The Queensland Government's response to coronial recommendations 2009

Queensland Government

Includes the Queensland Government's response to coronial recommendations handed down between 1 January 2009 and 31 December 2009 and updated responses to recommendations that were under consideration at the time of publication of the Queensland Government's Response to Coronial Recommendations 2008.

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Inquest into the death of Kylie Maree Reid

Ms Reid, aged 19 years, died on 21 September 2006 at the Rockhampton Hospital.

Coroner Springer handed down findings on 8 January 2009.

Recommendation 1

In all hangings or attempted hangings, the relevant rope or other item used should be retained by police until the Coroner determines the cause of death, even where suicide or attempted suicide appears to be involved.

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

In response to this recommendation a review of existing Queensland Police Service policy was undertaken and amendments were prepared to the Queensland Police Service *Operational procedures manual*. These amendments remove uncertainty and clarify the items to be retained in the event of a suicide or attempted suicide. These amendments (to sections 8.5.1 and 13.26) were published on 11 December 2009.

Recommendation 2

Where practicable, the forensic pathologist who is likely to conduct the autopsy be encouraged to visit the scene.

Response and action
Agreed and completed
Responsible agency: Queensland Health

The intent of this recommendation is supported by the Chief Forensic Pathologist, however to implement this recommendation as written would be unnecessary, impractical and wasteful of resources if applied to all cases of hanging. It is recommended instead that:

- police photograph all hanging scenes including the body and noose or other item, place the images on the Forensic Register as a permanent record, and show them to the pathologist at the time of the autopsy
- that if the hanging is suspicious, police should consult with the pathologist to determine whether it would be useful and practicable for the pathologist to attend the scene.

Responsible agency: Queensland Police Service

All regions within the Queensland Police Service currently have protocols in place to request the attendance of a forensic pathologist to the scene of a sudden death. This attendance is negotiated based on the circumstances of each matter.

Inquest into the death of Phillip Henry Scholl

Mr Scholl, aged 42 years, died in Mareeba on 20 October 2005 when the micro light aircraft he was piloting crashed.

Coroner Braes handed down findings 20 January 2009.

Recommendation 24

Workplace Health and Safety Queensland should review its commitment to the regulation of the recreation aviation industry.

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

Workplace Health and Safety Queensland is undertaking a review of its responsibilities with respect to the recreation aviation industry. The review is taking into account the role of the primary regulators of aviation – Civil Aviation Safety Authority and the Australian Transport Safety Bureau – and will include the extent to which Workplace Health and Safety Queensland continues its role of investigating aviation incidents.

It has been agreed that the conclusions reached in the review be communicated to the primary regulators of aviation.

It is anticipated the review will be concluded and advice will be provided to the primary regulators of aviation by 31 June 2010.

Recommendation 25

Workplace Health and Safety Queensland should review its procedures for the registration of aircraft and airfields as workplaces under the *Workplace Health and Safety Act 1995*.

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

The recommendation deals with the registration of aircrafts and airfields and stems from a view that registration would aid in identifying things or places at which incidents may occur.

With respect to incidents at airfields, the *Workplace Health and Safety Act 1995* (the 'Workplace Health and Safety Queensland Act') already provides for notification of incidents to Workplace Health and Safety Queensland where the airfield is a workplace. This notification mechanism provides a suitable mechanism for Workplace Health and Safety Queensland to know that an incident has occurred so that a determination can be made about whether Workplace Health and Safety Queensland will investigate. It is considered that registration would not provide any greater benefit for alerting Workplace Health and Safety Queensland to incidents.

The Memorandum of understanding between Workplace Health and Safety Queensland and the Queensland Police Service sets out the arrangements for alerting Workplace Health and Safety Queensland to matters in which it may have an interest. The Memorandum of understanding is currently under review. The review will seek to provide greater clarity about when Workplace Health and Safety Queensland should be notified for incidents associated with work being conducted at workplaces that are airfields.

With respect to aircraft, certain types of plant, which are typically used for workplace activity, are registrable under the *Workplace Health and Safety Act 1995*. This registration provides an opportunity to know of the existence and ownership of the plant, which can then be used for targeting of compliance and enforcement activity (which may include campaigns involving inspections). The expertise for investigating aviation accidents and inspecting the suitability of aircrafts is vested with the aviation and or relevant transport regulators (e.g. Civil Aviation Safety Authority and Australian Transport Safety Bureau – which advertise on its website that it is 'Australia's prime agency for the independent investigation of civil aviation accidents, incidents and safety deficiencies'). Therefore, it is considered that registration would more appropriately rest with these regulators.

The aviation and relevant transport regulators are also best placed to determine the extent of their compliance and enforcement activity. It is not considered appropriate for Workplace Health and Safety Queensland to fill any gap in this compliance and enforcement activity when Workplace Health and Safety Queensland has not been deemed the primary regulator for these matters and does not have the relevant expertise in which to conduct the activity.

The recreational aviation sector is not the only area in which regulation of the sector is deferred to other agencies. In the case of the regulation of large road freight vehicles and marine vessels, proactive compliance, enforcement activity and incident response rests with the primary regulator, the Department of Transport.

Recommendation 58

Incident sites should be treated as a crime scene and should be isolated and guarded to protect the scene from possible outside interference and the integrity of all relevant evidence including documentation, aircraft wreckage and fuel.

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

The requirement for aircraft incident sites to be preserved, including any wreckage and marks made by the aircraft at the scene, is reflected in current Queensland Police Service policy. This policy is contained in section 17.3.5: *Aircraft incidents* and is reinforced in other sections within chapter 2: *Investigative Process* of the *Operational procedures manual*.

