experience to date also shows how meaningful these responses are to bereaved families who often express relief and gratitude that their concerns have been heard and acted on quickly.

Recent examples of care provider responses to Coronial Registrar referrals for internal review include the following outcomes:

- A metropolitan Hospital & Health Service developed a service-wide referral pathway for urgent and non-urgent inpatient MRI incorporating an escalation pathway for review of non-accepted referrals and delayed procedures
- A regional Hospital & Health Service developed a service-wide protocol for managing patients presenting with hypertension to define a clear pathway for assessment, risk stratification and appropriate referral pathways
- A regional Hospital & Health Service supported additional clinical staff from one of its small rural hospitals to complete ultrasound guided peripheral intravenous cannulation training
- A rural Hospital & Health Service identified the need to develop an emergency department model of care and a clear local facility work instruction for effective Massive Transfusion Protocol implementation at one of its rural hospitals
- A metropolitan tertiary hospital identified and took steps to address deficits in emergency department staff knowledge of patient transfer equipment and primary nurse/team lead communication with receiving wards
- A metropolitan tertiary hospital identified an opportunity to improve its clinical handover guidelines and the use of existing sections within the ieMR to alert clinicians to outstanding tasks relating to the care and monitoring of peripheral intravenous cannulas (PIVC)
- A metropolitan tertiary hospital identified an opportunity for the state-wide Guidelines for Anticoagulation using Warfarin – Adult, specifically relating to the thrombosis risk and bridging requirement, to be updated; formed a Surgical Anticoagulation working party to roll out a trial Therapeutic Anticoagulation Management Plan across its surgical and perioperative services and review its VTE/anticoagulation education for medical officers to include venous thrombosis risk rating, risk factors for sensitivities, bridging requirements and dosing
- A regional tertiary hospital identified opportunities to improve the process by which patients transition in and out of its COVID wards
- A regional tertiary hospital took steps to secure devices to enhance early access to bedside ultrasound in its emergency department for screening patients with high risk factors for abdominal aortic aneurysm rupture
- A metropolitan public hospital commenced a trial Transfer of Care documentation process across the facility including emergency department to ward, ward to ward and interhospital transfers
- A peripheral metropolitan public hospital standardised its process for public and private interhospital transfers
- A major private hospital provider implemented the Q-MEWT observation tools in all of its hospitals for its maternity patient population and took steps to examine its clinical governance structures, systems, processes and resources to ensure that widely accepted standards of care and associated clinical tools are considered and appropriately implemented across its hospitals
- A metropolitan private hospital took steps to improve its guidelines for the management of hypertensive disorders (including expectations of medical management and care pathways) and for the recognition, response and management of obstetric emergencies (specifically including triggers for critical care input and/or transfer)
- A metropolitan private hospital implemented the Cardiac Q-ADDS tool as the sole vital observation record for its coronary care unit and took steps to enhance its nursing education regarding the assessment of agitation and identifying the constellation of new confusion, hypertension and anticoagulation as an indication for escalation for medical review
- A regional private hospital commenced a review of its Heparin Intravenous Infusion Order and Administration Form and Guidelines to ensure its heparin use procedures minimise the incidence of Heparin Induced Thrombocytopaenia and Thrombosis Syndrome (HITTS)
- A regional public hospital took steps to identify triggers for real time escalation of multiple emergency department presentation patients for Senior Medical Officer review
- A regional public hospital revised its Permanent Cardiac Implantable Device procedure and Cardiovascular Implantable Devices clinical pathway to incorporate common post-permanent pacemaker complications and direct imaging and clear escalation pathways to the proceduralist in the event of a post-insertion complication
- A rural public hospital took steps to assign a pharmacist to its emergency department to help expedite the undertaking of Medication Action Plans for patients being admitted to the ward

- A registered NDIS service provider made changes to its risk management plans and the recording of client choices particularly where there is clinical or allied health advice recommending alternative strategies to the ones the client has elected and has capacity to choose
- A residential aged care facility revised its behaviour management and behaviour support policies to incorporate pain assessment and management, and behaviour charting in the context of dementia

During the reporting period the Coronial Registrars were also heavily involved in a number of bodies of work in relation to the COVID-19 pandemic. Registrar Kirkegaard worked closely with the Queensland Health Vaccine Command Centre to develop more detailed resources for clinicians to help them think through the question of vaccine relatedness when it comes to certifying a death of a person proximate to having received a COVID-19 vaccination. The resource *Attributing deaths to COVID-19 vaccines – a guide for medical practitioners Queensland Health*[10] was developed in consultation with the Australian Medical Association Queensland GP subcommittee and published.

The State Coroner and Coronial Registrars also met with representatives from the Office of the Chief Health Officer, Patient Safety Quality Improvement Services and QHFSS in January 2022 to enter into sharing arrangements to report on COVID positive deaths that enter the coronial system to assist with public health emergency responses.

In this regard Registrar Kirkegaard was also involved in assisting Queensland Health in developing their Information for Health Professional guide regarding reporting and recording COVID-19 deaths. The court also maintained a register of cases during the height of the pandemic in the reporting period in relation to COVID-19 related deaths and those proximate to a vaccination.

With the easing of COVID-19 restrictions, regular clinical education forums that the Coronial Registrar present to a variety of stakeholders were able to resume throughout parts of the year with nine presentations completed during the period[11].

In addition to clinical education forums, Registrar Kirkegaard progressed a body of work with Queensland Health through its online iLearn learning management system which hosts educational material for Queensland Health and others. The package was developed to target the four most commonly encountered knowledge gaps in the registrar's experience in fielding 'doctor calls':

- When is the death of a person who had a fall reportable to the coroner?
- When is a death "health care related" under the *Coroners Act 2003*?
- Understanding your death certification obligations
- Reportable deaths – managed the deceased person's body

The package comprises a short video presentation by Registrar Kirkegaard with a PowerPoint presentation followed by a series of scenario questions to test the participant's knowledge and opportunity for self-reflective learning. The course attracts clinical Continuing Professional Development (CPD) points. The Patient Safety Clinical Improvement Service will provide the CCQ with periodic data analysis about the participants as well as feedback about the materials so they can continue to develop them to meet clinical educational needs.

[10] https://www.health.qld.gov.au/__data/assets/pdf_file/0023/1094621/covid-vaccine-certifying-death.pdf
[11] Refer to Appendix 3 for Coronial Registrar presentations

Deaths in care

The focus of a coronial investigation into a death in care is whether the circumstances of the death raise issues about the deceased's care that may have caused or contributed significantly to the death. The *Coroners Act 2003*, s. 27(1) (a) (ii), mandates an inquest if any such issues are identified.

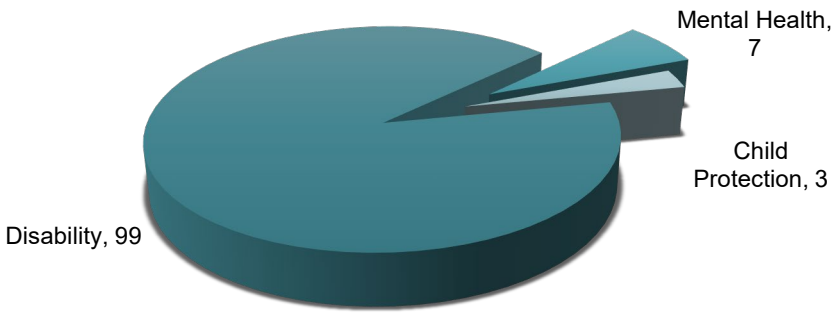
A 'death in care' is defined in section 9[12] of the Coroners Act and makes reportable the death of certain vulnerable people in the community, that is those with a disability or mental illness and children who are in certain types of care facilities or under certain types of care arrangements. These deaths are reportable irrespective of the cause of death or where the death occurred to reflect the underlying policy objective of ensuring there is scrutiny of the care provided to these people given their particular vulnerabilities.

Following the passage of the *Disability Services and Other Legislation (NDIS) Amendment Act 2019* sections 50 and 51 of that Act amended the Coroners Act to ensure a relevant service provider has a 'duty to report' a death in care and revised the definition of a 'death in care. In addition, on 1 July 2020 the National Disability Insurance Disability Scheme commenced in Queensland.

As a result of the system advocacy report by the Office of the Public Advocate (QLD) *Upholding the right to life and health: a review of the deaths in care of people with a disability in Queensland* in 2016, the Coroners Court has committed to report on data in relation to deaths in care each year, including the categories associated with the definition of a 'death in care'.

During 2021–22, 109 'death in care' matters were reported to the Court for investigation. Of these, the majority related to deaths in care of people with a disability. Further details on the categories of death in care that were reported to the Court for investigation are depicted below[13].

Figure 6 – Death in care matters reported



The majority of reported deaths in care of people with a disability related to NDIS participants receiving high level supports as residents in specialist disability accommodation or supported living arrangements operated by registered NDIS service providers. A subset of these reports related to residents of Accommodation Support & Respite Services operated by the Department of Communities, Housing and Digital Economy for people with a primary diagnosis of intellectual disability. There were only a small number of reports relating to residents of several facilities operated by Hospital & Health Services where people with disabilities reside on a permanent basis (Halwyn Centre, Birribi, Baillie Henderson Hospital and The Park Centre for Mental Health) or residents of level 3 accredited residential services regulated under the *Residential Services (Accreditation) Act 2002*.

[12] Refer to the *Coroners Act 2003* s9 for the full definition and categories of a death in care.

[13] Two of the 99 disability reports also were those that involved child protection and eight of the total 109 were open investigations at the time this report was prepared.

The Coroners Court has observed a steady increase in reporting of deaths in care of people with a disability, corresponding with the separate legal requirement for NDIS service providers to report the deaths of their clients to the NDIS Quality & Safeguards Commission. The Coroners Court anticipates ongoing increased reporting with an ageing population of NDIS participants.

The vast majority of deaths reported during the reporting period were from expected natural causes. As such these reports are triaged by the Coronial Registrars who, with independent clinical input and information provided by the Office of the Public Guardian Community Visitor & Advocate and the NDIS Quality & Safeguards Commission, examine whether the circumstances in which the person died raise issues about their care. Where there are none, the Coronial Registrar authorises the issue of a cause of death certificate for the person and the coronial investigation is finalised.

Only nine of the reported deaths occurred in circumstances raising issues about the deceased person's care, requiring post mortem examination and full coronial investigation. The issues arising in these matters include:

- Failure by carers to recognise and respond to changes in an NDIS client's condition, leading to delay in escalating the client for medical review and hospital transfer
- Missed opportunities for earlier investigation and diagnosis of an NDIS client's metastatic malignancy
- Logistical failings to ensure adequate equipment was available for a bed bound NDIS client following discharge from a protracted hospital admission
- Allegations of carer neglect for an NDIS client
- Management of a level 3 accredited residential service resident's diabetes
- Hospital discharge decision making for a level 3 accredited residential service resident whose complex needs exceeded the level of care able to be provided by this type of supported accommodation service
- Falls risk management for the resident of a level 3 accredited residential service during a hospital admission
- Sudden expected death requiring coronial autopsy to determine cause of death

During the reporting period, the Coroners Court referred one matter to the NDIS Quality & Safeguards Commission for regulatory review of the standard of care provided to an NDIS participant with advanced Huntington's disease during a temporary care placement while more suitable long term specialist disability accommodation was being sourced. While the care this client received during the temporary placement was not considered to have caused or contributed to their death, there was concern the NDIS service provider's carers did not understand how to manage the client's behaviours and this impacted on their ability to care for the client.

During the reporting period, Coroner Clements finalised her inquest into the death of Mr Craig Williams which was reportable as a death in care and as the coroner considered there were circumstances that raised issues about his care, an inquest was required. A summary of Mr Williams death, the investigation and inquest follow.

Deaths in care: case summary

Craig Leeton Williams
Coroner, Christine Clements – 30 November 2021

Circumstances of the death

Mr Craig Leeton Williams was aged 43 years when he experienced a cardiac arrest at his parent's home at Innisfail on the night of 4 October 2015. Family members who were present immediately commenced cardiopulmonary resuscitation which was continued by Paramedics on their arrival. Mr Williams heart rhythm was re-established, he was stabilised then flown to the Cairns Hospital and admitted to the Intensive Care Unit. Despite those efforts Mr Williams sustained a hypoxic brain injury requiring intensive treatment and rehabilitation for 10 months before he was discharged to the Jacana Acquired Brain Injury Clinic (Jacana) at Brisbane for continued rehabilitation. Mr Williams lived there for approximately 1 year before his sudden and unexpected death on 7 September 2017 following another cardiac event. A concern raised by Mr Williams next of kin, was that he did not receive any heart monitoring after his transfer to Jacana, despite an admission letter that recommended it.

The Inquest

Mr William's death was reportable pursuant to s 8 of the *Coroners Act 2003* (the Act) as a cause of death certificate was not issued and was not likely to be issued. His death also fell to be considered as a death in care in circumstances where there were issues raised about the care provided to him. An inquest was therefore required pursuant to s 27(1)(a)(ii) of the Act.

The Evidence

An autopsy performed on 12 September 2017, did not identify any ischaemic changes, inflammation or features of cardiomyopathy. Whilst there were some features of the heart, including but not limited to slight obstruction to the artery of the atrioventricular node, none of those features were considered to be of causal significance. The pathologist was unable to identify an obvious cause of death. Cause of death was "*not ascertained*".

Examination of Mr Williams' GP records identified the presentation of chest pains in March 2015 and again in September, with ECGs showing some minor conduction abnormalities. A referral to a Cardiologist was generated, with an appointment scheduled in late October, however Mr Williams cardiac event occurred before he had the benefit of that consultation. Following his admission to Cairns Hospital consideration was given to an automatic implantable cardioverter defibrillator (AICD) as the only treatment that could prevent a repetition of another arrythmia, however that would require a neurological assessment and would only be considered if Mr Williams recovered to a point where he was able to live independently.

Whilst genetic testing did not identify a genetic pathological abnormality, Mr Williams multiple ECGs were typical of type 1 Brugada. A presumptive diagnosis of Brugada Syndrome was developed, and treatment plan developed accordingly. The only management of Brugada Syndrome is secondary prevention by implantable defibrillator. After Mr Williams condition stabilised, he was transferred from ICU into the renal and respiratory ward, where he received cardiac monitoring for six months. No concerning cardiac symptoms were identified during that time accordingly a decision was made to cease cardiac monitoring. By August 2016 Mr Williams condition had improved to the extent that he was suitable for transfer to Jacana at Brisbane.

Consideration of the AICD was ongoing, but Mr Williams' treating team at Cairns determined that should be a matter for consultation with a Cardiologist after he had settled in at Jacana. Mr Williams discharge summary was forwarded to Jacana, it was detailed and lengthy, reflecting the period of his admission at Cairns Hospital. The discharge summary included a recommendation for Mr Williams to be referred to a Cardiologist for consideration of an AICD.

The discharge summary was not provided to Mr Williams next of kin notwithstanding they held positions as his statutory health attorneys. After being admitted to Jacana, it was noted there was a decrease in the level of care received by Mr Williams compared to Cairns in terms of contact hours with his treatment team.

Mr Williams treating physician at Jacana acknowledged that whilst the discharge summary recommended a referral to a cardiologist, this did not occur. In not generating that referral, the treating physician had failed to appreciate that whilst genetic testing had not confirmed Brugada syndrome this did not exclude it and Mr Williams ECGs were otherwise consistent with the diagnosis. Mr Williams treating physician ultimately underestimated the extent to which Mr Williams had settled after being admitted at Jacana and his capacity to successfully engage with allied health professionals.

Findings and Comments

The inquest found that Jacana was not an appropriate facility for Mr Williams rehabilitation. There was a serious failure in communication by Cairns Hospital, in not providing a copy of Mr Williams discharge summary to his next of kin. The family were therefore not informed and without access to critical information regarding Mr Williams need for further cardiology review after his transfer to Jacana. The AICD was the only possible life-saving intervention available to Mr Williams. Whilst it cannot be established what decision may have come from an additional cardiology review, there was a missed opportunity to seek additional therapy for Mr Williams.

Recommendations

It was recommended that Queensland Health and Hospital Service review its policies, and amend as necessary, to ensure Statutory Health Power of Attorney(s), or Enduring Power of Attorney are provided with the discharge summary, kept informed and consulted on a regular basis regarding significant health information, and information/decisions that are required to be documented in a patient's record.

At the time of findings, it was noted that the Jacana health facility had been relocated and sat within a different health unit. There were processes in place for a comprehensive assessment at the time of admission including completion of an ongoing medical management tool that would detail any additional investigations required or implanting of medical devices.

Forensic pathology services

Autopsies can be an important aspect of coronial investigations. However, they are invasive, costly, and can be distressing to bereaved families. In line with the State Coroner's Guidelines, coroners are encouraged to order the least invasive autopsy examination necessary to inform their investigation[14].

Coronial autopsies are performed by QHFSS-employed forensic pathologists in Brisbane, Gold Coast, and Cairns only. Some coronial autopsies are undertaken in Toowoomba and Townsville (and some at the Gold Coast and occasionally Cairns). From July 2021, the budget and administration of coronial autopsies was transferred to Queensland Health for management.

The sustainability of forensic pathology services continues to be a focus of the Court in conjunction with QHFSS to ensure Queensland has access to timely and quality forensic pathology services. The 'triaging' process and the introduction of the preliminary examination procedures are intended to divert cases from unnecessary autopsy.

Accordingly, during 2021–22, there continued to be a further reduction in the percentage of autopsies ordered (1,524) relative to the number of reported deaths overall.

Table 4 – Percentage of orders for examination issued in relation to reportable deaths

	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22
Deaths reported	5,287	5,587	5,812	5,797	5,631	5,714	**6,044**
Examinations ordered	2,550	2,730	2,629	2,476	2,353	2,095	**1,524**
Percentage	48.2%	48.9%	45.23%	42.71%	41.78%	36.66%	**25.22%**

Table 5 – Number and type of examination ordered

	2015–16	2016–17	2017–18	2018–19	2019–20	2020–21	2021–22
External	769	856	967	1,049	1,008	319	**296**
Partial internal	533	583	630	614	498	762	**677**
Full internal	1,248	1,291	1,032	765	800	520	**551**

[14] Refer to State Coroner's Guidelines – Chapter 5 'Preliminary investigations, autopsies and retained tissue' https://www.courts.qld.gov.au/__data/assets/pdf_file/0015/206124/osc-state-coroners-guidelines-chapter-5.pdf

Funeral Assistance

DJAG can arrange for a simple burial or cremation service, where someone has died in Queensland and has no known relatives or friends who are willing or able to pay for a funeral, or where the deceased person's assets cannot cover the costs. This is referred to as 'Funeral Assistance'.

In 2021–22 the Coroners Court has continued to deliver the enhanced CCQ Funeral Assistance Scheme (the Scheme) under the authority of the *Burials Assistance Act 1965* (the Act).

Funeral assistance is not a monetary grant and eligibility is based on a set list of criteria which must be met by the relevant applicants. Applications can be made by either Individuals or Agencies (such as police officers or social workers where there are no known or willing next of kin) and are submitted in person at Courthouses across Queensland (including Regional Services Outlets). When an application is approved, the CCQ authorises a simple funeral (burial or cremation) to be conducted by the Government Contracted Undertaker (GCU) in the Local Government Area boundary where the person died, and according to the deceased person's wishes (if known).

The CCQ is responsible for the administration of the Scheme, the budget, cost recovery activities, policy, procedure, strategic oversight and management and reporting. Appeals on applications also sit with the CCQ and are reviewed by the Director of the CCQ. Funeral costs may be recovered by the Department, subject to conditions of section 4A of the Act. This can include recovery of monies from the deceased's bank account, money held by the Public Trustee of Queensland (PTQ), the Queensland Police Service (QPS), Queensland Health, and other agencies as appropriate.

Under the Scheme, the CCQ also authorises return to Country transfers for First Nations persons who have passed away outside of Community, to enable them to be laid at rest within their traditional homelands. The cost of this transfer is usually required to be covered by the Individual applicant. However, Individual applicants may now also apply for special consideration for the Department to fund a return to Country transfer under the Scheme if they cannot cover the cost of the transfer themselves. This special consideration is subject to additional delegate approval and may involve a substantially longer application processing time. If approved, the return to Country transfer will be undertaken by an appropriate Supplier as determined and contracted by the Department and will not be paid as a monetary grant to the applicant, or as a reimbursement of any transfer costs incurred by the applicant outside of the approved Departmental arrangement.