Queensland Police Service policy also provides for the creation of temporary property points where storing evidence in an established property point is not practicable. This policy is contained in section 4.5: *Property Points* of the *Operational procedures manual*.

Inquest into the death of Phillip Henry Scholl

Comment 1, page 54

Civil Aviation Safety Authority, Australian Transport Safety Bureau, Recreational Aviation Australia Incorporated, Hang Gliding Federation of Australia, Queensland Police Service and Workplace Health and Safety Queensland must review the way that these crashes are investigated. Queensland Police Service *Operational procedures manual* contains references to aircraft incidents resulting in death. [See sections 8.5.12 and 17.3.3.OPM]

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

Queensland Police Service policy concerning the investigation of aircraft incidents is largely drawn from information provided in a document titled *Civil and Military Aircraft Accident Procedures for Police Officers and Emergency Services Personnel*. This document is produced by the Australian Transport Safety Bureau and the Department of Defence and is available on the Australian Transport Safety Bureau website.

In light of the Coroner's comments, in February 2009, the Queensland Police Service sent correspondence to the Australian Transport Safety Bureau as the national lead agency, indicating that the Queensland Police Service would support a review of policy relating to the investigation of aircraft crashes. However, the Australian Transport Safety Bureau advised that for various reasons it was not in a position to review its policy.

The Queensland Police Service has subsequently liaised with relevant sport and recreational flying associations including the Australian Ballooning Federation; Gliding Federation of Australia; Hang Gliding Federation of Australia; Australian Parachute Federation; Australian Sport Rotorcraft Association; Recreational Aviation Australia and the Australian Warbirds Association Limited, concerning current investigative processes and the assistance these bodies may provide in the investigation of certain aviation incidents. As a result of this liaison it was determined that current practices were generally adequate. To address the areas in which greater information could be provided to police, an amendment to the Queensland Police Service *Operational procedures manual* (section 17.3.5) was published on 11 December 2009. This amendment provided information regarding the types of aircraft incidents not generally investigated by the Australian Transport Safety Bureau and contact details for the various recreational sporting organisations that may be able to provide investigative assistance.

In September 2009, at the request of the Queensland Police Service, an On-site Aircraft Accident Investigation Fundamentals Course was conducted in Brisbane by the Australian Transport Safety Bureau to improve the quality of police investigations into such incidents.

In addition, the Queensland Police Service is currently undertaking a review of its existing Memorandum of understanding with Workplace Health and Safety Queensland. This Memorandum of understanding includes provisions relating to the investigation of aircraft incidents.

It is anticipated the review of the Memorandum of understanding and any amendments to Service policy required as a result, will be completed by late 2010.

Comment 2, page 61

Ideally, the Queensland Police Service, Workplace Health and Safety Queensland, Civil Aviation Safety Authority, Australian Transport Safety Bureau and Recreational Aviation Australia Incorporated would have co-operated to determine a head investigator and the appropriate investigative steps to take.

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

The Queensland Police Service agrees that investigating agencies should cooperate to determine the appropriate investigative steps to take. However, it is not agreed that one agency could take the lead investigative role in these types of investigations. Other investigative agencies such as the Civil Aviation Safety Authority of Australia and the Australian Transport Safety Bureau have different purposes to the criminal and coronial investigations conducted by police. Additionally, legislation would prohibit some information obtained as part of the police investigation being provided to other agencies or by other agencies to the police. The Queensland Police Service has previously been criticised by coroners for relying too heavily on investigations conducted by other agencies and the point has been made that the Queensland Police Service is not able to abrogate its responsibilities for coronial investigations to other agencies which may also have a role in investigating fatalities. This does not preclude the Queensland Police Service from cooperating with other agencies and obtaining expert assistance where necessary. The Queensland Police Service has current policy (within sections 2.6.17, 2.17.19, 8.5.6, 8.5.12 and 17.3.5 of the *Operational procedures manual*) to address this issue. Cooperative arrangements for investigating these types of incidents are also incorporated in the Memorandum of understanding between the Queensland Police Service and Workplace Health and Safety Queensland.

To remind officers of the existing Service policies in relation to the conduct of coronial investigations involving other agencies, a memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all staff on 6 April 2009.

Comment 3, page 69

In recommending that there be a review by Civil Aviation Safety Authority, Australian Transport Safety Bureau, Hang Gliding Federation of Australia , Recreational Aviation Australia Incorporated, Queensland Police Service and Workplace Health and Safety Queensland of policies and procedures in respect of all matters relating to the recreation aviation industry, I point out that the

Queensland Police Service *Operational procedures manual* at 17.3.3 specifically provides that, 'officers who attend an aircraft incident where any person has been killed or injured or where there has been damage to property, are to ensure that the following agencies are advised of the incident; …(ii) if the aircraft incident may have occurred at a workplace (see section 9 of Workplace Health and Safety Act), a local Workplace Health and Safety inspector'. This procedure appears to limit the police officer's duty to report the incident to Workplace Health and Safety Queensland to the occasion where the incident occurred at a workplace. With respect to the many dedicated police officers involved in investigating accidents of all sorts, a police officer may not necessarily be appropriately equipped to determine whether an event occurred at a workplace.

The procedure is in conflict with the Memorandum of understanding between Queensland Police Service and Workplace Health and Safety Queensland paragraph 10 schedule I 'dealing with incidents and complaints where aircraft are involved', which is to the effect, 'Queensland Police Service agrees that Queensland Police Service officers who attend an aircraft incident where any person has been killed or injured will advise the local Department of Industrial Relations' office'. Although paragraph 10 does go on to say that, 'if the aircraft incident falls within the scope of the Workplace Health and Safety or Electrical Safety legislation, DIR procedure, "dealing with incidents and complaints where aircraft are involved" will apply'. The latter part obviously is an obligation on the Department of Industrial Relations officer to determine the procedure to be adopted whereas the obligation on the police officer is to report every death and injury to the Department of Industrial Relations' office. The Queensland Police Service *Operational procedures manual* should be reviewed to ensure consistency with the Memorandum of understanding.'

Response and action
Under consideration
Responsible agency: Queensland Police Service

The Memorandum of understanding between the Queensland Police Service and Workplace Health and Safety Queensland is currently being reviewed and the issue noted by Coroner Braes has been specifically raised for clarification. The matter has also been raised with the State Coroner who is also involved in the renegotiation of the Memorandum of understanding. Consequently, it is expected the issue of whether police are obliged to report every incident involving death or injury to Workplace Health and Safety Queensland will be clarified in the next version of the Memorandum of understanding. Any consequential amendments to Queensland Police Service policy will be made then.

It is anticipated the review of the Memorandum of understanding and any amendments to Service policy required as a result, will be completed by late 2010.

Comment 4, page 69

Where an incident occurs that involves the crash of an aircraft it would seem sensible that all regulators and investigators be involved and that either a joint preliminary investigation be undertaken or that a lead investigator be appointed to conduct the immediate inquiry with a view of then determining whether or not other investigators and/or regulators would become involved in the inquiry.

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

The Queensland Police Service supports cooperative investigations with other agencies and adopts a practice of conducting a preliminary investigation with a view to determining which other agencies or investigators are required. The Queensland Police Service does not support appointing a single lead investigator from among the agencies involved due to the vastly different investigative aims and legislative authorities relevant to the various agencies. Current policy to give effect to this position is contained within section 8.5.12 and section 17.3.5 of the Queensland Police Service *Operational procedures manual*. Cooperative arrangements for investigating these types of incidents are also incorporated in the Memorandum of understanding between the Queensland Police Service and Workplace Health and Safety Queensland.

Inquest into the sinking of the Malu Sara

On Friday 14 October 2005 immigration vessel, the Malu Sara, disappeared while travelling from Saibai Island to Badu Island. On board was Wilfred Baira, Flora Rose Enosa, Ethena Enosa, Ted Cyril Harry and Valerie Saub. None of them survived.

State Coroner Barnes handed down findings on 12 February 2009.

Recommendation 1

The Queensland Police Service should review the performance of the Search and Rescue Mission Co-ordinator in this case. The Queensland Police Service should consider whether further training is necessary for all officers likely to fulfil this role on Thursday Island. The evidence suggests senior members of the water police with search and rescue responsibilities have developed a cavalier attitude to marine incidents.

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

The Queensland Police Service agrees that the Search and Rescue Mission Coordinator's actions in this case be reviewed. The actions of Sergeant Flegg have been investigated by Ethical Standards Command and are being dealt with in accordance with existing Queensland Police Service disciplinary procedures.

A review of the Search and Rescue system used by the Queensland Police Service was run parallel to this inquest. This review resulted in nine recommendations, all of which have been addressed, including a significant increase in the number of courses conducted across the State in the past two years. Officers stationed at Thursday Island have been given priority to attend the National Search and Rescue Managers Course for the last four years. Currently there are five members trained in Search and Rescue to the State level at Thursday Island.

It is anticipated the disciplinary process regarding the actions of the Search and Rescue Mission Coordinator in this particular case will be finalised by the end of 2010.

Recommendation 2

Queensland Police Service policies should be reviewed to ascertain whether the Search and Rescue Mission Co-ordinator on Thursday Island should be authorised to task a rescue helicopter at his/her discretion.

Response and action
Recommended review completed. Proposed change to policy not being implemented
Responsible agency: Queensland Police Service

While cost is not a factor in the decision to use an asset, such as the rescue helicopter, prudent assessment of the deployment of an asset that ranges in cost of $5000 to $8000 per hour of use is seen by the Queensland Police Service as demonstrating appropriate financial accountability.

While the Search and Rescue Mission Coordinator must receive two levels of approval to engage the helicopter, experience has shown that approval is provided in a short time frame.

Recommendation 3

Whenever a Queensland Police Service officer is involved in search and rescue activities and the person in distress is not rescued alive, the death be investigated by an independent officer who has not been involved in the attempted search and rescue and who is sufficiently trained and experienced to critique the performance of those who were.

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

In response to this recommendation, an amendment to section 8.4.1: *Responsibility for investigating and reporting on deaths* of the Queensland Police Service *Operational procedures manual* was published on 11 December 2009.

This amendment stipulates that where a deceased person was the subject of a search and rescue operation, the investigation of the death should be conducted by a suitably experienced officer who was not involved in the search and rescue mission. The amendment also provides that if necessary, where the investigating officer is not a qualified search and rescue mission coordinator, advice should be sought from a suitably qualified search and rescue mission coordinator not involved in the rescue mission.

Recommendation 5

If it has not already done so, Maritime Safety Queensland should either address weaknesses in its boat builder and boat designer accreditation regime or take steps to immediately rescind all such existing accreditations and advise the public that it has done so.

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

Since the loss of the Malu Sara, Maritime Safety Queensland has taken the following steps to address weaknesses in its ship builder and ship designer accreditation regime:

- As at 1 December 2008, the accreditation regime for ship builders, ship designers, and ship surveyors administered by Maritime Safety Queensland became subject

to the Department of Transport and Main Road's *Organisational policy for accreditation schemes*. The organisational policy requires Maritime Safety Queensland to participate in quarterly reviews of the accreditation regime.