In 2021–22, the CCQ experienced a significant increase in applications received (22% more than the previous financial year). Of these applications, 384 were approved (in comparison to 308 approved in 2020-21) at a total state-wide cost of $677,144.18. This figure is based on total expenditure outlaid by the Department ($945,583.36), less the total monies recovered under the Scheme ($268,439.18).

In comparison to 2020-21, the cost recovery rate dropped from 44.02% to just 28.39% due to required internal policy changes and reduced capacity to progress cost recovery activities under the Scheme. It is expected that the current trends in funeral assistance applications, expenditure, and cost recovery will continue (or exponentially increase) from 2022-23 onwards and will require significant additional resources and funding in the very near future to ensure continued service delivery.

Note: All revenue reported as cost recovery under the Scheme each year includes funds recovered against applications approved in previous financial years, as applicants may discover funds at a later time, or the PTQ may administer a deceased's estate that the Scheme has registered an interest in.

Funeral Assistance Scheme figures for 2021–22:

384	**$677,144.18**	**$268,439.18**	**23.39%**
applications approved	state-wide expenditure	expenditure recovered	of expenditure recovered

Case summary: QCAT decision

Angelopoulos v State of Queensland [2022] QCAT – 11 May 2022

The applicant's father was Greek and had strong Greek Orthodox religious, spiritual and cultural beliefs. Sadly, and unexpectedly, he passed away in hospital on 23 June 2018. The applicant applied for financial assistance for the funeral service and burial of his father under the *Burials Assistance Act 1965* to the Coroners Court of Queensland. The application for financial assistance was approved on the condition that the arrangement would be for a burial in an appropriate, conventional shape and suitably lined coffin.

The applicant requested additional funding for burial according to Greek Orthodox religious requirements. This was because an adherent of the Orthodox religion cannot be buried unless a funeral service is performed in the church prior to the burial. It is also a requirement to conduct the service in an open coffin whereby the deceased can be viewed privately prior to the church and burial service.

This request for additional funding was refused and the applicant complained to the Anti-Discrimination Commissioner of Queensland. The applicant argued that this refusal was indirect discrimination under s.11 of the *Anti-Discrimination Act* 1991 (Qld) ('AD Act'), by requiring him to bury his father without a church service or private viewing. The Queensland Civil and Administrative Tribunal (QCAT) considered that the case raised questions of statutory construction as to the meaning of various terms within the *Burials Assistance Act*, including the meaning of 'buried or cremated' in the context of the overall purpose of the Act.

The purpose of the *Burials Assistance Act* is to assist in the disposal of bodies by providing for the burial or cremation of deceased persons in certain cases for purposes connected therewith, and to validate certain burials. Section 3 imposes a duty of the chief executive to cause to be buried or cremated the body of any person who has died or has been found dead in Queensland, in any case where it appears to the chief executive that no suitable arrangements for the disposal of the body have been or are being made otherwise than by the chief executive. Section 4 of the Act provides that the expenses associated with the burial or cremation shall be met by the chief executive. Notably, there is an absence of the word 'funeral' in the Act, which refers only to 'burial' or 'cremation'.

QCAT found that the *Burials Assistance Act* does not provide for the payment of expenses related to religious or cultural ceremonies or civil remembrance ceremonies and associated additional conveyancing costs of those ceremonies. If the intention of the *Burials Assistance Act* was to provide for such ceremonies, it would have been clearly stipulated.

QCAT found that the decision to refuse the additional costs was reasonable in all the circumstances and did not amount to unlawful discrimination. The refusal was reasonable and otherwise exempt under s.106 of the *Anti-Discrimination Act* 1991 on the basis that it was necessary to comply with, or is specifically authorised by, the *Burials Assistance Act*. The decision to refuse the additional costs was properly made under the Act and not because of the applicant's or his deceased father's religious or cultural beliefs.

The application was dismissed.

The decision is available on the Queensland Courts website at: https://archive.sclqld.org.au/qjudgment/2022/QCAT22-163.pdf.

Government-contracted undertakers

Government contracted undertakers (GCU) are funeral directors who are engaged when a deceased person is required to be transferred from the place of death to another destination for the purposes of coronial investigation, such as the mortuary of a local hospital. Depending on the type of death and the local health resources available, the deceased person may be transported to another hospital or health facility for further pathology or autopsy to be conducted. GCUs are also authorised to perform funeral services including simple burial and cremation, for approved applications made under the CCQ Funeral Assistance Scheme. GCUs provide services for the entire state of Queensland and have responsibility for their contracted Local Government Area (LGA) boundaries only. There are 77 LGA boundaries within Queensland.

The current contracts, formally referred to as standing offer arrangements (SOA), have been in effect since February 2018, with 33 government contracted undertakers acting as Suppliers under the current SOA. The services comprise of Service A – the conveyance of human remains and Service B – the burial or cremation of deceased persons. The CCQ was successful in obtaining permanent funding for the Finance and Contracts Coordinator position in 2021-22, a temporary position previously established in response to the Queensland Audit Office recommendation to improve the performance monitoring and management of the GCUs. This position is now a critical part of service delivery within the CCQ, continuing to implement this specialised function, as well as other essential business improvement projects for the court.

The current contracts for the provision of coronial services in Queensland are due to expire in early 2023. Prior to the end of the 2021–22 financial year, the CCQ engaged with the Queensland funeral industry through a public survey, to gauge interest in the upcoming tender process for these services. The tender process will continue throughout 2022-23, and new standing offer arrangements with Suppliers are expected to be finalised no later than the end of the 2023 calendar year (dependent on any required extensions to current contracts, due to the complexity of the tender process).

The total number of conveyancing claims accepted by CCQ via the portal for this reporting period is 4,009, relating to 5,597 conveyances of deceased persons in Queensland (including initial, further and return conveyance journeys). The total amount expended by the CCQ in relation to the conveyance of bodies in 2021-22 was $3,274,746.84. The online invoice system portal developed in partnership with the Registry of Births, Deaths and Marriages in 2019-20 is now in full operation. The CCQ Business Services team is in the planning stages for additional enhancements to the portal, which aim to create more efficiencies in invoice processing and accounts receivable for conveyances and burials/cremations, and to further streamline the internal progression of CCQ Funeral Assistance applications.

Regular site visits under the Voluntary Trial Assurance Program were unable to recommence in the 2021-22 financial year, due to continued COVID-19 related staff absences within CCQ and competing priorities relating to the significant of work and projects currently being undertaken by the Business Services team. It is expected that the site visits will commence once the tender process is underway and additional resourcing is available within the team. This program will also be renamed to the Assurance Program under the next SOA and be implemented permanently as part of the day-to-day performance management and relationship building with both new and existing CCQ Suppliers.

GCU conveyancing figures for 2021–22:

5,597
conveyances by GCU

$3,274,746.84
state-wide expenditure of conveyances

Inquests

An inquest is the 'public face' of the coronial process; an open proceeding that scrutinises the events leading up to the death. An inquest can help families understand the circumstances of their loved one's death, provide the public with transparency about a death, and it provides the legislative authority for coroners to make comments and recommendations that aim to prevent or reduce deaths from similar circumstances in future. Each year only a small percentage (< 1%) of matters proceed to inquest.

Finalised inquests

During the reporting period the Court finalised inquests into the deaths of **35 persons with 27 inquest findings completed**[15]. It is important to note that this figure does not account for the number of inquests that were opened or had ongoing hearings by coroners during the reporting period.

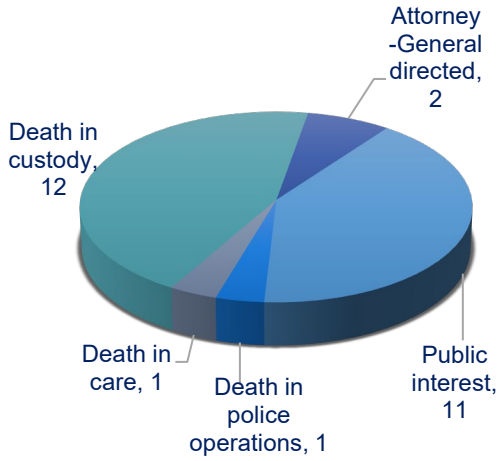
Pursuant to the Coroners Act it is mandatory that certain deaths be investigated at inquest, including, those that are in custody, those in care or police operations, where there are issues about the care or police involvement, and those directed by the Attorney-General or District Court.

A coroner may also convene an inquest if there is reasonable doubt about the cause or circumstances of the death or they are satisfied it is in the 'public interest' in so far as drawing attention to the matter may prevent similar deaths in future.

Counsel assisting

Each of the full-time coroners is assisted by a legal officer, known as 'counsel assisting'. These legal officers perform the role of counsel assisting and during 2021-22 assisted as either counsel assisting or instructing counsel assisting in all except two inquests that were finalised during the period. Having in house counsel assisting is beneficial as coroners are supported by lawyers with specialised skills and experience in the jurisdiction and inquest costs are kept to a minimum.

Figure 7 – Inquests finalised by category



Inquest categories

During 2021-22 approximately 40% of inquests finalised were those in the 'public interest' with the same number finalised in relation to death in custody investigations.

Media and community interest

Coronial inquests and coroners findings at inquest continue to receive considerable media attention and community interest. **During 2021-22 the Court responded to 401 media queries** (up from 338 in the previous financial year) received on behalf of the courts media unit, relating to investigation updates, requests for exhibits, witness list and other general investigative enquiry updates.

The **Coroners Court received over 484,000 page views** on the '*Findings and upcoming inquests and search findings*' page (up from 445,000 the previous year) with a significant spike in interest at the end of the reporting period, likely in relation to findings into the death of Hannah Clarke and her three children.

[15] One inquest may include multiple deceased.

Table 6 – Inquests finalised during 2021-22

Deceased name	Coroner	Counsel assisting	Keywords
Luke Cunningham	Ryan	Sarah Lio-Willie	Suicide, death in custody, young remand prisoner.
Cary Saunders	Ryan	Sarah Lio-Willie	Death in custody, natural causes, infective endocarditis leading to cerebral haemorrhage.
Benjamin Batalha	Ryan	Matthew Hickey	Death in custody, cause of death not determined, availability and misuse of prescribed and non-prescribed medication in custody.
Zamia Eli-Smith	Bentley	Kate McMahon Sarah Lane	Baby, neonate, home birth.
John Harris	Ryan	Melia Benn	Death in custody, suicide, hanging.
Corey Christensen **Thomas Davy**	Bentley	Joseph Crawfoot	Stabbing, double fatality, police investigation.
Logan Dreier	Bentley	Rhiannon Helsen	Queensland Police Service, pursuit, pursuit policy.
Enid Hyde **Norman Hyde** **(First Nations)**	Wilson	Joseph Crawfoot	Reopening of 1973 coronial investigation and inquest, deaths at sea 100 metres off False Cape, Yarrabah.
Omid Masoumali	Ryan	Emily Cooper Megan Jarvis	Death in custody, refugee, health care in regional processing countries.
Lorraine Grover	Wilson	Joseph Crawfoot	Attorney-General direction to conduct an inquest, 1983 cold case, female self-inflicted gunshot wound.
Frederick Row **(First Nations)**	Ryan	Rhiannon Helsen	Death in custody, First Nations man, hanging.
Craig Williams	Clements	Sarah Lane	Death in care, Brugada syndrome, Hypoxic brain injury.
Casey Brown	O'Connell	John Aberdeen	Road accident, passenger on 'route service' bus fatally injured when bus overturned, passenger seatbelts not fitted to bus.
Noombah **(First Nations)**	Ryan	Sarah Lio-Willie	Death in custody, emergency examination authority, detention under Public Health Act 2005.
Monique Clubb	Bentley	Alana Martens	Missing person, fentanyl, prescribing, doctor shopping.
Daniel Lewis	Ryan	Rhiannon Helsen	Death in custody, avoiding being placed into custody, use of force.
Johann Ofner	MacKenzie	Sarah Lio-Willie	Non-intentional shooting in theatrical setting, criminal acts, role of armourer and adequacy of applicable work.
Christopher Powell	MacKenzie	Mark Plunkett Rene Jurkov	Elevated work platform, outrigger collapse, unstable ground, Mobile Crane Code of Practice 2006.

Tyson Jessen	Ryan	Melinda Zerner Grace Deveraux	Death in custody, police shooting, prisoner arrested on interstate warrant.
Troy Mathieson **Hughie Morton** **(First Nations)**	Ryan	Melia Benn	Death in custody, suspected offending, avoiding being placed in custody.
Jason Guise	MacKenzie	Sarah Lio-Willie	Unknown cause of death, body found in sewer, suspicious circumstances.
Mark Sheppard	Ryan	Joseph Crawfoot	Death in custody, police shooting, chronic illness.
Jesse Kermode	Ryan	Rhiannon Helsen	Death in custody, Police shooting, edged weapon.
Doreen Langham **Gary Hely**	Bentley	Ben Jackson Katie Ward	Domestic and family violence, suicide, intimate partner homicide.
Hannah Clarke **Aaliya Baxter** **Trey Baxter** **Laianah Baxter** **Rowan Baxter**	Bentley	Dr Jacoba Brasch QC Ben Jackson Katie Ward	Intimate partner homicide, retaliatory filicide, lethality risk factors.
James Tabuai	Wilson	Molly Mahlouzarides	Head trauma, skull fracture, non-accidental.
Ezekiel Pini	Wilson	John Aberdeen	Youth residential care, voluntary placement 13 year old male child, forcible entry into residential facility office.

Public interest inquests: case summaries

The Coroners Act in s28 notes that an inquest may be held into a reportable death if a coroner investigating the death is satisfied it is in the “public interest” to do so. The “public interest” is a discretionary consideration by a coroner. Some factors when assessing whether an inquest should be held include, but are not limited to, reasonable doubt about the cause or circumstances of the death, drawing attention to the death to prevent similar deaths in future, have previous inquests dealt with similar deaths and made recommendations that have not been adopted or is there the potential for publicity from an inquest to generate new evidence. The Attorney-General can also direct that an inquest can be held.

The following sections provides a summary of inquests finalised by coroners during the reporting period that were convened in the “public interest’.

Zamia Ely-Smith

Deputy State Coroner, Jane Bentley – 17 September 2021

Circumstances of the death

Infant Zamia Ely-Smith was born unresponsive on 10 January 2018, during a home birth at the residence of her mother Ms Ely and father Mr Smith. The midwives, Blyth and Oliver, eventually called an ambulance, which conveyed baby Zamia to the Gold Coast University Hospital (GCUH) where she later died on 13 January 2018. Early ultrasounds conducted whilst Zamia was in utero were normal. During the pregnancy, her mother Ms Ely had decided on a home birth and engaged midwife Ms Blyth for that purpose. Both Ms Blyth and her colleague Ms Oliver were private practising registered midwives and Directors of 'My Own Midwife' (MOM). They were both present for Zamia's birth.

On 4 January 2018, at approximately 39 weeks gestation, Ms Ely reported decreased foetal movements to Ms Blyth. When the problem persisted, she presented to GCUH on 7 January 2018. At that time, an ultrasound was performed by a specialist, which showed a normal amount of amniotic fluid around the baby and no signs of the membranes having ruptured. The foetal heart rate (FHR) was normal. A vaginal examination confirmed she was 2-3 centimetres dilated. The doctor recommended an immediate induced labour and emphasised the risks associated with a home birth. Ms Ely declined but agreed to return the next day.

On 8 January 2018, Ms Ely re-attended GCUH, reporting good foetal movement. She began to have contractions later that day. She described to Ms Blyth that she had a "light bloody flow" for eight hours on this day. She asked whether she should return to the hospital, but Ms Blyth advised her against doing so at that time. The midwives' notes recorded the rupture of the membrane at midnight on 8 January 2018 (27 hours and 40 minutes before the birth).

On 9 January 2018, at 10.40 p.m., Ms Blyth arrived at Ms Ely's home to assist with the birth. Ms Oliver also attended as second midwife to take notes whilst Blyth provided care and to help in the birth itself as required. At 10.46 p.m., their notes recorded: *"no membranes felt"*.

From 1.22 a.m. on 10 January 2018, Ms Ely was in active labour. By 2.50 a.m., she could feel her baby's head. At 3.10 a.m., Zamia's FHR was 77 beats per minute and dropping. It did not recover to a normal range at any time after that. The abnormal FHR was not called by Ms Blyth and none of the FHRs from then were recorded accurately. For the last eight minutes of labour, the midwives did not auscultate the FHR at all.

At 3.39 a.m., the baby's head was out except the chin and Ms Blyth provided manual assistance. At 3.40 a.m., Zamia was born unresponsive with her cord wrapped around her neck, body and leg. Her Apgar score was falsely recorded as 1 within minutes of the birth when it was, in fact, zero. Ms Blyth cut and applied a single clamp to the cord whilst Ms Oliver commenced resuscitation by intermittent positive pressure ventilation (PPV) with a Neopuff device. When Zamia did not respond, Ms Blyth called triple zero and commenced CPR. QAS paramedics attended and intubated and ventilated Zamia. She was transported to GCUH, where she was diagnosed with brain damage and declared deceased on 13 January 2018.

The Investigation

The most crucial piece of evidence turned up by the coronial investigation was a video recording of the birth itself made by Mr Smith. This was the subject of expert interpretation at the inquest. Collectively, this was characterised as "the only accurate evidence of what occurred at the birth". Statements from the midwives Blyth and Oliver and their medical records were also obtained but given far less weight.

The autopsy determined that the cause of death was hypoxic-ischaemic encephalopathy (brain damage due to lack of oxygen). The pathologist remarked that it was possible that Zamia succumbed to the effects of chorioamnionitis (a bacterial infection of the membranes surrounding the foetus and the amniotic fluid in which it floats) shortly before the time of her birth, causing her to be born with an Apgar score of zero and hypoxic-ischaemic encephalopathy developing afterwards. However, the pathologist could not exclude the possibility that Zamia's death was caused by complications of the birth.

The Inquest

The inquest into Zamia's death was conducted in Southport over a total of four (4) days: 18 to 19 May 2021 and 24 to 25 August 2021. Several medical witnesses gave evidence, including the midwives Blyth and Oliver, Irvine (attending paramedic), Heath (expert midwife), Dr Allen (expert obstetrician), and Dr Rashford (Medical Director of QAS).

The issues explored at the inquest included the appropriateness of a home birth for Zamia Ely-Smith, and whether the care provided by the midwives at the home birth was adequate.

In the course of evidence, it became clear that the "contemporaneous" records made by the midwives had been deliberately altered by them after Zamia died (e.g. by falsifying foetal heart rates that they had never taken), in order to conceal their failure to take appropriate action during the birth and portray the facts more favourably to themselves. Consequently, their evidence about the circumstances of Zamia's death was rejected as lacking credibility.

Expert witnesses, Ms Heath and Dr Allen, observed the recording of the birth and opined that the midwives' auscultations were not recorded accurately or actioned appropriately. Dr Allen, due to his experience, was able to discern the FHR from listening to the recording and identified that the numbers called by Ms Blyth bore no resemblance to what he heard and that the midwives' records had been falsified to give the impression that the FHR remained within normal limits until the end of the birth. He explained that the true rates demonstrated a situation of foetal distress that was not acted upon. Dr Allen also expressed concerns about how the labour was managed, including that the cord was not double clamped, the delivery of the head was not managed appropriately, and there was a failure to recognise foetal compromise and transfer Ms Ely to hospital.

Dr Allen concluded that Zamia was born lifeless with no heart rate and possibly had no heart rate for the last eight minutes of birth. With respect to the cause of death, he excluded that Zamia died from the cord being around her neck, as her head was not swollen and there was no other evidence of occlusion of blood from the head. Dr Allen concluded that it was most likely that Zamia died from chorioamnionitis due to the rupture of membranes occurring more than 18 hours prior to the birth, which had allowed time for bacteria to enter and infect the uterus. The lack of detail in the midwives' records about how long before the birth the membranes had ruptured was, in his view, a glaring omission.

Dr Rashford gave evidence that PPV should have been commenced within one minute of the birth and resuscitation should have been commenced immediately to prevent brain damage. He opined that, had QAS been called earlier, effective resuscitation by paramedics could have occurred sooner after the birth.

Findings and Comments

The Deputy State Coroner accepted that the hypoxic-ischaemic encephalopathy was caused by chorioamnionitis, due to the membranes rupturing more than 18 hours prior the birth and a lack of treatment of this condition at a hospital. In doing so, Ms Blyth's evidence that there were no clinical signs of chorioamnionitis was rejected.

The Deputy State Coroner adopted the expert evidence that there were significant antenatal indications to abandon home birth and that the home birth should not have proceeded in this case. It was held that Blyth should have refused to assist in a home birth following the decreased foetal movements on 7 January 2018 and the doctor's advice for the birth to occur at GCUH.

The Deputy State Coroner found that Zamia's death was preventable, and, in fact, the midwives had missed several opportunities to refuse a home birth and send Ms Ely to hospital. Those opportunities for intervention included when decreased foetal movement was obvious on 7 January 2018; when there was evidence of the membranes rupturing on 8 January 2018; when the rupture of the membranes was confirmed at 10.46 p.m. on 9 January 2018; and when they failed to call an ambulance at 3.10 a.m. on 10 January 2018 as Zamia's heart rate dropped. It is likely that, had intervention occurred at those points and the birth occurred at hospital, Zamia would have been a healthy baby. However, earlier resuscitation was unlikely to have changed the outcome, as Zamia was beyond saving by the time she was born.

Finally, the Deputy State Coroner recommended the development of standard guidelines for home births to prevent similar deaths occurring in future. It was envisaged these guidelines would include suitability criteria for home births; information for pregnant women about the risks; rationale for transferring care to hospitals during a home birth; details of necessary equipment; minimum standards of training for practitioners; and a checklist for midwives relating to the resuscitation of neonates during home births.

Corey James Christensen & Thomas Ian Davy – 'Alva Beach'

Findings delivered – 6 October 2021

Circumstances of the death

At the time of their deaths on 1 October 2018, Corey James Christensen was 37 years old and Thomas Ian Davy was 27 years old. Mr Christensen and Mr Davy met each other first the first time on 30 September 2018, at Alva Beach. Mr Davy was spending the weekend with his partner Candice Locke. Mr Christensen and his friend Louis Bengoa were locals and were driving along the beach in Mr Bengoa's Polaris ATV. Mr Christensen and Mr Bengoa met Mr Davy and Ms Locke on the beach and invited them to a NRL Grand Final party that afternoon.

Later that night, Mr Davy left the party leaving Ms Locke as she wanted to remain. Sometime later Mr Bengoa took Ms Locke for a ride in his Polaris. It was during this drive that she sustained an injury to her left shoulder after falling from the buggy. Mr Bengoa did not heed her request to seek medical attention for her injury. Ms Locke became uncomfortable and got out of the Polaris and hid behind a car until Mr Bengoa left. She remained hidden until about 10 minutes later when the Polaris returned and she heard Mr Christensen's voice call out for her. She got in the Polaris with them and they drove off, but she soon felt uncomfortable again and asked them to stop the Polaris at the houses at the entrance to Alva Beach. She got out of the Polaris and walked to the first house she saw, which was the home of Dean Webber. Mr Webber was the only person home that night, he was 19 years old at the time.

Ms Locke knocked on Mr Webber's door requesting an ambulance because she had fallen off a buggy with two men she had just met, and he let her inside and called triple zero and was connected to the Queensland Ambulance Service (QAS). After a few minutes of being inside, Mr Bengoa, Mr Christensen and Mr Davy were yelling her name and banging on the door. Mr Webber told the emergency operator he did not feel safe. The call taker told him to call back if anything changed and created a job for the Queensland Police Service (QPS) to assist in the matter. A police officer called Mr Webber within 10 minutes to ascertain the situation. Mr Webber informed them that Ms Locke was injured and scared in his house, and identified Mr Christensen and Mr Bengoa were outside his house looking for her. The officer advised Mr Webber police should be there within 30 minutes and to call triple zero if the situation escalated.

Mr Webber locked the doors, told the men to leave his property. About ten minutes later he called triple zero again, advising that people were trying to break into his home. Mr Webber became fearful and armed himself with a knife. The call ended with the sounds of shouting and Ms Locke screaming in the background. At this time Mr Christensen and Mr Davy gained entry to the house and a scuffle ensued. During the struggle, Mr Webber stabbed both men and they withdrew from the house.

Mr Webber made a third triple zero call and informed the call taker that he had "stabbed a bloke" who broke into his house", that there were three males, and he was scared that the other male was going to kill him. When emergency services arrived both men were pronounced deceased at the scene. Mr Christensen sustained two wounds – a stab wound to the left upper side of the chest, damaging the right side of the heart, and a tear of the back left of the scalp. The cause of death was a stab wound to the chest.

Mr Davy sustained six distinct knife wounds the two most serious of which were to the left and right chest. Both of those wounds perforated the sac surrounding the heart, one of which also breached the front wall of the right side of the heart. The cause of death was blood loss caused by the stab wounds to the chest. Mr Webber was found to have sustained bruising to his head, face and limbs.

The Investigation

Mr Webber was not charged with any criminal offence, police citing he acted in self-defence. The Queensland Police Ethical Standards Command Investigation had concluded that the emergency response by police was consistent with authorised policies, practices and procedures.

The Inquest

The inquest into the deaths of Messrs Christensen and Davy was conducted by the Deputy State Coroner between 12 and 16 October 2020. Nineteen witnesses gave evidence at the inquest. The inquest investigated the following issues:

1. *The findings required by s.45 (2) of the Coroners Act 2003; namely the identities of the deceased, when, where and how they died and what caused their deaths.*
2. *The circumstances surrounding the death of Thomas Ian Davy and if any person caused his death.*
3. *The circumstances surrounding the death of Corey James Christensen and if any person caused his death.*
4. *The adequacy of the emergency response provided by the Queensland Ambulance Service and whether the response was consistent with authorised policies, practices and procedures.*
5. *The adequacy of the emergency response provided by the Queensland Police Service and whether the response was consistent with authorised policies, practices and procedures.*
6. *Whether any internal review or investigation was conducted by the Queensland Police examining the police response to the emergency, the outcome of those reviews or investigations, and the adequacy of those reviews and investigations.*

7. *Whether the officers on duty at the Ayr Police Station at the relevant times, performed their duties in a manner that complied with the authorised policies, practices and procedures of the Queensland Police Service.*
8. *The decision by Queensland Police not to charge and/or prosecute any person in relation to the deaths of Thomas Ian Davy and Corey James Christensen.*
9. *Whether earlier intervention by the Queensland Police Service may have prevented the deaths of Thomas Ian Davy and/or Corey James Christensen.*
10. *Whether earlier intervention by the Queensland Ambulance Service may have prevented the deaths of Thomas Ian Davy and/or Corey James Christensen*

The inquest heard evidence that it was the QAS who initially notified police of the incident and classified the job as "urgent", assigning paramedics who were staged nearby to await police attendance. However, the callout was rated as non-urgent by the police communications centre in Townsville. QAS had been waiting nearby for police for about 30 minutes, before attending Mr Webber's home.

The QPS were aware of the Alva Beach incident some 30 minutes before the stabbing. The only other task being managed by officers at Ayr Police Station at that time was an objection to bail affidavit in relation to a person in watchhouse custody.

Findings and Comments

The Deputy State Coroner found that the deaths of Messrs Christensen and Davy would have been prevented had QPS or QAS arrived at the house prior to the two men entering the house. The Deputy State Coroner also found that Mr Webber was genuinely concerned for his own safety and that of Ms Locke when he made the first call to triple zero and continued to be so until the arrival of police.

The Deputy State Coroner made the following findings:

1. *The decision by QAS to stage and wait for police was consistent with authorised policies, practices and procedures. No adverse comments were made of the QAS response.*
2. *The initial emergency response of the QPS, with respect to assessing the incident in accordance with the Commissioner's Instructions and assigning Priority Codes was inadequate.*
3. *The review conducted by Ethical Standards Command was inadequate as it failed to investigate in any depth or address appropriately the failures of the QPS to comply with relevant policies and*

procedures, and, significantly, the failure to give appropriate heed to the urgent nature of the incident and the need to assist the QAS when requested to do so.

4. *That the exercise of discretion to not charge Mr Webber with any offences was appropriate and in accordance with police procedures and policies. However noted that, if new evidence were to emerge there is no reason to believe that such a decision could not be revisited.*
5. *It is very likely, had either paramedics or police officers attended before the stabbings occurred the situation would have de-escalated and the deaths of Mr Christensen and Mr Davy would have been prevented. However, once they had sustained their fatal wounds there was no intervention by either QPS or QAS that might have prevented their deaths.*

The Deputy State Coroner found that there were two critical circumstances that contributed to a delay in the police officers responding in a timely manner:

a. *A failure to code the incident as a Code 2 rather than a Code 3; and*
b. *The decision to prioritise attending a Justice of the Peace to have an objection to bail signed before attending Alva Beach.*

Upgrades to the Townsville Police Communications Centre, and amendments with respect of priority codes and the role of tasking officers has occurred since the deaths. The Deputy State Coroner was satisfied that such amendments will assist responding officers in their decision-making process regarding timeframes for priorities and attending an incident.

The Deputy State Coroner made one recommendation in relation to the QPS Operations and Procedures Manual concerning the ambiguous definition of “rostered on duty” officers and the wearing of accoutrements.

LOGAN DREIER

Deputy State Coroner, Jane Bentley – 14 October 2021

Circumstances of death

Mr Logan Dreier (Logan) was 18 years of age at the time of his death on 9 August 2019. The circumstances surrounding his death involved two police pursuits.

The first pursuit occurred after police responded to a reported burglary at Maudsland. The three suspected offenders were Logan, a man named John and another person. All three left the scene in a Nissan Pulsar sedan. Police pursued that car behind Movie World where the driver lost control of the car in bushland at around 9.10am. The suspected offenders abandoned and ran away from the car. One offender was apprehended by Movie World staff.

At around 9.14am, Logan and John stole a white Toyota Hilux dual cab utility (“the utility”) owned by Movie World, parked outside the maintenance shed of the “Wild West” ride. John drove the utility but prior to exiting Movie World, the utility stalled, and Logan and John swapped seats. Logan drove the utility from that point on. By this time, police were around the area as a result of the first pursuit.

The utility entered the M1 travelling southbound and police commenced following the utility. Logan ignored police and continued driving. The utility drove through a number of streets/roads, at speed at times, on the wrong side of the road and weaved in and out of traffic to avoid police. At around 9.30am, the utility travelled from the second turning lane at the intersection of Southport Nerang Road and Queen Street at Southport. The front wheel collided with the centre median causing the utility to travel sideways, roll three times and land to rest on the driver’s side. Logan was ejected from the driver seat as it rolled, and he struck the concrete curb.

Police officers arrived at the scene within seconds and provided first aid until paramedics arrived. Logan was transported to the Gold Coast University Hospital where he underwent surgery. Logan had suffered a “massive non-survivable intracranial haemorrhage”. He was transferred to ICU and palliated. Logan died at 9.55pm. Logan’s cause of death was found to be multiple injuries due to a motor vehicle collision.

The Investigation

Forensic Crash Investigation (FCU)

A FCU Investigation report was prepared outlining the mechanism of the crash. An examination of scene indicated that the construction of the road and its condition did not contribute to the traffic crash. There were also no atmospheric conditions nor substances on the roadway that may have contributed to the incident.

An examination of the utility indicated that it was in an unsatisfactory mechanical condition at the time of the crash due to minor free play in the idler arm and pitman arm moveable points. However, these defects were considered not serious enough to affect the safe operation of the utility.

Ethical Standards Command (ESC) Investigation

Investigators from the ESC investigated the circumstances of the engagement of police units and the pursuit. A comprehensive Coronial Report, with extensive annexures was submitted with details of the relevant findings and recommendations. ESC investigators made the following recommendations:

• QPS consider the current policy wording of Chapter 15 of the OPM's in view of the perceived and apparent inconsistencies; and
• QPS reinforce the Safe Driving Policy through continuous training, refinement and where required, improvement to reduce the risk of a similar event occurring.

A disciplinary report was prepared by ESC investigators in relation to the actions of some of the officers involved in the pursuit.

The Inquest

The inquest was heard over six days in Southport, from 19 July to 23 July and 28 July 2021. There were 23 witnesses who gave evidence during the inquest. The Deputy State Coroner explored the following issues:

- *The findings required by s45(2) of the Coroners Act 2003;*
- *The adequacy and appropriateness and actions taken by various members of the QPS to follows the vehicles containing Logan, including but not limited to, whether such actions were contrary to the interests of community safety;*
- *The overall management of the pursuit of the vehicles containing Logan by the QPS, including whether the police officers involved acted in accordance with the applicable QPS policies and procedures;*
- *The adequacy of the QPS investigation into the circumstances surrounding Logan's death; and*
- *Further actions, if any, which could be undertaken to prevent a similar incident from occurring again.*

Evidence at the inquest from ESC Investigators (like in their report) identified a number of areas of concern relating to the conduct of the police officers involved. It was concluded that there was a lack of effective command and control of the incident from the time the utility left Movie World until it crashed. There was no clarity about how the incident was unfolding and this should have been the cue for the pursuit to be terminated pursuant to Chapter 15 of the QPS Operational Procedures Manual (OPM) which deals with policy relating to police pursuits.

The actions of some of the officers in pursuit of the utility *"created an undue risk to the other road users"* which is a cause for abandoning the pursuit as per the policy. It was found that the on-ground practice in place showed an erosion of the safe driving policy, resulting in unsafe driving practices. The main concern was the risk against the benefit of continuing with the pursuit given the high risk to other road users as required by OPM 15.5.3 and that there is concerning practice for officers to operate outside the policy and citing the "protracted follow" provisions, which fails to enliven the continual risk assessment safeguard under the policy.

There were issues with management in that adherence to the OPM's must be operationally driven by supervisors and lower-level staff. Organisational issues were also identified in that there appears to be a 'significant' disconnect between the operational practice and QPS policy. There were also some ambiguities in aspects of the Safe Driving Policy under the OPM which may have influence the decisions made during this incident. The "Protracted following of a vehicle provisions" (OPM 15.4.6) states that the continued following of a vehicle where the vehicle is committing a driving offence or avoiding detection constitute a pursuit. However, this appears to be in conflict with the provisions of Pursuits (15.5) in that the definition of pursuits under the OPM does not apply to the protracted provisions and attempt to intercept a vehicle.

Findings and Comments

The Deputy State Coroner found that Logan's death was preventable and unlikely to have occurred had all police officers involved in the pursuit complied with the QPS pursuit policies. A number of officers involved in the pursuit were found to have not complied with OPM policies, leading to confusion and crucial information being communicated to other officers, that resulted in the pursuit being continued as opposed to being abandoned. The Deputy State Coroner noted evidence provided by an experienced Polair officer that it would be extremely helpful for police vehicles to have call signs on the bonnets and roofs to be easily identifiable from the air. Whilst this was trialled it was not continued after the trial.

Recommendations

The Deputy State Coroner recommended:

1. *The QPS continue and expedite the review currently in progress to consider the Safe Driving and Pursuit Policy. This review could consider whether the threshold for what is a pursuable matter needs to be heightened from simply an indictable offence.*

2. *The QPS consider the introduction of practical scenario based pursuit refresher training to be provided to all officers at regular intervals. Such training needs to provide officers with the skills to conduct the necessary risk assessments per the pursuit policy under stressful and difficult conditions and effectively utilise police communications.*

3. *The QPS consider branding the bonnets and roofs of police vehicles with their call signs to assist in identification by Polair personnel.*

Gwen Lorraine Grover

Northern Coroner, Nerida Wilson – 9 November 2021

Circumstances of the death

At about midday on 14 October 1983, Gwen Grover was located deceased in a green 1975 Valiant Galant sedan on Lake Street in Cairns. She was found by a passer-by who contacted police. Mrs Grover was positioned in the driver's seat of the vehicle, with a single gunshot wound to her left temple. She was slumped to the left and was holding a rifle across her lap, with her right hand clenched around the muzzle. There were a large number of empty 'stubbies' and cigarette ash/butts on the floor of the vehicle.

An external and internal autopsy was performed on 17 October 1983 . Her cause of death was determined to be 1a. cerebral destruction, due to or as a consequence of, 1b. bullet wound to the head.

Mrs Grover was the mother and primary carer of two children who were aged 15 and 12 respectively. At the time of her death, Mrs Grover was estranged from her husband, Duncan Grover. Mrs Grover and Duncan had married in 1968 and moved from NSW to Cairns in about 1974 or 1975, before separating in April 1982. Mrs Grover re-partnered with Kenneth Soper in 1983, however they separated shortly prior to her death.

Duncan is now married to Elizabeth Grover, who had been a close friend of Mrs Grover. They commenced a relationship sometime prior to Mrs Grover's death, which was a significant stressor for Mrs Grover. She was also experiencing financial difficulty and was in the process of moving into a new unit after separating from Mr Soper, which was described by witnesses as unsuitable and almost uninhabitable. Mrs Grover was highly stressed about the suitability of the unit for her children, and was concerned about affording basic necessities including school uniforms. These aspects of Mrs Grover's social history were considered relevant factors towards the original and subsequent finding of suicide.

The Investigation

The original police investigation into Mrs Grover's death found that there were no suspicious circumstances. In 1984, it was recommended by Coroner Scanlan that no inquest be held.

In December 2019, the Attorney-General issued a direction to the State Coroner that the coronial investigation into Mrs Grover's death be reopened following a request made by Mrs Sue Cole, Mrs Grover sister, who raised a number of issues with the investigation and findings, and further information that had since come to light. A review was subsequently sought from the Cold Case Investigation Team, Homicide Group. The Northern Coroner took carriage of the matter for the purpose of an inquest. The Cold Case investigation into Mrs Grover's death was thorough during which numerous additional witness statements, expert reports, and recorded scene re-enactments were obtained.

The Inquest

The matter proceeded to inquest in October 2021 and considered the findings required by s45 of the *Coroners Act 2003* as well as the adequacy of the original investigation by the Queensland Police Service. Nine witnesses gave evidence over two days of hearing, and a variety of questions and concerns were explored, including the nature of the firearm, the extent and adequacy of the original investigation, and Mrs Grover's social history, both generally as well as her movements in the day prior to her death.

In relation to the findings required by s45, Coroner Wilson found that even taking into account the comprehensive Cold Case investigation and new lines of enquiry, ultimately there were no suspicious circumstances and Mrs Grover died as a result of a self-inflicted gunshot wound. As to the initial investigation conducted by Police, Coroner Wilson considered it to be perfunctory. It was noted that lines of enquiry which could have possibly shone light on Mrs Grover's final movements were now unavailable, due to the passing of key witnesses. Ultimately, Coroner Wilson found that the original conclusion of suicide was sound. However, the initial investigation was lacking as not all of the relevant available evidence was obtained.

Casey Lenard Brown

Central Coroner, David O'Connell – 16 December 2021

Circumstances of the death

On 16 February 2016, 19-year-old Casey Lenard Brown was sitting in the second last row of a bus travelling to Proserpine from Airlie Beach. He was one of ten passengers, plus the driver, travelling on the fifty-two seat bus. The road had a 100km/hr posted speed limit, but roadworks at the time reduced the speed limit to 80km/hr. At about 1:00pm, the bus slowly drifted off the left-hand shoulder of Shute Harbour Road and struck a concrete culvert at the entrance to a rural property, which caused it to launch into the air and roll over onto its' passenger side. The bus drifted along a wide grassed table drain before coming to rest. The total distance from where the bus left the road surface until it came to rest was approximately 95 metres. Mr Brown was thrown upwards during the accident, before being projected into the opposite wall and fatally striking his head.

The Investigation

An investigation into the circumstances of the accident was conducted by police. They gathered evidence including witness statements and CCTV footage showing the actions of the driver, the

movements of the passengers, and of the bus itself as it travelled along the road. What was clear on the evidence was that the incident was a single vehicle accident, and that there was no mechanical defect of the bus, second road user, defect in the road surface, or sudden avoidance of an object or animal, that caused or contributed to the accident. The weather was fine and dry, and at approximately 1:00pm, sunlight glare into the driver's eyes was not considered a possible factor.