- As at 5 August 2008, Maritime Safety Queensland issued a policy document *Standard for auditing of accreditation schemes*. This policy establishes a standard for conducting audits of accreditation schemes including the ship builder and ship designer accreditation regime, in accordance with the Department of Transport and Main Road's *Organisational policy for accreditation schemes*.

- As at January 2009, Maritime Safety Queensland issued a revised guidance manual for accredited persons, entitled *Accredited person's guidance manual* (version 4). Amongst other things, this document sets out the legislative and other obligations applicable to accredited ship builders and ship designers.
- As at 26 November 2008, Maritime Safety Queensland issued a compliance standard for the ship builder and ship designer accreditation regime. This standard establishes methods for monitoring the compliance of accredited persons with relevant statutory provisions and Maritime Safety Queensland's *Accredited person's guidance manual*. The standard requires all accredited persons to be subject to a full audit at least twice in every three year period of accreditation.

In applying the compliance standard, Maritime Safety Queensland also maintains an Accredited Designer and Builder Audit Schedule.

Prior to 2006, a ship builder or ship designer could qualify for accreditation by relying on relevant qualifications plus five years of appropriate experience or by demonstrating 10 years of appropriate experience. The accredited boat builder and boat designer who was responsible for the building of the Malu Sara and her sister ships, Mr Radke, qualified for accreditation by demonstrating 10 years of appropriate experience to Maritime Safety Queensland. The option for qualifying for accreditation by demonstrating 10 years of appropriate experience without relevant qualifications was removed in 2006 when the Transport Operations (*Marine Safety - Accreditation for Ship Designers, Shipbuilders and Marine Surveyors*) Standard was remade in 2006.

Recommendation 10

Australian Search and Rescue (AusSAR) and the Queensland Police Service should review the adequacy of search assets routinely available in the Torres Strait. In my view a search and rescue helicopter with night winch and auto hover capabilities is essential for the safety of the local population and others traversing the area by boat.

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

In response to the State Coroner's recommendation, the Queensland Police Service has conducted a review of the search and rescue assets routinely available for deployment within the Thursday Island policing division. The availability of these assets is now being

monitored by the Queensland Police Service on a weekly basis. This on-going review of available search and rescue assets has been included in local standing operating procedures and risk management processes and is expected to enhance the collective response to any given search and rescue operation.

In reference to the Coroner's view of the rescue helicopter's capabilities, the Queensland Police Service acknowledges the value of the additional proposed capabilities. However, the Queensland Police Service is unable to commit to this provision as any upgrade of the equipment contained on the helicopter would need to be negotiated between the contracted parties, namely Australian Helicopters and Emergency Management Queensland.

In response to this issue, the Queensland Police Service has recently commenced officer level discussions with the Helicopter Network Coordinator, Helicopter Service Unit and the Executive Manager, Emergency Management Queensland. The Queensland Police Service has also completed an analysis of data relating to the use and potential use of helicopters in search and rescue situations in the Torres Strait, during the last three years. This analysis was conducted with a view of determining the circumstances where a helicopter, equipped with a night winch and auto hover capability would have proved a valuable resource.

The results of this analysis were included in correspondence sent to the Director-General, Department of Community Safety in December 2009, requesting that consideration be given to the State Coroner's recommendation.

On 25 January 2010 the Director-General replied advising that, in response to a request in mid-2009 from the Australian Maritime Safety Authority (AMSA), his department has provided information to the AMSA in regard to the feasibility and indicative cost of fitting auto-hover and night vision goggles capabilities to the contracted helicopter which operates in the Torres Strait area.

The Queensland Police Service will make further enquiries to ascertain the outcome of consideration of this matter.

Comment 1, page 4

The debriefing appears not to have engaged in any critical analysis of Sergeant Flegg's performance during the evening of Friday 14 October 2005 as Search and Rescue Mission Coordinator, nor the fact that AusSAR did not receive timely information that the vessel skipper reported that it was sinking at about 2.30am on Saturday morning. It also failed to critique AusSAR's characterising of all sightings of people in the water after the vessel sank as 'non-confirmed'. To that extent it was a wasted opportunity to improve the performance of the respective organisations through reflective introspection. It may be however that to expect critical analysis of the performance of officers from other agencies in such a setting is unrealistic. I shall leave it to the managers of those agencies to consider whether improvements in this regard are possible.

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

It is current Queensland Police Service policy that where practicable, debriefings should be conducted as soon as possible after the conclusion of a major incident (section 1.4.8 of the *Operational procedures manual* refers). Debriefings are structured meetings which aim to evaluate the successes and problems experienced during an incident, although it is acknowledged that a critical analysis of Sergeant Flegg's performance did not occur within this particular debriefing.

To ensure the actions of Queensland Police Service search and rescue mission coordinators are properly scrutinised, an amendment to section 8.4.1: *Responsibility for investigating and reporting on deaths* of the Queensland Police Service *Operational procedures manual* was published on 11 December 2009. This amendment stipulates that where a deceased person was the subject of a search and rescue operation, the investigation of the death should be conducted by a suitably experienced officer who was not involved in the search and rescue mission. The amendment also provides that if necessary, where the investigating officer is not a qualified search and rescue mission coordinator, advice should be sought from a suitably qualified search and rescue mission coordinator not involved in the rescue mission.

In addition, on 23 December 2008, the Queensland Police Service established significant event review panels within each region and command to critically analyse the appropriateness of police actions in response to events, including critical incidents involving death or serious injury (see Commissioner's Circular 34/2008). In the case of critical incidents, the significant event review panel is chaired by the relevant assistant commissioner, and must commence the review within 14 days of the incident. Although finalisation of the review of a critical incident may take some time, monthly interim reports must be supplied to the relevant deputy commissioner concerning the status of such reviews.