The driver of the bus was Mr Alan Dorman, who was 70 years old at the time. He declined to be interviewed by police following the accident and passed away before the inquest. Attempts were made by the Coroners Court of Queensland to obtain an induced statement from him for coronial use, but although promising, were unable to be finalised prior to Mr Dorman's passing. As such, the only statements made by Mr Dorman were the accounts he gave to various health professionals in the months following the accident. Mr Dorman reportedly told psychologists that he had no memory of the incident. Additionally, medical records revealed that at the time of the accident, Mr Dorman was likely suffering from undiagnosed lung cancer. The possibility of a minor medical episode was raised during the investigation because of his senior age, and that he passed away in September 2017 after being diagnosed with significant and advanced lung cancer in August 2016. Mr Dorman had no formal diagnosis at the time of the accident, however, was feeling episodes of breathlessness which were being investigated by health practitioners.

The Inquest

The inquest into Mr Brown's death was conducted over two days, from 2 March 2021 to 3 March 2021. Evidence was heard from six witnesses including the investigating police officer, an officer from the Forensic Crash Unit, a local bus proprietor, the Executive Director and Principal Engineer from Transport and Main Roads, and a forensic pathologist. In addition to the requirements under section 45(2) of the *Coroners Act 2003*, the issues for inquest were:

1. *What caused the bus to leave the sealed carriageway on Shute Harbour Road and to overturn?*
2. *Would the nature of the injuries suffered by Mr Brown have been less serious:-*
    a. *If the bus had been travelling at a slower speed; or*
    b. *If Mr Brown had been wearing a properly fitted and worn seatbelt?*
3. *Should the issue of safety for passengers in 'route' buses be reconsidered by the State government, with particular regard to:-*
    a. *Requiring route buses to be fitted with compliant lap/sash seatbelts for the driver and all passengers either:*
        i. *Immediately; or*
        ii. *Over the course of a fixed phasing-in period?*
    b. *Limiting the speed of route buses during operations to a specific maximum speed, even if that is lower than that of the relevant applicable speed zone?*
    c. *Requiring that any new bus, even if it is intended to be used only for 'route' services, be fitted with compliant lap/sash seatbelts?*

Findings and Comments

The Central Coroner found that the crash which caused Mr Brown's death occurred because of a period of Mr Dorman's momentary inattention to the task of driving. However, he could not identify, with the necessary degree of certainty, the 'underlying' cause for the lack of attention, nor could he completely exclude the various possibilities such as a 'microsleep' episode or a lapse in awareness due to underlying detrimental lung condition. On the issue of whether Mr Brown's injuries would have been lesser had the bus been travelling at a slower speed or fitted with properly worn seatbelts, the Central Coroner found that as a general proposition, it was reasonable to conclude that he would have suffered non-fatal injuries, and therefore survived the crash, in those circumstances. He described Mr Brown's death as 'entirely preventable' and concluded that compliant lap/seat belts for all passengers should be available on route buses, to be phased in over an appropriate period of time.

Recommendations

The Central Coroner made one recommendation: *That the State Government implement within one year a requirement that buses on Route Services must have compliant lap/sash seatbelts fitted for each*

passenger seat for every newly manufactured bus entering service after 1 December 2022, and that within an appropriate horizon timeline (of 10 or 12 years) for any remaining buses to be made lap/sash seatbelt compliant or that bus is retired from Route Services.

Monique Irene Clubb

Deputy State Coroner, Jane Bentley – 13 January 2022

At the time of her disappearance on 22 June 2013, Ms Clubb was 24 years old. She resided with her mother, Sheena McBride, at Point Vernon at Hervey Bay. Tragically she was involved in a serious car accident and suffered quite serious back and leg injuries. Due to the ongoing pain, she suffered from these injuries she became addicted to opioid drugs. Ms Clubb had battled with drug addiction for many years which continued to the time of her disappearance.

Circumstances of the death

Ms McBride last saw Ms Clubb on 20 June 2013 when she left Hervey Bay at about 10.30am with three friends, one of whom was Alan-Lee Heginbotham. Ms Clubb told her mother that they were going to Brisbane for the night. Apparently Ms Club and two of the three friends planned to go to Caboolture to purchase some “patches” (fentanyl patches).

Ms Clubb spent the next two nights in Brisbane with various people. On the morning of 22 June 2013 Ms Clubb called her mother and told her she was at a friend’s house with Mr Heginbotham and that another friend would drive her back to Hervey Bay if they could get money for fuel. Ms McBride told police that this was the last contact she could recall having with Ms Clubb.

Later that day Ms Clubb attended MediPrac, a medical centre, at the Beenleigh Market Place shopping centre. Using her mother’s name, she obtained prescriptions from Dr A for 50 x Diazepam (5mg), Bactrim and 5 fentanyl (75mcg) patches. At 2.24pm Ms Clubb phoned Mr Heginbotham and told him she had obtained fentanyl. That was the last time Ms Clubb used her phone although phone records revealed many unanswered phone calls and text messages to her phone after that time.

At 2.56pm Ms Clubb entered Spend Less Shoes and attracted attention due to her erratic behaviour. Staff called the security officer, Red Apolo, to “get rid of a drunk woman.” When Mr Apolo arrived at the store, staff said that Ms Clubb had just left, and pointed her out to Mr Apolo. She headed towards entrance three and then out of the centre. Mr Apolo followed Ms Clubb outside, and was told by passers by that she had just jumped over the concrete wall of the complex into Hugh Muntz park and ran toward the creek. Mr Apolo looked toward the creek and saw Ms Clubb in the middle of the creek walking towards the bank on the other side. She stumbled in the creek but got up and continued walking to the far side of the creek. She appeared to be uninjured at this time. She was still carrying a large handbag. The creek was only a couple of feet deep at the point she crossed it. This was the last sighting of Ms Clubb.

The Investigation

Ms McBride reported to police officers at Hervey Bay police station that Ms Clubb was missing on 28 June 2013. Senior Constable Shannon Gray received the report and made numerous inquiries and investigations over the next days. He then briefed the Missing Persons Unit (MPU) in relation to the information he had obtained. Proof of life checks confirmed that there was no trace of Ms Clubb after she left the complex. The investigation was transferred to the Hervey Bay Criminal Investigation Branch (CIB) and subsequent inquiries were carried out by numerous officers from a number of regions including Hervey Bay, Beenleigh, Brisbane and Dutton Park as well as the MPU.

Extensive searches were conducted for Ms Clubb in the park and the area surrounding it. Searches included air searches by police helicopter, two land searches, police dog searches for human remains, SES searches and water searches by the police Dive Squad. Police received numerous intelligence reports and reports from informants about what may have happened to Ms Clubb. Police investigated all reports and information received but could find no credible or reliable information or evidence which would corroborate any of the allegations.

On 27 February 2015 Detective Senior Sergeant Powell of the MPU reported to the Detective Inspector of the Homicide Investigation Unit that it was his view that Ms Clubb overdosed within the bushland or nearby or met with foul play shortly after exiting the bushland.

The Inquest

All of the police investigation material was tendered at the inquest and evidence was heard from 19 witnesses. The issues explored at the inquest were: whether or not Ms Clubb was deceased; if so, the findings required by s. 45(2) of the *Coroners Act 2003*; the appropriateness of the medications prescribed and dispensed on 22 June 2013; and the adequacy of the QPS investigation.

Findings and Comments

The Deputy State Coroner found that Ms Clubb is deceased, that she is not in Hugh Muntz park at Beenleigh and left the park shortly after entering it and that Ms Clubb died soon after leaving the park. It is possible that she travelled from Brisbane to the South Brisbane area, however, as she did not contact any family or friends it is likely that she died soon after the last sighting of her by Mr Apolo.

The Deputy State Coroner found that the prescribing of five fentanyl patches and 50 diazepam tablets to Ms Clubb by Dr A was inappropriate.

The Deputy State Coroner commented that, despite the search and rescue coordinators coming to the conclusion that Ms Clubb was not in the park soon after the searches commenced, the police investigation failed, at that time and when further CCTV footage and relevant transport records were available, to concentrate on ascertaining her next movements. Police reports concluding that she had died in the park relied on misconceptions that she was very intoxicated, that she was running away from Mr Apolo, that she was last seen entering thick bush in the park and that the bush and waterways had not been thoroughly searched. The conclusion reached by investigating police is inconsistent with the evidence.

Recommendations

The Deputy State Coroner made two recommendations:

1. *QPS consider a further trial and/or implementation of airborne phone location systems; and*
2. *QPS consider amendment of the relevant sections of the Operational Procedures Manual to remove possible confusion as to which region or unit is responsible for allocation of a lead investigator for missing persons investigations.*

JOHANN OFNER

Brisbane Coroner, Donald MacKenzie – 25 January 2022

Circumstances of death

Mr Johann Ofner was a professional actor and a highly skilled and athletic stunt performer. At the time of his death, he had been hired as a stunt performer by The Dreamers Creative Agency Pty Ltd (The Dreamers) for a music video by the Australian Group “Bliss n Esso”.

On 23 January 2017, Mr Ofner died of ‘gunshot to the chest’ (on front left side of chest) resulting in heart failure due to laceration, hypovolemic and cardiogenic shock (transmitted force rather than penetration of the projectile). The circumstances of Mr Ofner’s death involved a gun fight scene for the music video that was filmed at the Brooklyn Standard Bar, Eagle Lane in Brisbane. Mr Ofner’s stunt scene involved being shot by a 12-gauge sawn-off shotgun at close range in the chest.

The shotgun that was used, despite not having a metal “projectile shot”, contained shells with ignition powder”, cloth wadding and a plastic casing which was effectively a “projectile”. The shotgun was still an operable firearm and not permitted for theatrical production. No one in the production crew or the other actors were aware that the firearm was still operable. The shotgun was provided by an experienced and licenced theatrical armourer.

There was no test fire conducted of the shotgun during dress rehearsals so there was no way of knowing it would discharge a projectile like it did until it came time to filming the fatal scene.

The Investigation

The Queensland Police Service were involved in the investigation of Mr Ofner's death. The police investigation was assisted by the availability of camera footage that had recorded the fatal scene. The brief of evidence included a coronial report, witness statements, audio and video exhibits and photographs. Police did not charge any persons involved in the production. This was due to the failure to ensure that the lawful use of the weapon was the responsibility of the licenced theatrical armourer.

An investigation was also conducted by the Workplace Health and Safety Investigation Queensland (WHS) which took over three years to complete. The investigation identified potential breaches of duties and responsibilities held by the production crews/directors However, due to the "recklessness" of the licenced theatrical armourer, none could be held responsible for Mr Ofner's death. The investigation identified the following failures:

a. *" the failure to appoint a site safety officer with overall control of safety considerations";*
b. *"the failure to undertake dedicated firearms safety briefings";*
c. *"the failure to test firearm to establish safe distances for the actors";*
d. *the failure to realise aiming difficulties attached to firing 'from the hip';" and*
e. *the failure to consider more costly but safer production options such as computer enhancement or inoperable firearms.*

Investigators from WHS concluded that prosecution against the licenced armourer would have been likely had he not passed away of natural causes in August 2017. The above failures were identified by the Coroner as the shortcomings of training and safety of the scene production and one of the important issues raised during the inquest.

The Inquest

The inquest into Mr Ofner's death occurred on 23 August 2021. There were five witnesses who gave oral evidence. Written questions and answers were conducted on five expert witnesses. The full brief of evidence was tendered at the time of the inquest. The Coroner identified the following issues during the inquest:

1. *The findings required by s45(2) Coroners Act 2003;*
2. *The circumstances and cause of the fatal shooting of Mr Ofner;*
3. *"The adequacy of training and safety briefings provided to the cast and crew on production sets;*
4. *"Consideration of the regulation and applicable standards of the use of firearms by which the entertainment, film and production industry operates in Queensland and Australia;"* and
5. *"Whether there are ways to prevent a similar death occurring in the future."*

Evidence was provided by some of the experts identifying critical shortcomings as a result of the absence of a site safety officer and dedicated safety briefings on the firearms. The licenced armourer should have taken this role even in the absence of direction from the director. Test firing of the shotgun like conducted with the other guns involved should have occurred and would have exposed the danger, and in particular the distance between Mr Ofner and the stunt actor who pulled the trigger. Another critical mistake was the assumption that the stunt actor who pulled the trigger could accurately aim "shooting from the hip".

The experts provided evidence of areas that could be improved with respect to theatrical armourers in the film industry, the lack of regulation and compliance checks relating to licensing and auditing of theatrical armourers and the use of firearms in the film and production industry. Armourers, theatrical ordinance, and the use of firearms and blank firing ammunition on a set or in a theatrical production is governed by individual state legislation like the Weapons Act and explosive laws.

Findings and Comments

The Coroner commented that Mr Ofner's death was avoidable and the circumstances surrounding Mr Ofner's death was an "accumulation of errors" that resulted in tragedy. Mr Ritchie, as the armourer, was primarily responsible for the safe use of the firearms on that day. The industry expert witnesses concluded that the armourers have the final say on a production set. The Coroner commented that having said that, the principle of work, health and safety is that all involved hold a duty to be safe and make a workplace safe.

The Coroner found that the artistic director, producer and stunt co-ordinator cannot escape some criticism for their part in failing to appoint a safety officer, firearm safety briefings, test fire of the shotgun, realizing aiming difficulties; and consider more costly albeit safer productions options like the use of computer enhancement or inoperable firearms.

The Coroner found the critical lesson from this tragedy is that Mr Ofner's death was as a result of criminal actions. The shotgun that was used was still operable and was not a 'blank-fire ammunition' as it used a plastic wad in the shot shell creating a secondary projectile. The theatrical licenced armourer was suffering from terminal illness and was on opioid medications at the time of the production. The Coroner commented that had Mr Ritchie survived, he would have faced the prospect of being charged with Manslaughter and weapons related charges.

Recommendations

The Coroner recommended:

1. *That the Queensland Government review the relevant provisions of the Weapons Act (Qld) and Weapons Act Regulations (Qld) as it relates to:*
    i. *The definition of "blank-fire" ammunitions, and their practical use in theatrical productions.*
    ii. *The establishment of a section of the Queensland Police Service specific to review the role of theatrical armourers; defining their lawful rights and obligations, the serious penalties facing Weapons Act offenders and introduce standards for qualification including training and testing, in order to obtain a Theatrical Ordinance Supplier, Firearms Dealer and/or an Armourers Licence.*
    iii. *Making it absolutely clear that operable firearms and non-blank firing weapons cannot be used in theatrical performances.*

2. *That the Office of Industrial Relations consider creating a Code of Practice for armourers and the use of firearms in the film industry, modelled from the Chapter E, Section 1 of The National Guidelines for Screen Safety, in consultation with the requisite industry stakeholders.*

3. *That the Minister for Police liaise with his interstate counterparts to ensure that there is a consistent Australia-wide legislative code for theatrical armourers outlawing the use of operable firearms and nonblank firing weapons in theatrical performances.*

Accessing coronial information

The coronial system is an important source of information for researchers, whether it be to inform medical, scientific, or other research, who in turn provide an invaluable resource for coroners in their preventative role. Section 53 of the Coroners Act facilitates access to coronial documents by researchers. Additionally, the information gathered during a coronial investigation and the appropriate release of that information can also be therapeutic for a deceased person's family or for other investigative, systemic, legal, or other processes running concurrently in respect of a death.

Finalised information requests

Determining whether the release of coronial investigation documents (other than for research purposes) requires the '*consideration and balancing of competing interests – the privacy of the deceased and his or her family members; the openness and transparency of official processes; and the potential benefits to public health and safety'*. The deceased's family will generally be entitled to access coronial information however will determine whether someone has 'sufficient interest' in a document as per section 54 of the Coroners Act.

During the reporting period the Information Release unit in the Court revised internal procedures for the actioning of finalised information requests and the data below refers to a six-month capture of data (1 January 2022 – 30 June 2022).

Information requests in 2021–22:

7	**164**
Genuine Researchers approved	Individual requests for documents on finalised cases

Genuine Researchers

Generally, researchers may only access coronial documents once the investigation is finalised. However, the State Coroner may give access to documents on open files if the State Coroner considers it appropriate having regard to the importance of the research and the public interest in allowing access before the investigation has finished. The Coroners Act requires the names of persons given access to documents as genuine researchers to be noted in the annual report. The following genuine researchers were approved under s. 53 of the Coroners Act during the reporting period:

Dr Samara McPhedran: Project to lead a systemic review into male suicides, in partnership with the Queensland Mental Health Commission (QMHC), and State Coroner of Queensland (CCQ). This review sought to examine coronial documents relevant to male suicide and explore potential opportunities to reduce suicide rates by improving the understanding of contributing factors. This review will inform both the Coroners Court of Queensland in its preventative role and the QHMC in its targeted strategy for men's suicide prevention, per '*Every Life: The Queensland Suicide Prevention Plan 2019-2019*'

Dr Freya McLachlan: Dr McLauchlin was previously granted genuine research status in the 2020-21 financial year to conduct the project: *Predicting intimate partner homicide: Key risk factors and the heterogeneity of male offenders*. The project aimed to examine the role and impact of criminal history and individual-level risk factors when predicting intimate partner homicide. Approval was extended on 8 September 2021 so that Dr McLachlan could contribute to peer-reviewed journal titled: *Violence against Women on intimate partner femicides in rural areas.*

Dr Jennifer Bell & Dr Ashleigh Larkin: Dr Bell and Dr Larkins, as a part of Queensland Corrective Services, Research and Evaluation Group were approved to undertake a project titled: *Predictors of Suicide in Queensland Correctional Centres*, with the aim of exploring characteristics of a prison environment and the corresponding factors that contribute to an increased risk of suicide. The project was approved on the basis of data being used by corrective authorities to prevent future incidents occurring.

Dr Melissa Thompson, Dr Alex Olumbe, Dr Issac Han, Mr Luke Faulder and Ms Isabella Thompson: Involves a retrospective research study, identifying demographic and toxicological characteristics of drug-related deaths in the Gold Coast coronial district with specific regard to the impact of the Covid-19 pandemic. The aim of project is to identify local at-risk populations and allow for development of targeted prevention strategies, tailored to the region.

Professor Lorraine Mazerolle, Prof. Janet Ransley, Prof. Elena Marchetti, Mr Lincoln Crowley QC (now Justice), Dr John Gilmour and Ms Peta Colbert: Research project as recommended by the State Coroner in his findings of inquest into the death of Cindy Leigh Miller delivered on 22 January 2021. The project aims to examine and make recommendations with regards to the current arrangements for the investigation and oversight of police-related deaths; and the most appropriate mechanism to ensure that prior police involvement in domestic and family violence deaths is subject to timely, independent, and transparent review.

Dr Huynh Nguyen: Genuine researcher section has been uniquely utilised so that the researcher might access coronial tissue, as donated to the Queensland Tissue Bank. The project aims to scan held tissue and develop a virtual library. The suggested purpose being to facilitate better health outcomes, by decreasing surgical wait times and reducing wastage of a limited resource (tissue samples).

Dr Rexson Tse: Project to develop and improve Queensland Health, Forensic and Scientific Services (QHFSS) processes with regards to the examination and assessment of the heart during post-mortem examination. The researcher highlights that the project will assist pathologists to ascribe a more accurate cause of death when heart weight is unavailable due to trauma or decomposition.

Reducing preventable deaths

Responses to coronial recommendations

All responses to recommendations directed at the Queensland Government are published on the Queensland Courts website adjacent to the relevant inquest finding. The response indicates if a recommendation is under consideration, if and how it will be implemented or the reason a recommendation is not supported. The Queensland Government aims to respond to coronial recommendations (involving government agencies) within six months of the recommendation(s) being made and provides implementation updates every six months until the recommendation(s) is implemented, or a decision made not to support the recommendation(s).

Some of the responses of note made during the reporting period include:

Casey Lenard Brown – Coroner O'Connell

On 24 May 2022 the Minister for Transport and Main Roads advised the recommendation regarding the implementation of buses on routes services to have compliant lap/sash seatbelts for newly manufactured buses (after December 2022) and a timeline for retirement of remaining buses was under consideration.

Logan Dreier – Deputy State Coroner Bentley

On 23 June 2022 the Minister for Police and Corrective Services and Minister for Fire and Emergency Services responded to three recommendations, in respect of review of pursuit policies, introduction of scenario-based pursuit refresher training and branding bonnets and roofs of police vehicle with call signs to assist PolAir personnel. The first two recommendations were in progress and the third, under consideration with stakeholder collaboration to continue.

Corey James Christensen and Thomas Ian Davy – Deputy State Coroner Bentley

On 23 June 2022 the Minister for Police and Corrective Services noted recommendation one was implemented resulting in the amendment of section 14.1 of the Operational procedures manual (the wearing of firearms and accoutrements). In response to the coroners comment regarding the need for ongoing and further education to police officers particularly those in communication centre it was noted this was in progress with training planned, including joint work to better understand processes with Queensland Ambulance Services underway including a co-location of QPS and QAS staff to improve levels of communication and responsiveness.

Liam Cooper Scorsese – State Coroner Ryan

On 29 November 2021 the Minister for Police and Corrective Services and the Minister for Fire and Emergency Services implemented the recommendation regarding the viability of purchasing Bluetooth enabled feature for body-worn cameras. It was noted this was previously considered but current policies in relation to the activation of body worn cameras were effective. In respect of recommendation two regarding random audits of body worn cameras to ensure compliance it was noted the recommendation was agreed to in part and implementation complete with monthly audits, one-off issue-based inspections, and the requirement for a program of annual inspection by assistant commissioners.

SVE – State Coroner Ryan

On 31 May 2022 the Minister for Police and Corrective Services and Minister for Fire and Emergency Services noted the recommendation to publish annual updates detailing its strategy for the implementation of safer cells and progress against that strategy was in progress with Queensland Corrective Service progressing a document for publication to its website.

Anna Damjanovic – Coroner Clements

On 1 December 2021 the Minister for Transports and Main Roads noted upgrades to the bridge and intersection were in progress with installation of changes expected to be completed by 30 June 2022.

Systemic death review initiatives

Domestic and Family Violence Death Review Unit (DFVDRU)

The DFVDRU is based within the CCQ and provides specialist advice and assistance to coroners in their investigations of domestic and family violence related homicides and suicides and the deaths of children who were known to the child protection system. Through analysing demographic characteristics and static and dynamic risk indicators, and lethality risk indicators, the DFVDRU identifies trends and patterns regarding domestic and family violence related homicides and suicides to assist in identifying opportunities for prevention.

In the 2021-22 financial year, the DFVDRU completed 56 comprehensive case reviews to assist coroners in their investigations of domestic and family violence-related deaths, and deaths of children known to the child protection system. Case reviews, and the supporting research summaries provided by the DFVDRU, have been referenced in numerous coronial findings, including multiple published findings. Of particular note are Deputy State Coroner Jane Bentley's findings at inquest in the death of Hannah Clark and her children as well as Doreen Langham.

During 2021-22 the DFVDRU were requested to present to various high-risk teams, the Red Rose Foundation Strangulation training and for non-Government agencies highlighting critical findings across a multitude of reviews. A need for greater community awareness and understanding of domestic and family violence, including identifying and responding to risk and coercive control featured across reviews undertaken by the unit. The DFVDRU are committed to engaging with the service system and community to deliver presentations focusing on service system contact prior to death and critical areas of intervention. The DFVDRU in conjunction with the DFVDRAB recognise a strong integrated service system that collaborates, and shares information has the most impact.

The DFVDRU provides secretariat support to the Domestic and Family Violence Death Review and Advisory Board (The Board). The Board is an independent body established by the *Coroners Act 2003* to undertake systemic reviews of domestic and family violence deaths in Queensland. The Board make recommendations to the Queensland Government to improve legislation, policy, and practice to prevent or reduce the likelihood of domestic and family violence deaths. This year, the Board has worked closely with the Women's Safety and Justice Taskforce to support the recommendations made to the Queensland Government and look forward to implementation.

Importantly, systemic death review processes have been established across jurisdictions to facilitate these types of deeper learnings. They currently operate within the Queensland coronial jurisdiction for domestic and family violence related homicides and suicides and the deaths of children known to the child protection system (including suicides). The information obtained by undertaking these reviews and the work of the Board contribute to the Queensland Government's commitment to addressing the incidents of domestic and family violence across the community.

In addition, the DFVDRU supports other death prevention activities within the CCQ and provides advice on national and state policy and practice initiatives, as they relate to the coronial jurisdiction. Data held by the DFVDRU is shared with government and non-government sectors to inform policy and practice reforms.

The DFVDRU is a founding member of the Australian Domestic and Family Violence Death Review Network (the Network) and continues to work closely with other death review mechanisms in Australia and undertake research in partnership with ANROWS.

The DFVDRU maintain two comprehensive statistical databases:

- the Queensland Domestic and Family Homicide Database; and
- the Queensland Domestic and Family Suicide Database.

Further information about the Board can be found in the Board's annual reports available on the Queensland Courts website[16].

[16] Reviews of deaths from domestic and family violence https://www.courts.qld.gov.au/courts/coroners-court/review-of-deaths-from-domestic-and-family-violence

Sudden and Unexpected Death in infancy (SUDI) Multiagency Advisory Meeting Pilot – partnership with the Queensland Paediatric Council

The infant mortality rate in Queensland is higher than the rest of Australia for reasons that currently remain unclear. It is recognised that while the coronial process, through autopsy, may determine a cause of death, it is not always able to identify or examine the complex set of risk and contributory factors that may be present in the events leading to the infant's death that could inform death prevention opportunities.

During the 2020-21 financial year, the CCQ partnered with the Queensland Paediatric Quality Council (QPQC) to pilot a process to improve the coronial investigation of Sudden and Unexpected Deaths in Infancy (SUDI).

The purpose of the multiagency advisory meeting process is to provide advice and make recommendations to the investigating Coroner in relation to SUDI deaths reported under the *Coroners Act* 2003 and to coordinate timely and tailored support to families bereaved by SUDI.

The meetings are convened by CCQ through the DFVDRU which provides secretariat support for the trial and includes various experts and professionals from QPS, Queensland Health, QPQC and the Queensland Family and Child Commission. The pilot process will be evaluated in the 2021-22 financial year in partnership with the QPQC, and this process will inform prevention initiatives and the development of investigation guidelines for SUDI.

The evaluation of this project found that a multi-agency approach ensured the sharing of critical information and highlighted the importance of understanding the role of each agency. Feedback received from participants claimed, "*it was useful to see the potential for cross agency communication and action both in terms of what can be learnt from these deaths and how to best support families in the community moving forward*".

Systemic review of male suicide deaths – partnership with the Queensland Mental Health Commission

In recognition of the need for a deeper understanding of the context in which male suicides occur, *Every life: The Queensland Suicide Prevention Plan 2019-2029*[17] committed to undertaking a trial systemic review process to inform a comprehensive strategy for men's suicide prevention in partnership with the Queensland Mental Health Commission (QMHC). The project aimed to identify prevention points and how best to assist Coroner's reviewing male suicides. The final report identified that a sizeable amount of men do seek help and are prescribed medication, however, the report found that the same men are not receiving the help required.

It is intended that learnings from this review process will be used to inform the development of investigation guidelines for apparent suicides to assist all coroners in their investigations of these types of deaths. This will support a more consistent approach to such investigations, which over time will lead to improvements in the type of information that is available to inform research and prevention activities.

A report which collates the systemic findings from this review process has been completed and provided to QMHC for further consideration.

[17] The QLD Suicide Prevention Plan 2019-2029 (Every Life)
https://www.qmhc.qld.gov.au/sites/default/files/every_life_the_queensland_suicide_prevention_plan_2019-2029_web.pdf

Deaths in custody: case summaries

The term 'death in custody' is defined in s10 of the Act to include those who at the time of their death, are in custody, trying to escape from custody or trying to avoid being placed into custody. 'Custody' is defined to mean detention under arrest or the authority of a court order or an act by a police officer or corrective services officer, court officers or other law enforcement personnel. An inquest is mandatory in these circumstances.

As per section 77(b) of the Act the following contains a summary of the investigation, including the inquest into each death in custody finalised during the reporting period.

Luke Cunningham

State Coroner, Terry Ryan – 19 July 2021

Circumstances of the death

Mr Luke Cunningham was aged 21 years when he died at the Arthur Gorrie Correctional Centre (AGCC) on 15 September 2018. He was first remanded 20 April 2018 then transferred to AGCC on 24 April 2018 after being charged with murder along with other offences. Mr Cunningham was housed in Unit C3, Cell 8 with one other cellmate. They had been cellmates for approximately four weeks at the time of Mr Cunningham's death. At the time of his death Mr Cunningham's charges were still awaiting committal.

At 4:30pm on 15 September 2018 all prisoners at AGCC were locked down in their cells for the night. Mr Cunningham was last seen alive in his cell at about 8:34pm. At about 11:25pm his cellmate woke and found him hanged and cold to touch. The cellmate immediately called for assistance.

Staff that arrived at the cell cut down Mr Cunningham and commenced attempts at resuscitation. Advanced Care Paramedics also attended the scene and continued attempts at resuscitation. Despite those attempts Mr Cunningham could not be revived and was declared life extinct at 11:59pm.

The Investigation

The Corrective Services Investigation Unit investigated the circumstances of Mr Cunningham's death. A search of the cell in which Mr Cunningham was located did not identify any suspicious circumstances. Investigators obtained a copy of his medical records, interviewed prisoners and obtained statements from Corrective Services staff at AGCC. The Queensland Corrective Services Chief Inspector also investigated the circumstances of the death and provided a report that was tendered at the inquest.

The Inquest

All witness statements, medical records and other material gathered during the investigation were tendered. Queensland Corrective Services (QCS) and the GEO Group Australia Pty Ltd, the operators of AGCC at the time of the death, were both granted leave to appear at the inquest. The issues considered at the inquest were the findings required by s45(2) of the *Coroners Act 2003*, and whether there were ways to prevent a death occurring in similar circumstances in the future.

Mr Cunningham was known to Corrective Services and had previously served terms of imprisonment for other offending. Upon being transferred to AGCC he was seen by a Provisional Psychologist who conducted an Immediate Risk Needs Assessment (INRA). He self-reported not having any personal safety concerns nor any history of suicidal or self-harm ideation. There was no information to the contrary that may have raised any concern with his self-reports.

Mr Cunningham was able to identify protective factors (a partner). There was nothing in his presentation that gave rise to any concern. During his remand period Mr Cunningham did not disclose or seek any assistance for any mental health concern. Interviews with other prisoners identified that whilst Mr Cunningham expressed concern with the nature of his charge, he was otherwise considered to be "*happy go lucky*", was planning for his future once released from custody and did not express anything to indicate he was at risk of self-harming.

Examination of Mr Cunningham's call history identified a number of calls made by him on the day of his death. Those calls were to his partner and to friends. During some of the calls to his partner Mr Cunningham expressed anger and frustration toward her and accused her of being unfaithful. In their final call, Mr Cunningham informed her that would be their last. Whilst he appeared upset at the end of that call he was considered back to his 'usual self' by the time of lockdown. The investigation identified Mr Cunningham had used his own jumper as a makeshift ligature. It had been secured to ceiling-height bars located above a wall-mounted cabinet.

An autopsy of Mr Cunningham, including a CT scan, identified an abrasion to the neck that was consistent with a ligature mark. There were fractures to the sternum and ribs that were consistent with the attempts at resuscitation. There were no other significant injuries, nor any evidence of defensive wounds or any other evidence of a struggle. Cause of death was given as hanging.

The Office of the Chief inspector identified that whilst there had been some minor departures from applicable procedures, all staff responding to the incident had acted promptly and appropriately. None of the departures contributed to Mr Cunningham's death. The primary matter seen as contributing to the death was the positioning of the of the bars which created a 'hanging point'. These 'hanging points' have been identified in previous coronial inquests as a "*longstanding (but not fully implemented) recommendation*" for change.

Findings and Comments

The inquest found there was no evidence to indicate Mr Cunningham was intending his own death by suicide. There were no opportunities for intervention that might have changed that outcome. Whilst there were no outward signs or expressions of mental distress, the potential life sentence likely "*weighed heavily*" on Mr Cunningham. It was also possible that immediate stressor following the argument with his partner, may have contributed to an impulsive decision to end his life.

Recommendations

The Office of the Chief Inspector proposed four recommendations concerning 1) the regular checking of defibrillators and other medical equipment, 2) ensuring incident debriefs are undertaken in accordance with relevant practice directions, 3) retaining handwritten notes and 4) assessing, managing, and recording decisions in relation to cell placement to minimise risk of suicide by hanging. Having regard to that proposal no further recommendation was made about those matters.

It was acknowledged that work continued to be done in relation to the upgrading of cells to remove hanging points. It was noted there were still 340 cells to be modified, of which 268 were at AGCC. Refurbishment remains a priority for the QCS 2020-2024 Strategic Asset Management Plan. The recommendations arising from the inquest into the death of SVE, that the Queensland Government continue to publish annual updates in relation to the rollout of the safer cell's strategy was again noted.

Cary James Saunders

State Coroner, Terry Ryan – 26 July 2021

Circumstances of the death

Mr Cary James Saunders was a prisoner at Capricornia Correctional Centre (CCC), where he was serving a sentence for multiple sexual offences for which he had been convicted on 19 August 2016. Mr Saunders was admitted to the Rockhampton Hospital on 15 October 2017, and later transferred to the Princess Alexandra Hospital (PAH) at Brisbane, where he died on 24 October 2017, aged 57 years.

Mr Saunders had a pre-existing history of heart disease including aortic regurgitation and mitral valve prolapse (improper closure of heart valves). The conditions had been monitored within the community over the years and were documented at an early stage of Mr Saunders' prison term. At a check-up on 22 July 2017, medical staff noted an aortic heart murmur with a normal echocardiogram and an inguinal (groin) hernia.

From 25 September 2017, Mr Saunders reported suffering regular nausea and pain from the hernia. He continued to be monitored by medical staff in early-October 2017 as his symptoms persisted and was treated with antibiotics. On 15 October 2017, Mr Saunders was transferred to Rockhampton Hospital Emergency Department for treatment of a suspected infection. On 19 October 2017, a transthoracic echocardiogram revealed a large vegetation (accumulation of bacteria and clot material) on the mitral valve with moderate regurgitation.

Following signs of rapid deterioration, Mr Saunders was transferred to PAH on 20 October 2017, where he was diagnosed with infective endocarditis (an infection caused by bacteria entering the bloodstream and settling the heart valves). Days later, a CT scan revealed he had a large intracerebral bleed secondary to a ruptured aneurysm; surgery was undertaken to drain the fluid from his brain. Despite the surgery, the hydrocephalus (build-up of fluid on the brain) worsened, and he suffered irreparable brain damage. Mr Saunders died on 24 October 2017 after life support was withdrawn.

The Investigation

The QPS CSIU investigated Mr Saunders' death. A report, along with medical records, prison records, and statements from medical staff and family members were submitted. The investigation concluded that there were no suspicious circumstances surrounding the death.

Dr Samantha Duncan from the Clinical Forensic Medicine Unit (CFMU) provided an opinion in relation to Mr Saunders' medical treatment in custody. She was unable to identify any missed opportunities that might have changed the outcome in this case. She observed that Mr Saunders' condition had been kept under appropriate surveillance during his time in custody; his hernia had not been caused or exacerbated by his living conditions in prison; and his transfers to Rockhampton Hospital and PAH had occurred in a timely manner.

The autopsy determined that the cause of death was intracerebral haemorrhage (bleeding on the brain), due to ruptured mycotic aneurysm (an infected clot settling in a major cerebral artery that subsequently ruptured), due to infective endocarditis. The pre-existing mitral valve prolapse was noted as a significant contributing factor.

The Inquest

In addition to the factual findings required by s 45(2) of the *Coroners Act*, the inquest examined the adequacy of health care provided to Mr Saunders whilst in custody.

Findings and comments

The State Coroner accepted that Mr Saunders' death was caused by an intracerebral haemorrhage, resulting from an infected clot in a cerebral artery. This was a recognised complication of infective endocarditis, a rare condition with non-specific symptoms that can be difficult to diagnose; and a condition to which Mr Saunders was more susceptible due to his pre-existing heart conditions.

The State Coroner was satisfied that the care provided to Mr Saunders at CCC, Rockhampton Hospital and PAH was appropriate in the circumstances and did not contribute to his death. The death could not have been prevented and, as such, no other comments or recommendations were made with respect to issues of public health.

Benjamin John Batalha

State Coroner, Terry Ryan – 2 September 2021

Circumstances of the death

Benjamin John Batalha was aged 35 years when he was found deceased at the Arthur Gorrie Correctional Centre (AGCC) on 28 June 2017. He was found unresponsive in bed in a single cell at 8.00am. Statements taken from prisoners housed in adjoining cells suggested he could be heard snoring loudly up until around 1.00am, after which no further noise was heard.

Mr Batalha had an extensive history of illicit drug use prior to his incarceration, including daily use of methamphetamine. In 2016, he had been assaulted at a previous correctional centre, and as a result he was very anxious and struggling in the custodial environment. He had been seeing a psychiatrist since January 2017 and was diagnosed as having an adjustment disorder and mild anxiety and depressive disorder. He was prescribed five different medications to manage his pain, Mirtazapine, Escitalopram, Diazepam, Pregabalin (Lyrica), and Baclofen. A month before his death, Mr Batalha was found in possession of medication that had not been prescribed to him.

The forensic pathologist was unable to determine Mr Batalha's cause of death. Toxicology showed a total of seven different drugs in his system, Diazepam, Buprenorphine, C. Citalopram, Mirtazapine, Quetiapine, Paliperidone, and Pregabalin (Lyrica). Mirtazapine was the only drug near toxic levels, but not in the lethal range. Of the drugs found in Mr Batalha's system, three were non-prescribed medications (an opiate and two antipsychotics).

The Investigation

An investigation into the circumstances surrounding Mr Batalha' death was conducted by Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) and the Office of the Chief Inspector (OCI). Correctional files and medical records from AGCC and Princess Alexandra Hospital (PAH) were obtained, together with statements from the relevant custodial correctional officer, medical staff and other prisoners. No issues of concern were raised by those prisoners relating to Mr Batalha's health or welfare.

An examination of Mr Batalha's cell located two prescription tablets concealed in an empty sugar package and an empty asthma inhaler. Subsequent analysis confirmed the tablets were Quetiapine (Seroquel).

The Inquest

The inquest into Mr Batalha's death was conducted by the State Coroner on 7 June 2021, with 4 witnesses called to give oral evidence. The inquest investigated the following issues:

1. *The findings required by s.45(2) of the Coroners Act (2003); namely the identity of the deceased, when, where and how he died and what caused his death;*
2. *Whether Mr Batalhá's care at Arthur Gorrie Correctional Centre and/or West Moreton Hospital and Health Service (WMHHS) was appropriate and sufficient;*
3. *The availability of non-prescribed medication to Mr Batalha at Arthur Gorrie Correctional Centre; and*
4. *Whether there are any further recommendations which can be made which could prevent deaths from happening in similar circumstances in the future.*

During the course of the inquest a psychiatrist gave evidence that at the time of his last review of Mr Batalha before his death, he presented as "settled, reactive with no evidence of significant mood disturbance such as a major depressive episode." There was no evidence of any significant distress.

A review of Mr Batalha's care and management whilst in custody, was conducted by the Clinical Forensic Medicine Unit, who ultimately saw no reason to be critical of the care provided to him at AGCC, WMHHS and the PAH. It was stated that combining his prescribed medication diazepam with the Buprenorphine, Quetiapine and/or Paliperidone can lead to life-threatening additive central nervous system and respiratory depressant effects. Likewise, combining Buprenorphine with his prescribed Citalopram may have additive central nervous system effects or cause serotonin syndrome, which can be life-threatening as it can lead to seizures and arrhythmias. The Senior Forensic Physician considered that although the precise cause of death was inconclusive, it was possible that Mr Batalha died as a result of respiratory depression caused by mixed drug toxicity. Alternatively, the combination of drugs detected could have precipitated a fatal arrhythmia.

There was evidence in the inquest to suggest that Mr Batalha was diverting medication, most likely Lyrica (Pregabalin), within the prison environment. At the relevant time, AGCC had systems in place to ensure that medications were kept securely, and they were dispensed appropriately.

Findings and comments

The State Coroner accepted that Mr Batalha's medications were reviewed frequently. He was seen regularly by the Visiting Medical Officer and his treating psychiatrist, who were both aware of his drug diverting behaviour and were taking steps to address it. The State Coroner made no adverse comments about AGCC or the WMHHS. The State Coroner did not make any recommendations, in light of the actions already being implemented and reviewed by Queensland Corrective Services in conjunction with Queensland Health in combatting the illicit use and diversion of drugs in the prison system.