Comment 2, page 97

It is the State Coroner's view that a prescribed officer could conclude Sergeant Flegg's conduct amounted to misconduct or that he acted incompetently in the discharge of his duties in that there is a substantial body of evidence indicating he:

- failed to keep an accurate log of the search and rescue incident concerning the Malu Sara
- failed to adequately respond in a timely manner as the seriousness of the incident escalated throughout Friday evening and Saturday morning
- failed to pass onto AusSAR information he well knew was crucial to its assessment of and response to the incident.

Response and action
Agreed and partially completed

Inquest into the sinking of the Malu Sara

Responsible agency: Queensland Police Service

The Queensland Police Service has a comprehensive complaint management and discipline process, designed to satisfy the requirements of the *Police Service Administration Act 1990*, Police Service (Discipline) Regulations 1990 and *Crime and Misconduct Act 2001*.

The actions of Sergeant Flegg have been investigated by Ethical Standards Command and are being dealt with in accordance with existing Queensland Police Service disciplinary procedures.

To improve the coordination of future search and rescue incidents, on 30 November 2009, a memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all staff. This memorandum stipulates that the minimum number of members required to coordinate a search and rescue incident is to be continually reviewed on a case by case basis in line with the *National search and rescue manual*, depending on the complexity and size of the incident. This review may require a number of search and rescue trained personnel to undertake the roles identified in the *National search and rescue manual*, however, at the very least there must not be less than two search and rescue trained members coordinating each incident.

It is anticipated the discipline process in relation to this matter will be finalised by the end of 2010.

The contents of the Deputy Commissioner's memorandum will also be incorporated into the Queensland Police Service *Operational procedures manual* by mid 2010.

Inquest into the death of Barry John Charles Cusack

Mr Cusack died on 24 November 2004 whilst employed at the Mount Norma Mine, southeast of Cloncurry. Mr Cusack was tasked to drill holes in the northern mine face bench. He died due to injuries he received when the machinery he was operating went over the bench, sliding down and coming to rest 20 metres below the bench.

Coroner Luxton handed down findings on 27 February 2009.

Recommendation 1

The mines inspectorate consider legislative change for small mines and quarries (those which employ ten persons or less) to develop and implement a safety and health management system to suit the nature and complexity of the operation.

Response and action
Agreed and completed
Responsible agency: Department of Employment, Economic Development and Innovation

The *Mines and Energy Legislation Amendment Act 2010* received assent on 21 April 2010 and the relevant amendments to the *Mining and Quarrying Safety and Health Act* commenced on 1 September 2010.

Inquest into the death of Maurice Henry Bauer

Mr Bauer, an electrician, died on 1 March 2006 from electrocution during the course of his employment. The electrocution occurred as, unknown to Mr Bauer, he was working 'live', meaning mains connection to the house he was working on had not been turned off.

Coroner Fingleton handed down findings on 5 March 2009.

Recommendation 1

Safety Alerts should be issued as soon as possible after a death or a serious incident has occurred at a workplace. In relation to a risk arising from a workplace hazard, regardless of any detailed investigations being carried out, to best warn or remind those working in the industry as to those hazards.

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

The safety alert procedure for workplace health and safety matters has been reviewed and revised since the death of Mr Bauer. The application of the revised procedure has resulted in timely development and publishing as illustrated by the following safety alerts:

- safe filling of portable aluminium alloy cylinders – incident occurred on New South Wales north coast on 16 August 2009, confirmation of incident details from New South Wales WorkCover on 28 August 2009 and safety alert published on 4 September 2009
- Hendra virus – incident associated with Hendra virus occurred on 21 August 2009, safety alert was published on 4 September 2009
- asbestos bags recycled for use in carpet underlay – concerns raised through media report on 24 August 2009, safety alert published on 4 September 2009.

Safety alerts are published on the Workplace Health and Safety Queensland website, emailed to e-Safe newsletter subscribers (there were 6400 subscribers as at 20 December 2009) and promoted through targeted communication opportunities.

The Electrical Safety Office has introduced safety e-alerts as a means of targeting risks arising from electrical fatalities. The following examples illustrate the timely publication of these alerts:

- fatality of an unlicensed worker in January 2008 and fatality of fencing contractor in February 2008 – e-alert issued in March 2008
- fatality of an electrical worker on 17 November 2008 – e-alert issued on 10 December 2008
- station manager fatality on 22 December 2008 – e-alert issued on 22 December 2008.

Recommendation 2

There is no requirement presently in the Wiring Rules that manufacturers packages for electrical tapes should indicate the

number of the appropriate Australian Standard being present on packages for electrical tapes. The Professor found no evidence that tradesmen use only tapes certified to standards and this would appear to be poor practice. It may arise from an influx onto the market of cheaper tapes. However, steps should be taken to institute or reinstitute such a requirement in the Wiring Rules.

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

The recommendation was not specifically directed to the Office of Fair and Safe Work Queensland. However, actions have been taken to support the implementation of the coroner's recommendations.

The Australian and New Zealand Standard 3000:2007 addresses the insulation requirements for insulating connections between insulated conductors to provide the degree of insulation not inferior to that of the conductors. The current edition of the wiring rules further addresses this issue in clause 3.7.3(d) Australian and New Zealand Standard 3000:2007.

Both editions of the joint Australian and New Zealand Standard were prepared by the joint Technical Committee EL/001. The Electrical Safety Office wrote to the technical committee on 4 September 2009 highlighting the coroner's recommendation for the committee's consideration.

The Office of Fair and Safe Work Queensland has received correspondence from Standards Australia outlining the Technical Committee's assessment of the coronial recommendation and its relationship to the findings of the coroner. A copy of the Standards Australia correspondence has been forwarded to the coroner for information.