John Edward Harris

State Coroner, Terry Ryan – 20 September 2021

Circumstances of the death

Mr John Harris was 47 years old when he died in the Harold Gregg Units at Townsville Correctional Centre ('TCC'). Mr Harris was a prisoner in custody at the time of his death, serving sentences for manslaughter and drug/property offending, as well as a life sentence for the murder of Ms Tia Landers in 2014. He was not eligible to apply for parole for 27 years, placing his parole eligibility date in 2041. 3 July 2014 was the date that Mr Harris and his co-offender and partner, Ms Linda Appleton, were remanded in custody for the charge of murder. The day after the fifth anniversary of being remanded, namely in the early hours of 4 July 2019, Mr Harris was found deceased in his cell.

Mr Harris was the sole occupant of cell 10 in the Harold Gregg Unit 3. At around 8:40pm on 3 July 2019, officers conducted a headcount of prisoners. It was noted that Mr Harris appeared in good health and was not displaying any unusual behaviours. The next morning at around 4:50am, the officer conducted a headcount and located Mr Harris hanging in his cell, having used a bed sheet tied around the exposed metal bars above the door. Officers commenced CPR while awaiting the assistance of the Queensland Ambulance Service, however Mr Harris was declared life extinct at 6:13am on 4 July 2019.

The Investigation

A full external and internal autopsy examination was conducted, with associated toxicology testing. The autopsy confirmed injury to the neck, namely a circumferential abrasion and fracture of the left greater horn of the hyoid bone and concluded the cause of death to be hanging.

The Queensland Police Service Corrective Services Investigation Unit ('CSIU') also investigated Mr Harris' death. The investigation was thorough and included prison and medical records, as well as interviews with other prisoners at TCC, and statements from Mr Harris' mother and partner. One topic of focus for the investigation was the decision to place Mr Harris in the Harold Gregg Units, given his previous Notice of Concern episodes in 2014. The CSIU investigation concluded that the death was not preventable as compliance with policy was adhered to, and there were no indications that Mr Harris had been contemplating suicide.

The State Coroner was also assisted by a report from the Office of the Chief Inspector ('OCI'). The OCI report identified some of Mr Harris' behaviour in the weeks leading up to his death that was consistent with self-harm indicators, such as social withdrawal and agitation. The OCI report also analysed the two letters located in Mr Harris' cell, addressed to his mother and partner, which revealed he had been contemplating suicide for months prior. The OCI report concluded that Mr Harris' behaviour (e.g., anger and social withdrawal) was in line with his longer-term behaviour and was not seen to be out of character. Staff could therefore not have known that he was at risk of harming himself.

The Inquest

All statements, medical records, and material gathered during the investigation into Mr Harris' death were tendered to the court, and several witnesses were called to give oral evidence. The issue for inquest was the findings required by section 45 of the *Coroners Act 2003*.

Findings and Comments

The State Coroner was satisfied that there were no suspicious circumstances present in relation to Mr Harris' death. He accepted the OCI report and agreed that staff would not have been readily able to discern suicide risk indicators in the context of Mr Harris' usual demeanour, which included being quick to anger and socially withdraw. In relation to the findings required by section 45 of the *Coroners Act 2003*, the State Coroner concluded that Mr Harris intentionally took his own life after fashioning a ligature from a sheet which was tied to exposed metal bars in his cell.

Recommendations

The State Coroner considered any recommendations to be made under section 46 of the *Coroners Act 2003.* He referred to previous similar cases and the upgrades currently being advanced within correctional centres in relation to a 'safer cell design'. No further recommendations were made.

Omid Masoumali

State Coroner, Terry Ryan – 1 November 2021

Circumstances of the death

Omid Masoumali was a 24-year-old Iranian refugee. He and his partner travelled by sea to seek asylum in Australia. They arrived on Christmas Island on 13 September 2013 and were detained because they didn't hold a valid visa. Omid and his partner were transferred to Nauru on 24 September 2013 and detained in a Regional Processing Centre.

On 8 December 2014, the Government of Nauru granted refugee status to both Omid and his partner. The couple were released from detention and allowed to settle in Nauru. They lived in self-contained accommodation at the Nibok settlement.

The couple discovered their refugee status effectively meant they couldn't leave Nauru in the absence of resettlement arrangements or a temporary transfer to another country for medical treatment. No resettlement arrangements were readily available, and the couple were deeply frustrated by a lack of information about their future plans. The couple began to despair about their situation.

On 26 April 2016, Omid asked to see a psychologist employed by International Health and Medical Services (IHMS) at the Settlement Clinic, which was collocated with the Republic of Nauru Hospital. IHMS was contracted by the Australian Government to provide health services to asylum seekers and refugees in Nauru. Omid wasn't contacted about this request, but staff did schedule him to see a psychologist on 2 May 2016.

On the morning of 27 April 2016, representatives of the UNHCR went to the Nibok settlement to interview refugees. Omid's partner was seen by a UNHCR employee and was very unhappy after that meeting. Omid left with his partner. Omid returned to the area and set himself alight after fuel was applied to his clothing. It is not clear who applied the fuel.

Before igniting the fuel, Omid described his frustration with his situation. He said he was tired, miserable and exhausted. Omid suffered severe burns to over 50% of his body. He was taken to the Republic of Nauru Hospital where staff tried to treat his burns, with the guidance of IHMS clinical staff. Omid went into cardiac arrest but was stabilised.

Omid was airlifted by LifeFlight Australia from Nauru to the Royal Brisbane and Women's Hospital on 28 April 2016. He arrived 31 hours after sustaining his burns. By that time his condition was irretrievable. After palliative treatment he died the following day.

The Investigation

Omid died in Queensland as an 'unlawful non-citizen' pursuant to the *Migration Act 1958 (Cth)*, notwithstanding the Government of Nauru determining Omid was a refugee. As a result, Omid was detained at the Royal Brisbane and Women's Hospital (RBWH), with security officers assigned to him. Omid's death was therefore a 'death in custody', as recognised by the *Coroners Act 2003 (Qld)*. An inquest was required.

The first concern was determining the scope of the investigation, and inquest. The State Coroner determined the medical care provided to Omid in Nauru, then during his transit to Australia, and finally at the RBWH, were all within the scope of the inquest. The State Coroner also extended that scope to include the provision of mental health services on Nauru, and whether any gaps in those services contributed to Omid's death. The State Coroner made clear the inquest would not examine the broader issue of Australia's offshore detention policy. The inquest would focus on those particular facts, circumstances and issues directly related to Omid's death.

The Inquest

Evidence was heard from 23 witnesses over a one week sitting from 25 February 2019 to 1 March 2019. A further five witnesses gave evidence at an additional sitting in April 2020. The majority of those witnesses were medical professionals, providing evidence about the medical and psychiatric care Omid received, and the sufficiency of that care.

The inquest heard evidence from Omid's partner, and others, about the timeline of events leading up to 27 April 2016. Omid did not suffer any known mental health conditions. Despite this, he found his circumstances challenging, and sometimes overwhelming. He did seek mental health assistance in late 2013 and in 2014. On 25 August 2014, in one of his mental health appointments, Omid was described as having a positive attitude about his situation, and a strong relationship with his partner. The inquest heard Omid's actions on 27 April 2016 were unexpected.

On 26 April 2016, Omid asked to see a psychologist. He did this by writing on a self-referral form the words '*I want to visit psychologist*'. An appointment was made for Omid to see a psychologist on 2 May 2016, but this was done administratively and Omid wasn't directly contacted. It was uncertain whether Omid received any notification of the appointment. Certainly, no one called Omid to ask why he wanted to see a psychologist, and whether anything was really troubling him.

The inquest heard about the events on 27 April 2016, including what people saw and heard of Omid's actions immediately before setting himself on fire. Omid returned to the meeting with UNHCR in a very agitated state. He spoke in Farsi, but recordings of him were translated. Omid told those gathered, '*You have made our lives miserable and hopeless. I am very tired and exhausted….You want to see how miserable we are? This is how miserable we are; you have watched up enough. It's three years, you have made us feel quite miserable. This is our situation*'. Very soon after saying these words, Omid was engulfed in flame.

Omid suffered severe injuries, which worsened after a short time. He was treated at the Republic of Nauru Hospital. The medical staff did the very best they could to treat Omid. Extensive evidence was heard about the hospital's medical facilities for severe burn injuries, and the medical staff's training and expertise to treat those injuries. Burn injuries require specific equipment, medication and training to properly treat them. The evidence showed the facilities and staff training were completely inadequate and at a standard below a regional Australian hospital. In short, if Omid had suffered his burn injuries in Australia, even in a remote or regional location, his chances of survival would have been much higher.

LifeFlight transported Omid to Brisbane for treatment. The inquest heard from LifeFlight medical and operations staff to detail the care they gave Omid, and the logistical challenges in getting the transfer flight into and out of Nauru. The LifeFlight team did all they could in the circumstances and provided Omid with the level of care expected in the Australian community.

Findings and Comments

The State Coroner found Omid died on 29 April 2016, at the RBWH, from the burn and related injuries he suffered on Nauru on 27 April 2016. The State Coroner specifically found, 'The level of care [Omid] required could not be provided at the Republic of Nauru Hospital. [Omid] could not be transferred to a hospital with the necessary equipment and clinical skills in time to treat his burns'.

By the time of Omid died, he and his partner had been 'in the position of not knowing what would happen to them (apart from not being able to settle in Australia) for 959 days'. The State Coroner accepted the submission on behalf Omid's partner that refugees had been expressing 'feelings of hopelessness, helplessness and uncertainty' in the period before Omid set himself alight.

The State Coroner considered the available information at the time meant the risk of a serious event occurring, such as with Omid, 'was not low'. Steps should have been taken by the relevant agencies to mitigate against the risks of public protests, and in particular, the risks of self-harm.

The State Coroner found Omid deliberately set himself on fire, however it could not be concluded Omid's actions were planned with his partner nor with other refugees. The State Coroner also considered Omid's actions could not have been anticipated. However, in all the circumstances, the

triaging clinicians should have called Omid to discuss why he wanted to see a psychologist. The State Coroner considered this to have been an important, and missed, opportunity to obtain more information.

Omid had suffered a life threatening injury that required 'prompt and specialised care'. This care wasn't available on Nauru, and Omid's 'best chance of survival was early evacuation to a tertiary hospital' in Australia. The State Coroner found local medical staff on Nauru assisted appropriately in the circumstances, and the LifeFlight retrieval team also did the best they could in the circumstances. It was clear, however, that the local medical staff didn't have the skills nor training to deal with Omid's severe burn injuries. Once accepted by Nauru as a refugee, Omid was entitled to care that would be broadly expected in the Nauruan community, not in the Australian community. The State Coroner noted the 'standard of emergency medical care available in Nauru was well below that which would be expected in rural Australia'.

Recommendations

The State Coroner accepted the submission from the Commonwealth that circumstances on Nauru have changed significantly since April 2016, including significant efforts to improve the medical facilities available to refugees. However, the State Coroner considered that a refugee's release to the Nauruan community, with improved available medical facilities, did not remove the need for greater certainty for refugees in Omid's situation. The State Coroner made no further, specific recommendations, given the changed circumstances in Nauru since 2016.

Daniel Patrick Lewis

State Coroner, Terry Ryan – 18 January 2022

Circumstances of the death

Daniel Lewis was aged 36. He died on 31 August 2018 after being shot by Queensland Police Service officers responding to a 000 call from the 19-year-old son of his partner, Ms McIntyre. The son told the call taker Mr Lewis had hit his mother, gone 'ape' and chased him outside.

At 11 years of age, Mr Lewis had sustained a head injury during a fight with his brother which left him with temporal and frontal lobe damage. His mother reported that he had *'no consequential thinking because of his brain damage'*. Mr Lewis had a criminal history and had served time in custody. In 2016 he was referred to a psychiatrist and, over the next two years until his death, had contact with various hospitals and treating practitioners in respect of poor coping strategies related to the use of illicit substances and alcohol.

Mr Lewis and Ms McIntyre met through an online dating site 14 weeks before Mr Lewis' death. Ms McIntyre described her relationship with Mr Lewis as 'really good'. Ms McIntyre admitted that while they had arguments, Mr Lewis had not been physically violent towards her until the night of his death. She was aware of Mr Lewis' brain injury and that he was on medication and drank alcohol excessively. She said he tried to get help but "it fell on deaf ears".

Ms McIntyre's children also described Mr Lewis a good person. However, his behaviour changed when he consumed alcohol. They agreed he had not been aggressive towards them or their mother until the night of his death.

On that night, Ms McIntyre told 000 Mr Lewis 'laid' into her and her son. When police arrived, Mr Lewis was inside Ms McIntyre's home. Ms McIntyre, along with her son and eight-year-old daughter, were on their neighbour's driveway.

Mr Lewis did not respond to police knocking on the front door of the house. Two of the police officers who had attended the scene jumped over a timber gate on the side of the house that was locked. They walked to the back of the yard and onto the patio. The officers announced themselves and then repeatedly yelled for Mr Lewis to come out.

After around five minutes, Mr Lewis yelled he had a *"shot gun loaded"* and threatened the officers in the backyard. Soon after, Mr Lewis came out of a side door of the house armed with three knives. An

attempt to Taser him was unsuccessful. He walked towards the back of the yard towards police and threw one of the knives at police. He was then fatally shot. The incident was captured on the attending officers' Body Worn Cameras (BWC).

The Investigation

An investigation into the circumstances surrounding Mr Lewis' death was conducted by Detective Sergeant Christine Knapp of the QPS Internal Investigations Group. DS Knapp provided a coronial report with various annexures, including witness statements, digital recordings, medical and offender records. A post-mortem examination found Mr Lewis died from gunshot wounds to his chest and abdomen.

The Inquest

The inquest was held at Gladstone on 18 and 19 October 2021. All statements, records of interview, photographs and materials gathered during the investigation were tendered at the inquest. Oral evidence was heard from 6 witnesses.

The issues for consideration at the inquest were: *The findings required by s. 45(2) of the Coroners Act 2003; the appropriateness of the actions of the attending police officers; the sufficiency of the training provided to officers in responding to a similar incident; whether any preventative changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances; and the sufficiency and appropriateness of the investigation conducted by Ethical Standards Command*.

Findings and Comments

The State Coroner found that

1. The constable who fired the shots acted appropriately in firing his weapon in response to the threat posed by Mr Lewis and that his application of lethal force was appropriate in the circumstances;
2. The decision by police to enter the yard was reasonable in the circumstances, consistent with police policies and procedure and was necessary given the unknown threat posed;
3. It was not possible in the five or six minutes over which this incident evolved for other measures such as the engagement of a negotiator or the Mental Health Liaison Service to be used;
4. The training given to police officers with respect to the situational use of force model, armed offenders, threat and risk assessments, as well as incident command and dealing with those in mental health crisis is sufficient to ensure that officers are trained effectively to respond to dynamic and challenging incidents such as that confronted on the night of Mr Lewis' death; and
5. The factual circumstances leading up to Mr Lewis' death were thoroughly and professionally investigated by Detective Sergeant Knapp from the Ethical Standards Command.

The State Coroner made no recommendations or referrals in this matter.

Tyson Lee Jessen

State Coroner, Terry Ryan – 26 April 2022

Circumstances of the death

On 9 November 2018, Tyson Jessen was taken into custody by the Queensland Police Service in relation to an arrest warrant issued by Victoria Police. During his arrest Mr Jessen developed cardiac symptoms and was admitted to the Ipswich Hospital for investigation and monitoring. While being guarded by a sole female police officer on 10 November 2018 in the Coronary Care Unit, Mr Jessen attacked the police officer, and in self-defence she shot him three times.

A post-mortem examination was carried out and showed Mr Jessen sustained three gunshot wounds, one to the front of the neck and exit to the back of the right side of the neck, one in the front of the chest without an exit wound and one in the left lower chest.

The Investigation

An investigation into the circumstances surrounding Mr Jessen's death was conducted by the Ethical Standards Command, Internal Investigations Group (IIG). A coronial report was provided in February 2020 with annexures, including witness statements, digital recordings, police records and medical records.

The report noted that there were no procedures within the QPS or interagency agreements on how offenders should be secured in medical facilities. It became the responsibility of individual officers to undertake a risk assessment, relying on their own judgements. By the time SC Richardson took over the guard details, the information originally relayed to the first guarding officers had been lost. With the benefit of hindsight, SC Richardson's risk assessment was clearly erroneous but reasonable in the face of available information.

The investigation concluded that all police officers involved complied with relevant legislation, policy and procedures, and should not be subject to any criminal or disciplinary action for their conduct.

The Inquest

The inquest was held over three days from 6 to 8 September 2021. Oral evidence was heard from twelve witnesses and over 190 exhibits were tendered.

The issues for the inquest included: (1) examining the facilities and resources available to securely accommodate and supervise Mr Jessen while he was in police custody as a hospital inpatient and what, if any, additional steps were undertaken by the hospital and the QPS to manage the risk of accommodating Mr Jessen at the hospital, (2) whether the actions of the police officers who were tasked to guard Mr Jessen were appropriate, and (3) whether information which was known about Mr Jessen was appropriately relayed to those police officers.

On 31 August 2018, Mr Jessen and two co-offenders committed an armed robbery in Victoria. Victorian police had information that Mr Jessen was in possession of a handgun and would likely use it to avoid arrest. A warrant was issued, and it was believed that Mr Jessen had moved to Queensland. Queensland police received information indicating his whereabouts and it was agreed that a special operations team be deployed to arrest him. Victorian police provided a 'risk summary', which included reference to his likely possession of a handgun and history of violent offending, which included a serious arson attack where a victim was set on fire.

On 9 November 2018, Queensland police attended the World Gym in Ipswich following information that Mr Jessen regularly attended. Four police officers attended and were advised that Mr Jessen was present in the gym at the time. After police saw Mr Jessen leave the gym, they gave chase. During the chase, Mr Jessen have the impression at times that he was carrying a firearm. He was eventually stopped and after approximately 20 minutes of negotiation, which included the deployment of a police dog, he was ultimately apprehended and taken into custody.

Shortly after Mr Jessen was detained, he complained of chest pain and breathing difficulties and was taken to Ipswich hospital by the Queensland Ambulance Service (QAS) who had been in attendance at the scene. A doctor in the emergency department examined Mr Jessen, who was restrained in handcuffs to the front of his body, and was told by police that he would not be uncuffed. Mr Jessen was eventually admitted to a ward for monitoring overnight.

On 10 November 2018, another doctor reviewed Mr Jessen, who had each of his hands cuffed to a bed rail. Following review, Mr Jessen had his medication increased and he continued to be monitored overnight. The plan was to review him the following day and potentially discharge him then or on the following day.

When it became apparent that Mr Jessen was going to stay in hospital, the police officer responsible for his arrest notified several officers by email, informing them of the need to guard Mr Jessen in hospital. That email provided a summary of Mr Jessen's background of offending and a risk assessment, recommending that a minimum of two police officers remain with him at all times. No entries were made on the police information database 'QPrime' (Queensland Police Records and Information Management Exchange) at that time; however, police Intel were working on a profile of Mr Jessen, which was later uploaded to QPrime. That entry included the following, which could be accessed on an individual officers 'Q-Lite' mobile device:

> *"Steroid User. Intelligence JESSEN is in possessin (sic) of a firearm. Recorded with interstate (VIC) history for violent offences. Wanted on Warrants in Victoria for Armed Robbery. Caution should be taken when dealing with JESSEN – known to be violent".*
>
> *Under the flag 'Cautions', it stated: "Caution should be taken when dealing with JESSEN – known to be violent".*

Most of the evidence at the inquest was from police witnesses who were assigned to guard Mr Jessen during his hospital admission. A total of 14 officers (7 teams of 2 officers each) were involved in guarding Mr Jessen at various times. They would be provided with handover information from the previous guards and occasionally received instructions from shift supervisors responsible for overseeing those officers.

When Mr Jessen first presented to hospital he was handcuffed, and his legs shackled soon after. Throughout his admission his behaviour was friendly and compliant, and he did not appear to pose a threat to officers. His handcuffs were removed during meal breaks and ultimately remained off while being guarded by the final 3 teams, and for several hours prior to his death.

At the time of the final handover, Mr Jessen was not wearing handcuffs but remained wearing leg shackles. On handover, the relieving officers, Constable Collihole and Senior Constable Richardson, were advised that Mr Jessen had been quiet and essentially there was nothing to worry about. They were not advised of his name, history of offending or QPrime caution. A risk assessment was not carried out.