Inquest into the death of Melissa Maree Blake

Ms Blake was assessed as having a major depression. A decision was made to treat Ms Blake in the community under the care of the Sunshine Coast District Mental Health Services Network. Ms Blake died on 16 January 2007 at her home as a result of suicide. Ms Blake's treatment in the month preceding her death was scrutinised at inquest.

Coroner Callaghan handed down findings on 16 March 2009.

Recommendation 1

A professional health worker be responsible for ensuring that the family understands the risk of suicide, explains fully the role the family is to play in helping prevent a suicide and reinforces this on a regular basis.

Response and action
Agreed and completed
Responsible agency: Queensland Health

The Queensland Health mental health statewide suite of clinical documentation includes several prompts to include the carer/appropriate others in the sharing of information and treatment planning, with the consumer's consent. For example, the Consumer intake and consumer assessment form includes a section where the assessor can indicate with whom the patient's information can be shared, e.g. GP, carer, referrer, etc.

The three components of the Recovery plan include prompts to promote inclusion of the patient's carer or family member in their planned care, and carers have the opportunity to sign off on the Recovery plan. In addition, the *End of episode/discharge summary* includes a section to identify who is available for ongoing consumer support, e.g. family, spouse, friend, etc.

A Queensland Health Consumer and Carer Participation Framework is under development which highlights the importance of involving the carer, family members or significant others in all aspects of the consumer's treatment. This important issue is reflected across a number of priority areas under the framework, including:

- Priority Area 1. Enhanced consumer and carer participation in initial and ongoing mental health assessment processes. This priority area includes the following standards:
    - respectfully and clearly communicate with consumers and carers, family members and significant others at all times.
    - share accessible explanations of the assessment, diagnosis and formulation with consumers and wherever possible carers (with the consumer's consent).
- Priority Area 2. Consumer centred and carer participation in recovery planning processes. This priority area includes the following standards:
    - communicate clearly and provide evidence based information about treatment options with consumers and whenever possible carers and/or family members with consumer's consent.

- identify consumers and carers lived experiences and individual strengths to inform individual care and recovery plans that are personalised and responsive to the individual consumer's goals.
- meet with consumers and carers in times of 'wellness', to invite their ideas to be incorporated into recovery relapse prevention plans.
- provide consumers and carers (with the consumer's consent) with copies of these individual care plans, recovery and recovery relapse prevention plans wherever possible. Explain these plans. Ensure the plans are written in accessible language and where possible incorporate consumer's own words.

Additionally, under the Carers Matter Website initiative, Queensland Health is providing free four- hour workshops at various locations across Queensland for carers facing the challenges of providing positive support for a family member with a mental illness. The workshop assists carers with strategies for supporting consumers with day-to-day difficulties and break down some of the barriers to communication with the person for whom they are caring. It assists carers to identify their role in the recovery process and provide information regarding managing situations when the consumer is unwell and may be suicidal.

Carers across Queensland in a number of locations are also given the opportunity to undertake free training in Mental Health First Aid, which specifically addresses the carer's and family member's role in supporting someone who is suicidal.

The draft Queensland Health *Mental Health Patient Safety Plan* includes a number of strategies and indicators highlighting the importance of involving carers and families in mental health assessment and care planning processes.

Recommendation 2

The plan for treatment of a person in the community, including medication, be itemised in the clinical notes separately with an indication as to who is responsible for carrying out the plan, and a copy of the plan be given to the family carers.

Response and action
Agreed and completed
Responsible agency: Queensland Health

In 2008, Queensland Health introduced standardised suites of clinical documentation for use in public mental health services. These suites of clinical documentation are composed of forms or templates for use during the intake, assessment, treatment and discharge stages of a consumer's engagement with a mental health service. A user guide and training program were integral parts of the documentation roll out statewide. The roll out was carried out in a staged manner and was completed in March 2009. This standardised suite of forms was not available in 2007. A 'treatment' plan is included in the Recovery plan. Instructions regarding the use of this form are detailed in the user guide. The National Mental Health Standards (1996) outline minimum standards for mental health services, including a 91 day review for community patients where the Recovery plan is reviewed and updated and plans are made for next 91 days of care. Notification of the due date for review is done through

the Consumer Integrated Mental Health Application (CIMHA). There is also provision for ad-hoc review when needed.

Consumer and carer involvement in the development and review of the Recovery plan is a key principle underpinning the suites of clinical documentation. Consumers and carers are asked to sign the Recovery plan. Consumers and carers should be given a copy of the Recovery plan unless (in very rare circumstances) this is contra-indicated or the consumer refuses permission for carers to be involved in treatment planning or to receive a copy of the plan. The plan must be regularly reviewed and kept up to date. The detail of the plan (including review periods) is determined by the complexity of the consumer and their associated needs. Every consumer of community mental health services must have their care plan reviewed at least every 91 days as a minimum standard. Medication is specified on the treatment plan. Reference is also made to the medication chart. The suite of forms is subject to continual review and a formal continuous improvement cycle including annual audits.

Statewide audits of (correct) use of the forms are currently being carried out across the state and audit findings will be used to improve functionality of the forms and to inform service providers of gaps in current documentation and associated clinical practice.

Inquest into the death of Liam John Wright and Charles Michael Powell

In July 2006 both Messrs Wright and Powell came into contact with the mental health service based at the Logan Hospital.

Mr Wright had been admitted to Ward 2B and later transferred to the secure Acute Observation Area of the Mental Health Unit based at the hospital. However, on 14 July 2006 a decision was made to place him in a general non secure mental health unit ward. He absconded soon after he was transferred into the open ward.