During their guarding of Mr Jessen, it was agreed that Constable Collihole would return to the station to retrieve dinner and be replaced by a relieving officer. Constable Collihole left on the understanding that the relieving officer was on her way up. Senior Constable Richardson spoke to the relieving officer telling her to hurry up as Constable Collihole had just left. Senior Constable Richardson had her back to Mr Jessen at this time, who was in a position to overhear the conversation.

Registered Nurse Kelly, who was nearby, heard a person in distress and furniture flying and went to investigate. She observed Senior Constable Richardson on the floor in the doorway with Mr Jessen hunched over her punching her in the face at least 6 times. She stood between them and was pushed away before being punched in the head. RN Kelly walked towards the nurse's station and heard 3 bangs from the room. It was concluded that RN Kelly's bravery allowed Senior Constable Richardson time to remove her service weapon from the holster and defend herself from the attack.

Findings and Comments

The State Coroner found Mr Jessen was appropriately accommodated by the Ipswich Hospital after his presentation with symptoms which warranted immediate assessment, treatment and ongoing management and monitoring. The QPS were responsible for managing the risks associated with guarding offenders in an acute hospital setting.

It was the responsibility of the individual officers to undertake a risk assessment. The critical requirement is that officers arm themselves with the relevant information through QPrime (in addition

to any briefing they receive) in order to undertake an appropriate risk assessment when circumstances change through the period of guarding.

The State Coroner ultimately concluded that the policies and processes of the QPS concerning managing the risk of guarding an offender, such as Mr Jessen, who had not been processed through the watchhouse were inadequate.

The State Coroner noted that the evidence supported a conclusion that information was not passed on from supervising officers and incoming officers were not briefed with Mr Jessen's name and that he was violent and dangerous. There was a wider failure by officers in leadership positions in the Ipswich District to share pertinent information relevant to the risk posed by Mr Jessen which would have informed the officers tasked to guard Mr Jessen at the Ipswich Hospital.

The State Coroner found that Constable Collihole and Senior Constable Richardson made some poor decisions, including making the telephone call in front of Mr Jessen, permitting one officer to leave before being replaced and not completing risk assessments. They did not appropriately manage the risks associated with guarding Mr Jessen and did not adhere to good policing practice in maintaining situational awareness. This sequence of decisions enabled Mr Jessen to take advantage of the situation. Notwithstanding, Senior Constable Richardson acted bravely in the face of the violent assault upon her by Mr Jessen. The courage both she and RN Kelly displayed should be formally recognised.

The State Coroner noted that the information provided by Victoria Police was comprehensive and it was not clear why this information, or the information contained in the earlier email, was not attached to QPrime. Mr Jessen was clearly a flight risk and a violent offender. More information should have been included in QPrime about his history. However, individual officers also needed to be disciplined in checking QPrime in order to appropriately complete a risk assessment.

The State Coroner concluded there was a failing by police in not having systems in place which avoided the need for officers to rely on verbal briefings in the absence of 'watchhouse paperwork', and in not having a direction in place that each officer was to independently verify an offender's history, warnings, flags and cautions on QPrime before being tasked to guard that offender.

Recommendations

The State Coroner made two recommendations.

The first was that the police consult with Queensland Health to ensure a consistent approach in relation to the deployment of security staff within hospitals to assist in the management of patients in police custody; explore the use of technology to reduce the need for medical transfers of persons in police detention to watchhouses; and consider whether other measures adopted by West Moreton Health could be applied in other hospitals.

The second recommendation was that the Operational Procedures Manual be reviewed to consider including an order that the risk assessment be completed, and relevant information recorded both on the QP0856 ('Offender Medical Transfer, Treatment and Clearance Sheet') and in an offender's QPrime cautions.

Mark Andrew Sheppard

State Coroner, Terry Ryan – 23 May 2022

Circumstances of the death

On 18 March 2019, police attended the Endeavour Caravan Park on Deception Bay Road, Deception Bay after receiving a triple zero call for assistance. The caller stated that a couple of people had been stabbed at "Endeavour". The call was then terminated and attempts to call the number back were

unanswered. Subscriber checks on the mobile revealed that the number was registered to Mr Mark Andrew Sheppard, who was aged 50 and lived at the Endeavour Caravan Park.

At around 2:15pm, Senior Constable Randall Jurd and Constable Amy Dallimore arrived at the caravan park in a marked police vehicle. The officers were approached by a park resident, Mr Geelmann, who lived next to Mr Sheppard. Mr Geelmann told the officers that Mr Sheppard had not been taking his medications. As they approached Mr Sheppard's site, they saw him sitting on a chair beside his caravan. He was armed with a tomahawk. A large knife and a cutlass machete were also next to him on the ground.

Senior Constable Jurd attempted to speak with Mr Sheppard, however Mr Sheppard did not wish to engage in a conversation. Mr Sheppard threw his tomahawk at Senior Constable Jurd, and it narrowly missed him, hitting the side of the caravan. After throwing the tomahawk, Mr Sheppard armed himself with the machete and the knife. He walked towards Senior Constable Jurd and threw the knife at him, hitting him on the left calf.

Mr Sheppard, still armed with the machete, then started walking towards Constable Dallimore, who was backed against a fence. The officers made multiple calls for Mr Sheppard to drop his weapons, which were ignored. After he came within six metres of her, he was shot three times. The duration of the police contact was less than 90 seconds. The Queensland Ambulance Service attended at the scene, but resuscitation efforts were unsuccessful.

The investigation

An investigation into the circumstances leading to the death was conducted by QPS Ethical Standards Command (ESC). A comprehensive coronial report was provided to the State Coroner in February 2020, including witness statements, digital recordings, medical records, and offender records. The coronial report discussed Mr Sheppard's death as a possible victim 'precipitated homicide' or 'suicide by cop'.

Of relevance was the fact that Mr Sheppard had emphysema/chronic obstructive pulmonary disease (COPD). In 2002 he was diagnosed with alfa-antitrypsin deficiency, which is an inherited disorder causing lung disease. At the time of his death he was using home oxygen. He also had mental and behavioural disorders connected to substance abuse. Three weeks prior to his death, Mr Sheppard was admitted to Caboolture Hospital for end-stage COPD.

The Inquest

Mr Sheppard's death was reported as a death in custody under the *Coroners Act 2003*, as he died while trying to avoid being put into custody. A pre-inquest conference was held on 30 September 2021 in Brisbane. In addition to the findings required by s 45(2) of the *Coroners Act 2003*, the issues for inquest were:

1. *Whether the actions of the police officers who attended at the Endeavour Caravan Park were appropriate in the circumstances; and*
2. *Whether there are ways to prevent a death occurring in similar circumstances in the future.*

The inquest was conducted in Brisbane on 25-26 October 2021. Over 130 exhibits were tendered in evidence, and oral evidence was called from 8 witnesses including a Forensic Pathologist, a psychiatrist, two civilian witnesses from the caravan park, the ESC investigator, and three QPS officers.

Findings and Comments

The State Coroner found that Mr Sheppard died from gunshot wounds to the chest, occurring during the circumstances described above. The State Coroner found that both Senior Constable Jurd and Constable Dallimore appropriately assessed the situation, attempted to engage with Mr Sheppard, and tried to de-escalate the situation. The State Coroner noted that the officers acted in accordance with

their training, and that other use of force options (such as Taser or oleoresin capsicum spray) would not have met the threat posed in the circumstances.

The State Coroner also considered whether Mr Sheppard partook in 'suicide by cop'. After considering the evidence, His Honour considered that it was likely Mr Sheppard was acting intentionally, and with sufficient awareness that the probable consequence of his actions would be that he would be fatally shot by police.

On the issue of whether similar deaths could be prevented in the future, the State Coroner noted that Mr Sheppard did not engage with the mental health system when he was referred for support. The last contact Mr Sheppard had with mental health staff was in August 2017 – nearly 18 months prior to his death. His last contact with the hospital was three weeks prior to his death, however at that time there was no indication of suicidal ideation. Consequently, the State Coroner did not identify a sufficient basis to recommend revision of mental health treatment practices and did not identify any further issues in relation to the treatment received by Mr Sheppard.

Jesse Aaron Kermode

State Coroner, Terry Ryan – 3 June 2022

Circumstances of the death

Mr Jesse Kermode was 24 years of age when he died at Ipswich Railway Station. Shortly after 4.00pm on 16 September 2018 police attended the Station to intercept Mr Kermode. Police had received several reports of him brandishing a knife in the Ipswich central business district. Mr Kermode, who was affected by methylamphetamine, was seated in a train when police entered the carriage. He produced a knife, waved it in a threatening manner, and advanced towards police. Police retreated from the carriage onto the platform. Mr Kermode continued advancing towards police with the knife, despite repeated calls for him to drop the knife. Police shot Mr Kermode. He died as a result of gunshot wounds to the chest and abdomen.

The Inquest

The inquest was held at Brisbane on 1 and 20 December 2021. All statements, records of interview, photographs, body worn camera footage, and other material gathered during the investigation were tendered at the inquest. In addition, five police witnesses gave oral evidence.

The inquest examined the following issues:

1. *The mandatory findings required by s 45 of the Coroners Act 2002 (Qld).*
2. *Consideration of the circumstances leading up to the shooting, including Mr Kermode's engagement with Queensland Corrective Services and mental health treatment after his release from custody in 2017.*
3. *Whether the police officers involved acted in accordance with policy and procedures, and whether their actions were appropriate.*
4. *Whether the training provided to police was sufficient.*

Mr Kermode had a significant mental health history and a long-standing drug problem that started when he was in high school. He had previously experienced drug induced psychosis. In the weeks prior to his death, it was suspected he had resumed using methylamphetamine.

Mr Kermode had a Queensland criminal history, including a conviction for robbery with violence and more. In 2017, he served time in custody and was subject to a probation order following his release. This order was in effect at the time of his death. In 2018, he had been found to breach this probation order.

On the day of his death, 16 September 2018, Mr Kermode was behaving bizarrely. He was approaching people to ask personal questions, murmuring biblical comments, yelling randomly, kicking cars, and speaking gibberish. He appeared drug affected and was confrontational with several people he

encountered. Later toxicology testing revealed a level of methylamphetamine, 0.35mg/kg, that was a potentially lethal range. Amphetamine was also detected, 0.06 mg/kg, at a non-lethal level.

Shortly after 4.00pm, Mr Kermode was sitting in a train at Ipswich Railway Station. Police had received reports of Mr Kermode having brandished a knife at other people earlier that day. Police attended the Station, and two officers entered his carriage. Mr Kermode started behaving erratically and threateningly. He produced a knife and gestured towards the officers. He approached police, who backed off the train onto the platform. Mr Kermode followed. The officers repeatedly yelled at Mr Kermode to drop the knife.

A third police officer attended the station. However, Mr Kermode charged towards the third officer and came within 2.5m of this police officer. The officer subsequently fired a string of shots at Mr Kermode. The other two officers also discharged their firearms. In total, 19 rounds were discharged with 6-7 bullets striking Mr Kermode.

Police immediately commenced cardiopulmonary resuscitation. Queensland Ambulance Service were called and arrived shortly afterwards. However, resuscitation was unsuccessful, and Mr Kermode was declared deceased.

Findings and Comments

Ultimately, the State Coroner concluded:

1. Mr Kermode died due to gunshot wounds to the chest and abdomen, in circumstances where he ran at an armed police officer while armed with a knife, having been repeatedly directed to drop the knife.
2. Mr Kermode had been engaging with his probation order and had been consistently afforded access to mental health services. However, his condition was chronic and largely treatment resistance. He was vulnerable to a rapid decline, and it was likely he was suffering a psychotic episode on the day of his death.
3. That the responding officers acted in accordance with policy and procedures, and their actions were appropriate.
4. That the training provided to police in relation to armed offenders is sufficient to respond to an incident of this nature.

Recommendations

The State Coroner concluded that there were no comments or recommendations to be made that would assist in relation to public health or safety, the administration of justice, or to prevent similar deaths in the future.

First Nations people: case summaries

The need for public scrutiny and accountability that requires all deaths in custody be investigated by the State Coroner or the Deputy State Coroner and mandates they be investigated arose out of the recommendations made in the Royal Commission into Aboriginal Deaths in Custody. The following section provides a summary of the mandatory death in custody and directed inquests finalised during the period that involved the passing of First Nations people.

WARNING: First Nations people are advised that the following section contains the names of people who have passed away.

Enid Cecilia Hyde & Norman Reeve Hyde (also known as Albert)

Northern Coroner, Nerida Wilson – 14 October 2021

Circumstances of the death and suspected death

On 28 March 1972, three people set out to travel, by small, motorised boat, from Yarrabah to Cairns. Aboard were Enid, a mother of six, her husband Charlie, and Enid's brother Conrad. But what commenced as a pleasant boat trip along Queensland's north tropical coast, was to become a tragic event when, on the return journey from Cairns to Yarrabah, Enid and Albert (his preferred name) were lost overboard, and perished. Following the reports that Enid and Albert had been lost at sea, sea and shore searches were commenced immediately. On 30 March 1972, Albert's remains were recovered about "one mile north-west of False Cape". No trace was ever found of Enid.

An inquest into the loss of Enid and Albert was convened in March 1973, before Coroner Scanlan. After hearing evidence from witnesses, including some of the people who had been on the boat. Coroner Scanlan found that Albert had died from asphyxia, due to drowning. As Enid could not be found, a cause was unable to be attributed to her death. In that respect, Coroner Scanlan found that "missing person [Enid] very intoxicated at the time of her disappearance from a small aluminium dinghy in choppy seas". The Coroner found that Enid was deceased, and that there was "no criminal negligence or fault on the part of any person".

Representations by Enid's family:
Enid's family did not accept the original findings by Coroner Scanlan, either that their mother had been "very intoxicated", or that there had been no criminal fault or negligence on the part of any person. In November 2016, Enid's daughter lodged an application to re-open the 1973 inquest, and at the request of the Attorney-General for Queensland, a direction was issued by the State Coroner in May 2019, to the Northern Coroner, to re-open the inquest, and to re-examine the findings of that inquest.

Background to the tragedy:
Yarrabah is east of Cairns, and the journey by road is just over 51 km. The trip to Cairns by water involved leaving Yarrabah, and travelling north-west, rounding False Cape, and then proceeding south-west parallel to the coast, to Trinity Inlet, and thence to the city of Cairns. The three travellers set off at about 7:00am, and upon arriving in Cairns, they attended to some personal tasks, and later met up with friends. They spent some during the day socializing with friends, which included Charlie's brother Norman – usually called Albert – and Cecil Smith. Over this period, alcohol was consumed by a number of the group. At about 4:30pm, the group departed from Cairns to return to Yarrabah. The original three occupants of the boat were joined for the return journey by Charlie's brother Albert, and Cecil Smith. The result was that the modest-sized 14-foot dinghy now carried five adult persons.

The group stopped at Koombal Park, a small settlement at East Trinity. Mrs Lawson, who ran a kiosk at Koombal Park with her husband, was able, in October 2021, to distinctly remember the group stopping at the Park. She knew Enid, and Enid's children, as she had previously been a teacher at Yarrabah. She was at the relevant time only about 50 metres from the group and could hear some of their conversation. In his evidence to an inquest in 1973, Charlie told the inquest that there had been an argument between Enid and himself while they were stopped at Koombal Park. Cecil Smith deposed that Enid had been crying when sitting in the boat when they left Koombal Park, and that Enid and Charlie had had an argument.

After this short stop, the group resumed their journey to Yarrabah. Although their journey to Cairns that morning had been relatively uneventful, the wind had increased during the day, to the point where Conrad described the water conditions as "choppy" and "rough", the latter opinion being shared by Cecil Smith. The rougher waters, and the greater load being carried by the boat, slowed their travel times, and although navigating around False Cape would usually have taken the boat some 15 to 20 minutes, it was to take perhaps double that time on the return leg.

Conrad had driven the boat to Cairns in the morning, and when they had left Cairns; but he had requested that Charlie take over driving for the leg from Koombal Park to Yarrabah. Conrad had felt tired – which may have been contributed to by the alcohol he had consumed – and wished to have a sleep during the final stage of the journey.

The 1973 inquest:

In his 1973 evidence to the inquest, Charlie had stated that Enid and he had argued while they were at Koombal Park, and said that "we were all pretty drunk by then." Conrad said that he was woken just 200 metres off the coast, and that by that time, Enid and Albert were missing from the boat. He quickly took over control of the boat from Charlie, re-started the engine (it was not running) and tried to retrace the boat's movements in a search for Enid and Albert. At that time, Conrad said that he was not provided with any information from the remaining occupants of the boat (Charlie and Cecil) as to precisely how Enid and Albert came to go overboard. At the re-opened inquest in 2021, Conrad (who was the last survivor of that boat trip) advised the Coroner that at no time since 1972 had any explanation been provided to him as to what had happened on the boat. He told Coroner Wilson, in 2021, that he knew something was not right at the time, and he suspected that Charlie knew more than he let on, and that Cecil was too frightened to say anything. Officer Howard, who was the police investigator at the time of the tragedy, gave evidence at the 1973 inquest that Conrad had told him that the boat had developed engine trouble, and for that reason Albert and Enid had jumped overboard.

The Inquest

The re-opened inquest was convened by Northern Coroner Wilson just 5 months short of the 50th anniversary of the tragic loss of Enid and Albert. Mrs Lawson, of the Koombal Park kiosk, gave her evidence as to seeing and hearing the group when they stopped at the Park on their homeward journey. Cecil Smith's 1973 evidence, that he had heard an argument between Enid and Charlie, that both were swearing at each other, and that Enid was sitting in the boat crying when they were leaving the Park, was reprised from Cecil's 1973 deposition. Cecil had also noted, in 1973, that "everyone in the boat was very drunk".

Conrad also gave evidence in the 2021 inquest. He confirmed his 1973 evidence, noting that he had told the truth at the time. He did say, in his evidence, that when he questioned Charlie and Cecil about what had happened, "they wouldn't tell me anything". The Coroner noted that Conrad had a theory that Charlie had hit Enid with a paddle, but also added that, when asked, "Charlie never give me a proper answer".

Some further light was thrown on the events in the boat by Wayne Connolly, Conrad's nephew. Conrad, now 68 years old, had come forward after hearing that a new inquest was to be held. He gave evidence that when he was 19 years old, his uncle Conrad spoke to him, shortly after the loss of Enid and Albert, and gave him information about what had happened. He told the Coroner that Enid and Charlie had been drinking at hotels on the day of their visit to Cairns, and that he (Conrad) had joined them for a time. They were all drinking on the trip back to Yarrabah. Enid and Charlie were arguing, and it "got a bit heated". He thought something had happened at Koombal Park, and when they were in the boat after leaving the Park, Charlie was hitting Enid with a paddle.

At about the same time, during sorry business following the loss of Enid and Albert, Wayne had also spoken with Cecil, who told him that Charlie was getting jealous about Enid and Albert, and that Charlie and Enid argued most of the way from Cairns. After leaving Koombal Park, and while heading towards False Cape, Charlie started digging "Aunty Enid and Albert with a paddle"; and when the boat motor stopped near Tomrock (False Cape), Albert jumped overboard to get away from Charlie. Charlie then turned on Enid, and although Cecil tried to calm Charlie down, Enid, who could not swim, also jumped out of the boat to get away from Charlie. Conrad had woken up after these events, had restarted the motor, and commenced to search for Enid and Albert.

Findings and Comments

Wayne's evidence, never previously heard by any Court, was important to the Coroner in reaching her conclusions. The Coroner found that both Enid and Albert had entered the water in the context of the argument with Charlie; there was no evidence, and there could be no suggestion, that either Enid, or Albert, had intentionally taken their own life. Whether Enid or Albert had jumped into the water first was a question upon which the Coroner had insufficient evidence to make a finding; but whatever the case, the Coroner found that Enid would not have jumped overboard unless she felt forced or compelled to do so. Although it was possible, in Albert's case, to determine a level of alcohol consumption, there was no similar evidence with respect to Enid. The Coroner thought it probable that Enid might have been under the influence to some extent, and that that may have been a factor in her decision to get away from Charlie by jumping into the water.