About a fortnight later, Mr Powell was assessed at the Emergency Department of Logan Hospital as to whether he should be admitted to the Mental Health Unit. A decision was made not to admit him.

Shortly after these clinical decisions were made, both of these young men took their own lives by jumping in front of a train.

Coroner Lock handed down findings on 20 March 2009.

Recommendation 1

The proposal to introduce a fully staffed 25 acute bed mental health ward at Logan Hospital as set out in the Mental Health Plan 2007-2011 be implemented with priority.

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

Work is progressing to ensure the 25 acute bed mental health ward is built at the Logan Hospital. A tender process has been finalised and the architect chosen for the building project. An internal planning group has also been established including representatives from Mental Health Services, a carer liaison representative, consultant psychiatrists, architects, Queensland Government Project Services and principal project officers. A number of building project designs have been developed and refined and a preferred option has been identified. The plan is to build to the east of the existing inpatient units, interconnecting and also accessible from Armstrong Road. The planned facility will enhance existing acute inpatient services by improving the critical mass for high dependency services, establishing a purpose built older persons unit and further enhancing the integration link for community services to dedicated inpatient services. Ward 2B will service the Logan Central Community Clinic and surrounding suburbs; Ward 2C will service the Beenleigh Community Health Clinic and surrounding suburbs; and the new unit will service the Logan West Clinic and surrounding suburbs.

The building project is expected to be completed by December 2010, and commissioned in February 2011.

Inquest into the death of Niceta Maria Madeo

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

State Coroner Barnes handed down findings on 26 March 2009.

Mrs Madeo's death is one of 10 deaths that occurred in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests have been held into each of those deaths.

The *Coroners Act 2003* authorises a coroner conducting an inquest to comment on anything connected to the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. To maximise the evidence base, the State Coroner postponed making any such comments in these cases until all 10 deaths had been heard. At that stage a further hearing was convened and evidence heard in relation to the Queensland Police Service's pursuit driving policy.

The State Coroner handed down thirteen recommendations on 31 March 2010 relating to the Queensland Police Service's pursuit driving policy. The Government's response to the State Coroner's recommendations will be included in the report *Queensland Government's response to coronial recommendations 2010*.

Comment 1, page 13

The policy required the pursuing officers to balance the utility of a pursuit against the risks it generates. The utility is gauged by considering the consequences of failing to intercept the pursued. In this balancing exercise issues of safety are to be paramount. Quite specific and useful examples are given of characteristics which will be relevant to assessing the risk of the pursuit resulting in injury or death. No guidance is given to assist officers to calculate the necessity of the pursuit with reference to the diminution of law enforcement.

Response and action
Under consideration
Responsible agency: Queensland Police Service

Beginning with a trial in two districts from 1 October 2006 and expanding to a statewide trial from 1 January 2008, the Queensland Police Service has introduced a rigorous and more restrictive safe driving policy to address the risks involved in urgent duty and pursuit driving. The new policy was complemented by new offence provisions to deal with motorists who seek to evade police. The policy introduced the concept of non-pursuit matters and gives detailed guidance on when a pursuit may be commenced, what risk factors must be considered and when a pursuit must be abandoned. Training was delivered to all staff (including civilian radio operators) up to and including the rank of inspector, in all districts and branches between 1 July and 31 December 2007. In addition, consistent with recommendations from the Crime and Misconduct Commission and the State Coroner, from

semester one 2008, police pursuits have formed part of ongoing operational skills and tactics training.

The State Coroner has indicated that at the completion of the seven inquests connected to police pursuits, the policy issues arising from the inquests would be addressed. Accordingly, the specific recommendations arising from this and the other inquests will be considered by the Queensland Police Service once the State Coroner's final report is delivered.

Finalisation of any policy recommendations made as a result of this and other related inquests will be subject to the timing of the State Coroner's final report.

Comment 2, page 18

The State Coroner found the Queensland Police Service pursuit policy was not adhered to by the senior officer in the pursuing vehicle or by the pursuit controller. The State Coroner acknowledged that in neither case was this was the result of a wilful disregard of those policies: rather, serious errors of judgement were involved. The State Coroner also acknowledged no malicious or improper purpose was involved in these errors.

Response and action
Under consideration
Responsible agency: Queensland Police Service

The Queensland Police Service has a comprehensive complaint management and discipline process, designed to satisfy the requirements of the *Police Service Administration Act 1990*, *Police Service (Discipline) Regulations 1990* and *Crime and Misconduct Act 2001*. The comments of the State Coroner in this instance are being addressed in accordance with this process.

It is anticipated the disciplinary process concerning this matter will be finalised by late 2010.

Inquest into the death of Stephen James Broe

On 28 April 2005, Dr Broe emerged from the ocean a few kilometres north of Moreton Island and climbed onto a charter boat, having completed the final dive in a technical deep diving course he had been undertaking over the preceding months. He almost immediately complained of burning pain in his chest and severe shortness of breath. Despite assistance from people on the boat, Dr Broe lapsed into unconsciousness and died a few minutes later.

State Coroner Barnes handed down findings on 24 April 2009.

Recommendation 1

The Memorandum of understanding between the Queensland Police Service and Workplace Health and Safety Queensland be reviewed to ensure it facilitates the specialist units in both agencies being expeditiously notified of all diving deaths. The review should involve the Office of the State Coroner so that procedures can be developed to ensure the early notification of the coroner.

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

In collaboration with Workplace Health and Safety Queensland and the Office of the State Coroner, a review of the existing Memorandum of understanding is currently in progress.