Charlie had provided a statement to police prior to the first inquest in 1973. The Coroner rejected an assertion by Charlie, in his statement, that there had been no argument on board the boat. Wayne's evidence, drawing upon what both Conrad and Cecil had told him, was much to be preferred to Charlie's denial of an argument, and assisted the Coroner to place the events on the boat in proper perspective.

The Coroner found that neither Cecil nor Conrad had caused, or contributed to, the deaths of either Enid or Albert. The formal findings recorded that Enid and Albert died by jumping from a 14ft dinghy into open waters. With respect to Enid, she was presumed drowned at sea.

Frederick Row Row

State Coroner, Terry Ryan – 23 November 2021

Circumstances of the death

Frederick Row Row was a First Nations man, aged 34 years, who took his own life while detained at the Capricornia Correctional Centre, outside Rockhampton, on 24 August 2016. Mr Row Row had a long history of engagement with the criminal justice system and had been taken into custody on 25 May 2016.

After being received in custody, he was interviewed by a psychologist, who identified a self-harm history, and several recent bereavements within his family, including a family suicide attempt within the previous seven days. Mr Row Row disclosed no self-harm episode since 2001 and told the psychologist that he had no mental health issues, nor any suicidal ideation.

On the 21 August, three days before his death, Mr Row Row was making a telephone call to his partner. During the call, he felt he was being "eyeballed" by other inmates. After the call, he was involved in a physical disturbance with F, another inmate, in the exercise yard. Mr Row Row punched F in the head a number of times, causing him to fall to the ground and start fitting. F was taken to hospital, and was found to have a fractured skull and a bleed in his brain.

At 7:30am on the morning of the 24 August, Mr Row Row was found crying in his cell by a corrections officer. He was visibly upset, and asked again about F's condition. The officer assured Mr Row Row that F was fine. Mr Row Row then asked to speak with the Cultural Liaison Officer (CLO). The corrections officer asked Mr Row Row if he was at any risk of self-harm, and Mr Row Row told him "no".

The officer decided to prepare a Notice of Concern. He advised a psychologist of Mr Row Row's request, and the psychologist waited until a CLO commenced work, as she was aware that there were cultural issues being discussed between Mr Row Row and the CLO. The psychologist and CLO met with Mr Row Row at about 8:20am. He told them he had had "a bit of a cry" that morning; he had a headache, as he had been awake all night "thinking about everything going on with him". He asked to be allowed to return to the Medical Centre, where he said he would have more frequent conversations with guards, and where he had access to the exercise yard. The psychologist told Mr Row Row that he would have access to exercise time, and that the psychology and CLO team could provide him with any

additional support. The psychologist told Mr Row Row that F was not going to die because of the assault upon him by Mr Row Row.

After the meeting, Mr Row Row requested to make a phone call, and to use the exercise yard adjoining his cell. The prison officer advised him that he didn't then have the paperwork in relation to whether the exercise could be opened up, but that he would get that information. Later, at inquest, the same officer advised the inquest that the open door, between Cell D5, and its exercise yard, was a known "hanging point". That is, it was recognised that the door, when open, could be used as a high point upon which to position a ligature.

Around 9:30am, the prison officer who had spoken to Mr Row Row obtained a Safety Order, and "At Risk" instructions relating to Mr Row Row. He brought a phone to Mr Row Row so that he could make a call to his partner and opened the connecting door between Mr Row Row's cell and the adjoining exercise yard. Mr Row Row's phone call was cut off after 9:58am, by expiration of allowable time. It was ascertained that he had been crying again during the call, and was still concerned that F might die. After completing the call, Mr Row Row thanked the prison officer for allowing him to make it. He asked if he could make another call, but that was advised that consecutive phone calls were not allowed. He then asked for a Bible, the only reading material permitted in the Detention Unit.

The CCTV footage at inquest showed that the connecting door between Mr Row Row's cell and the exercise yard was open at 11:15am. At about 11:20am, the prison officer allowed Mr Row Row a second call to his partner, but the call went to voicemail. At about 11:30, the officer left the Detention Unit to collect the meal trolley from the kitchen. It was at this time that that officer, who had been rostered on alone to supervise the Detention Unit, logged his final visual check on Mr Row Row in his cell. The connecting door to the exercise yard remained open.

The ensuing situation was captured on CCTV footage. At 11:33am, Mr Row Row took a bedsheet, folded it in half, and put the two ends of the sheet over the connecting door, just above the top hinge. He twisted the sheet several times, creating a loop. His actions from that point, resulted in this tragic death.

The prison officer returned to the Detention Unit at about 11:50am. He delivered a meal to the only other inmate in the Detention Unit, and then went to Cell D5. He heard the shower running, opened the food hatch and put the meal through the slot. He called to Mr Row Row but received no answer; from his position outside the cell, Mr Row Row appeared to be standing in the doorway. At 11:52am, he entered the cell and discovered what had occurred. He immediately called for emergency assistance, but Mr Row Row was unable to be revived.

The Investigation

An investigation into the circumstances surrounding Mr Row Row's death was conducted by the Corrective Services Investigation Unit (CSIU). A coronial report with annexures including witness statements, medical records and CCTV footage was provided to the State Coroner. In addition to the CSIU investigation, the Chief Inspector, Queensland Corrective Services, appointed investigators to examine the incident and a report was submitted to the Office of the Chief Inspector. Both reports were thorough and tendered at the inquest.

The Inquest

The State Coroner convened an inquest into Mr Row Row's death in May 2021 over three days and heard from nine witnesses. The inquest considered the adequacy of the risk assessment process that took place in the days leading, and on the day of Mr Row Row's death.

Findings and Comments

The Custodial Operations Practice Directives (COPD), in force at the prison at the time of Mr Row Row's death, had required that the connecting door between Cell D5, and the adjoining exercise yard, was to be kept closed and locked, unless accessed by a prisoner for a shower, or for exercise. When he initially

returned to Mr Row Row's cell after obtaining the meals, the running shower he heard from outside Mr Row Row's cell indicated to him that Mr Row Row's was showering. It emerged, at inquest, that there was an "accepted culture" at that prison that – contrary to the COPD – the exercise yard door could be left open for more than two hours, without any continuous observation.

The report by the Office of the Chief Inspector made a number of findings regarding the prevention of future deaths in custody in similar circumstances, including -

- The door to Cell D5 had been left open, and Mr Row Row had not been under constant supervision while this occurred; this was contrary to the Risk Management COPD;
- The level of risk management applicable to Mr Row Row at the relevant time, and in that Unit (ie two-hourly observations) was inadequate having regard to the risk factors known to exist;
- An effective anxiety-reduction strategy was not in place to reduce the anxiety level experienced by Mr Row Row after his assault upon F (eg high levels of anxiety, shame, and guilt); and a "negative emotion reduction plan" should be designed and implemented.

The State Coroner agreed with these findings, and with the recommendations made by the OCI, which included further staff training pertaining to these considerations. The problem of the connecting door had been the subject of immediate action at the Capricornia Center following Mr Row Row's death, by the requirement that two staff were to be rostered on duty at the Detention Unit at all times.

In addition, the State Coroner commissioned a report by a highly-qualified health professional, which examined the situation surrounding Mr Row Row's health assessments in custody, which recommended, among other improvements, the introduction of a separate risk assessment form for First Nation inmates, which recognised specialised cultural sensitivities.

Noombah

State Coroner, Terry Ryan – 11 January 2022

Circumstances of the death

Trevor King's Aboriginal skin name was Noombah; this name is used by family and friends when a loved one has passed. The name Noombah was used at inquest, and in the State Coroner's Findings of Inquest. Noombah was a 39-year-old First Nations man who lived with his family in Townsville. Noombah suffered several health conditions, including ischaemic heart disease.

On 9 February 2018, Noombah went fishing with a local elder, and some young community members. Noombah considered this an important cultural activity. Noombah's own sons didn't go fishing with him. When his sons didn't come along, he perceived a loss of connection to culture. This really upset Noombah. Late on 9 February 2018, his partner found Noombah sniffing petrol and threatening to hang himself. He ran off with a plastic bag and white cord. She called 000.

Police attended, as did the Queensland Ambulance Service (QAS). Police decided not to look for Noombah; they were told he'd driven off with his teenage son and a neighbour. His partner told police she'd call them when he returned home.

Noombah came home a short time later. He was calm and talked things over with his partner. At about 1:15 am, Noombah left to buy cigarettes from the local shop. Police were on their way to an unrelated matter when they saw Noombah walking along Banfield Drive. Police spoke to Noombah.

Noombah told police he didn't want to speak to them, and he'd done nothing wrong. Police knew details of his threats to kill himself and detained Noombah under an Emergency Examination Authority (EEA). A violent confrontation occurred between Noombah and police. Noombah was restrained by police, placed on the ground and handcuffed. Noombah's partner came over to them. She told police about Noombah's heart condition. Noombah was rolled onto his side. He was audibly groaning. Police called for an ambulance.

Two QAS paramedics arrived. Noombah's condition quickly deteriorated. He was put into an ambulance and transported to the Townsville hospital but within minutes of departure suffered a cardiac arrest. He couldn't be revived. Noombah was declared deceased at 2:56 am at Townsville Hospital.

The Investigation

Noombah was detained under an EEA, which is an authority under an Act of the State. His death was therefore considered a 'death in custody'. Although an inquest was not mandatory, Noombah's death also followed a police operation. The State Coroner considered the circumstances required the holding of an inquest. A post-mortem examination was conducted on 12 February 2018 by a Queensland government pathologist. An independent pathologist was also engaged by Noombah's family to review the post-mortem findings. The Queensland Police Ethical Standards Command provided a coronial report.

The Inquest

The inquest was held over four days in Townsville, at which twelve witnesses gave evidence and 158 exhibits were tendered. The inquest considered the following:

- The findings required by s45(2) *Coroners Act 20023*; namely the identity of the deceased, when, where and how he/she died and what caused his death;
- Whether the actions of attending police were appropriate in the circumstances;
- Whether the actions of attending QAS officers were appropriate in the circumstances;
- Whether there are ways to prevent a death occurring in similar circumstances.

The inquest heard Noombah had an enlarged heart with severe hardening and narrowing of two of his coronary arteries. Expert pathology evidence essentially concluded Noombah died from a cardiac arrest caused by a combination of his severe pre-existing heart condition, toxicity from petrol sniffing that night and the stress of his physical altercation with police.

The inquest heard from the police involved that night, and the two QAS officers. Police body worn camera (BWC) footage was available and tendered into evidence. The footage became very important in determining a timeline of events. Experienced police reviewed the restraint methods used on Noombah and whether there was any need to detain him under the EEA. Likewise, expert evidence was called about the actions of QAS officers and whether they properly discharged their obligations to Noombah.

Findings and Comments

The State Coroner found Noombah died on 10 February 2018 at the Townsville Hospital due to a cardiac arrest as a person who had pre-existing, severe ischaemic heart disease, had consumed volatile hydrocarbons and been restrained. The State Coroner considered it would have been better to allow Noombah to return home and provide a less threatening environment to engage with him. However, the inquest had the great benefit of hindsight.

In all the circumstances the police were right to perform some form of intervention with Noombah. Reasonable attempts were made to inform Noombah that police wanted to help him and take him to hospital under the EEA. As Noombah became increasingly aggressive toward police, their eventual use of force was appropriate and lawful in all the circumstances.

It was accepted by QAS that Noombah's care and treatment was deficient. The two QAS officers accepted they failed to carry out any medical assessment or take any of Noombah's vital signs by the roadside. Noombah's assessment and treatment was considered 'suboptimal', including when Noombah went into cardiac arrest in the ambulance. The two QAS officers have ceased practising as paramedics.

Recommendations

The assessment of Noombah's condition and vital signs was delayed because the police and QAS officers weren't sure which had primary responsibility for his care, once he was restrained. The State Coroner recommended changes to the Queensland Police Operational Procedures Manual, requiring

police to ask for an assessment and monitoring of vital signs when a person has been restrained and rapidly goes from heightened emotion to apparent compliance, as happened with Noombah.

The inquest heard evidence about a particular type of restraint mechanism, called a 'lateral vascular neck restraint'. The State Coroner accepted that particular type of restraint wasn't used on Noombah (although pressure was exerted to his general neck area during restraint). Nonetheless, the State Coroner questioned 'whether this type of restraint has a place in modern policing'. He recommended the Queensland Police should review whether it's even included in the 'situational use of force model'.

Finally, the State Coroner recommended the Queensland Government work with First Nations peoples in Townsville, and other relevant stakeholders, to develop culturally appropriate referral pathways, so First Nations people in mental health crisis have an alternative to hospital emergency departments.

Troy James Mathieson & Hughie Kirk Douglas Morton

State Coroner, Terry Ryan – 28 April 2022

Circumstances of the deaths

Cousins Troy Mathieson and Hughie Morton were young Aboriginal men, aged 23 and 21 years respectively. They drowned in Townsville on 4 February 2019, when they entered a flooded drain to evade police arrest.
In the early hours of 4 February 2019, amidst significant flooding in Townsville at that time, Mr Mathieson, Mr Morton and Mr Parker (a surviving relative of theirs) drunkenly embarked on a plan to break into a local bottle shop to steal alcohol and cigarettes. Their attempts to break into the premises triggered an alarm, and police attended in response at approximately 3.31 a.m. Mr Parker hid from police nearby, but the two deceased men jumped a fence and entered the flood waters.

Police officers saw the men enter and begin to traverse the waters towards a culvert pipe, but lost sight of them. Based on their observations, officers believed that the men had successfully crossed the waters and escaped. Their subsequent efforts were therefore directed to locating 'wanted' as opposed to 'missing' persons.

Inspector Whyte later reviewed the case when he resumed command at 5.45 a.m. and reconsidered this classification after extensive inquiries had been made to locate the men to no avail. A search and rescue mission was commenced. Aerial and foot searches were planned, but the exit point of the drain was not searched by police divers until 11.45 a.m. on 5 February 2019. Within four minutes, Mr Morton's body was found less than one metre underwater. Soon after at 12.02 p.m., Mr Mathieson's body was found 210 metres away.

The Investigation

The deaths were investigated by the QPS Ethical Standards Command (ESU). A report, along with photographs of the scene, dash camera and CCTV footage, as well as statements from attending police officers, forensic experts and family members were submitted. The investigation concluded that there were no suspicious circumstances surrounding the deaths nor any evidence of misconduct by police. It was considered that the deaths were 'not preventable', as they had occurred as the immediate result of the men's own decision to enter the flood waters.

The autopsies confirmed that the cause of each death was drowning/immersion. Intoxication was also noted as a significant contributing factor, as both men had substances present in their systems that may have affected their behaviour.

The Inquest

As Mr Mathieson and Mr Morton died whilst avoiding custody, their deaths were deemed to have occurred in custody and in the course of a police operation, thus requiring an inquest per s 27 of the *Coroners Act 2003*. Beyond the factual findings required by s 45(2) of the *Coroners Act*, the inquest examined two additional issues. First, whether having a grate installed on the culvert would have

prevented the deaths; and second, whether classifying the men as 'wanted' as opposed to 'missing' persons would have changed the outcome.

All statements, recordings and material gathered during the investigation were tendered at the inquest. Oral evidence was called from the surviving relative Mr Parker, attending police and superior officers within their chain of command, water police, the ESU investigator, the pathologist, and a civil engineer with expertise in hydraulics and stormwater management.

The engineer, Mr Witheridge, gave evidence that the conditions of the night were *"hydraulically the worst possible conditions that could have existed"*. Based on eyewitnesses' observations that water was lapping or overflowing the top of the culvert, he opined that the water level was close to the most dangerous flow condition that this type of structure could have for a person in the water, although the water would have appeared peaceful to those present. Although the installation of a grate may have deterred the men from entering the water, the expert did not recommend this action be taken because it would not have guaranteed their survival and may have actually increased the flood risk along the nearby main thoroughfare of Ross River Road, endangering pedestrians and traffic there.

Findings and Comments

The State Coroner accepted that the deaths were caused by drowning/immersion, likely within minutes of the deceased men being forced under water.

The State Coroner determined that the classification of the men as 'wanted' rather than 'missing' would not have changed this outcome. That is because the men were very likely to have already been deceased by the time they exited the culvert (they could have only held their breaths for 30 seconds and it would have taken at least a minute for them to be pushed through the culvert), so a search could never have been initiated in time to save them.

The State Coroner accepted that it was not possible to know whether a grate would have saved the men's lives given the variables such as the flow of the water, the unknown volume of submerged debris and the men's strength and swimming abilities; and further, accepted the expert's opinion that mandating such grates would have adverse outcomes. Lawyers for the next-of-kin submitted for a range of other preventive measures such as signs and fences in the vicinity of such culverts. The State Coroner concluded that this would be cost-prohibitive and ultimately do little to deter persons determined to enter a flooding drain.

The family representatives also submitted for improvements to police operations including specific flood water training and protocols when a person goes missing in flood waters. The State Coroner noted that the Commissioner of Police was closely considering these measures and therefore did not make any formal recommendations in this regard.

Higher courts decisions relating to the coronial jurisdiction

Where a person is dissatisfied with inquest findings or a decision by a coroner not to hold an inquest, they may apply to the State Coroner or the District Court. If the State Coroner declines the application, the person may apply to the District Court for an order that an inquest be held. The following section contains a summary of the decisions pursuant to the *Judicial Review Act 1991* handed down during the reporting period.

Angus Morant v Terry Ryan (State Coroner) [2022] QDC 134 – 10 June 2022

Jennifer Morant died of carbon monoxide poisoning on 30 November 2014, suffered in her car. Her husband, Graham Morant, was convicted by a jury of counselling and aiding her suicide. Angus Morant is the son of Graham Morant and step-son of Jennifer Morant.

On 30 July 2020 the Deputy State Coroner issued formal findings pursuant to s 45 of the *Coroners Act 2003* following a coronial investigation. She did not order that an inquest be held.

On 13 August 2021, Angus Morant applied to the State Coroner pursuant to s 30(4)(a) of the Act for an order that an inquest be held. On 24 November 2021, the State Coroner determined that he was not persuaded that it was in the public interest for an inquest to be held and declined to hold an inquest.

Angus Morant then applied to the District Court for an order pursuant to Section 30(6) of the Act that an inquest be held. To be successful, the District Court must also be satisfied that it would be in the public interest to hold an inquest. The application, which was heard on 16 May 2022, was refused by Judge Loury KC in the District Court on 10 June 2022.

The decision is available on the Queensland Courts website at:
https://archive.sclqld.org.au/qjudgment/2022/QDC22-134.pdf.

APPENDIX 1 Presentations by Coronial Registrar, Ainslie Kirkegaard

- **Patient Safety Clinical Improvement Service Education Session**
  - *Coronial Management Matters!* – 5 August 2021
- **Wide Bay Hospital & Health Service Grand Rounds**
  - When to make THAT phone call. - 18 August 2021
- **UQ Autopsy Symposium**
  - 14 September 2021
- **Mater Education**
  - When to make THAT phone call.. – 23 September 2021
- **Mackay Hospital & Health Service Grand Rounds**
  - When to make THAT phone call.. – 15 October 2021
- **Wide Bay Hospital and Health Service** (*presented by Registrar Jessica Lambert)
  - When to make THAT phone call – 16 February 2022
- **Royal Brisbane & Women's Hospital Resident Rounds**
  - When to make THAT phone call… - 5 May 2022
- **Royal Brisbane & Women's Hospital Neonatology Advanced Trainees**
  - When to make THAT phone call… - 21 May 2022
- **Greenslopes Private Hospital Grand Rounds**
  - My patient's death has been reported to the Coroner: what next? – 26 May 2022

APPENDIX 2 Glossary

ANC	Apparent Natural Causes death
APCS	Asia Pacific Coroners Society
CFMU	Clinical Forensic Medicine Unit
CCMS	Coroners Case Management System
CCQ	Coroners Court of Queensland
CSCG	Coronial System Coordination Group
CSB	Coronial System Board
DFV	Domestic and Family Violence
DFVDRAB	Domestic and Family Violence Death Review Advisory Board
DFVDRU	Domestic and Family Violence Death Review Unit
DJAG	Department of Justice and Attorney-General
Form 1	Form 1 – Police Report of a death to a coroner
Form 1A	Medical practitioner report of a death to a coroner
Form 9	Form 9 – cause of death certificate
FTE	Full-time equivalent
The Coroners Act	*Coroners Act 2003* (Qld)
QH	Queensland Health
QHFSS	Queensland Health Forensic and Scientific Services
QPS	Queensland Police Service