In addition, to ensure the early notification of the relevant coroner in the event of a diving death, draft amendments to the Queensland Police Service *Operational procedures manual* (section 8.5.4: *Diving deaths and incidents*) have been prepared and have been referred to the Office of the State Coroner for consideration.

It is anticipated the revised Memorandum of understanding and draft amendments to the Queensland Police Service *Operational procedures manual* will be finalised by late 2010.

Responsible agency: Department of Justice and Attorney-General

Workplace Health and Safety Queensland and the Queensland Police Service commenced a review of the existing Memorandum of understanding to address this and other coronial recommendations relating to the memorandum between the parties.

Finalisation of the review of the Memorandum of understanding is being monitored by the Workplace Health and Safety Queensland Investigations Governance Group. Finalisation of the review is anticipated by end of June 2010.

Recommendation 2

The Director, Forensic and Scientific Services, cause to be developed a protocol for the CT scanning of deceased divers in Queensland Health regional hospitals.

Inquest into the death of Stephen James Broe

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

The Director, Forensic and Scientific Services, supports this recommendation in principle as it will better support the Coroner's ability to investigate compliance with diving standards and prevent similar deaths from occurring in the future.

Forensic and Scientific Services will investigate and if feasible develop a protocol by June 2010. The development of a protocol such as this would require full consultation with the State Coroner and the relevant district staff.

Recommendation 3

Workplace Health and Safety Queensland consider amending the Recreational Technical Diving Code of Practice to provide guidance to dive operators on preferable methods by which divers may reboard the dive platform and highlight physical exertion following a dive as a risk factor for the onset of decompression illness.

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

In light of the coroner's recommendation and other industry feedback, a review of the code of practice has occurred. Consultation has been undertaken with the Recreational Dive Reference Group. A new code of practice has been produced.

The Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2010 was approved by the Minister and commenced on 1 March 2010.

Inquest into the death of Paul James Moore

Mr Moore died on 22 September 2006 as a result of injuries sustained when his car left the road and collided with a tree during a police pursuit south of Injune.

State Coroner Barnes handed down findings on 22 April 2009.

Ms Moore's death is one of 10 deaths that occurred in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests have been held into each of those deaths.

The *Coroners Act 2003* authorises a coroner conducting an inquest to comment on anything connected to the death that relates to public health or safety the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. To maximise the evidence base, the State Coroner postponed making any such comments in these cases until all 10 deaths had been heard. At that stage a further hearing was convened and evidence heard in relation to the Queensland Police Service's pursuit driving policy.

The State Coroner handed down thirteen recommendations on 31 March 2010 relating to the Queensland Police Service's pursuit driving policy. The Government's response to the State Coroner's recommendations will be included in the report *Queensland Government's response to coronial recommendations 2010*.

Inquest into the death of Brendan Scott Kay

Baby Kay developed a sub-glottic stenosis as a result of prolonged intubation following his premature birth at 26 weeks. His condition was investigated and found to be clinically insignificant. Having reached full-term he was discharged from hospital but stopped breathing on his return home.

Coroner Tonkin handed down findings on 21 April 2009.

Recommendation 1

Consideration should be given by the clinicians in all cases as to whether neonates returning from Royal Brisbane and Women's Hospital to the referring hospital should be returned for observation at the referring hospital before discharge, however there is no basis for a blanket policy in this regard.

Response and action
Agreed and completed
Responsible agency: Queensland Health

The recommendation is supported and is the usual practice of the Department of Neonatology at the Royal Brisbane and Women's Hospital. Back-transfer is much preferable to discharge home from the Royal Brisbane and Women's Hospital, even for the closer places like Bundaberg or Gladstone. Back-transfer to the referring hospital occurs in most cases, particularly if the baby is unwell at the time. If the baby is really well, the Royal Brisbane and Women's Hospital arrange for them to be reviewed in the ward of the back-transfer hospital at the very least. The Royal Brisbane and Women's Hospital agrees with the Coroner's statement that there is no basis for a blanket policy as there will from time to time be exceptions to this process. Brendan's case was an exception, and unfortunately an unforeseen event occurred. This event has strengthened the existing policy and the Royal Brisbane and Women's Hospital will continue to make it their general policy that back-transfer is much preferable to discharge home and to give very careful consideration to all discharges, but especially to those very few that may have once been considered suitable to be discharged home rather than back-transferred.

Recommendation 2

Where possible, babies with chronic lung disease born prematurely should travel in daylight after discharge home where travel exceeding 30 minutes is involved and full feeds avoided. Parents should also be seated next to the capsule, for maximum observation.

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

On consultation with expert neonatologists around the State, it is agreed that a parent/care giver should, where possible, sit next to the infant for maximum observation. This should be on the condition the infant is not placed in the front passenger seat, particularly in cars with

front passenger seat air bags. The neonatolgists suggest a protocol for transport of the premature, very low birth weight or medically at risk infant (upper airway obstruction) would be useful in Queensland. The protocol should include information for parents and could also make comment on other sitting devices or the use of the car seat out of the car. This recommendation and the supporting advice from the expert neonatologists has been distributed to all Neonatology Intensive Care Units with a request for a review of their protocols/guidelines for discharge and transportation of premature babies.

Recommendation 3

Where a death occurs within one month of hospital discharge, the post-mortem examination report should be provided as soon as it is available (promptly) to the treating hospital for provision to the relevant clinicians.

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

The Coroners Act 2003 (sections 25 and 54) requires pathologists to provide completed autopsy reports to the Coroner (and police).

It is not possible to implement the recommendation because the Act prohibits pathologists from providing completed autopsy reports directly to clinicians – only the Coroner can do this.
Clinicians wanting a copy of the autopsy report must apply to the Coroner arguing 'sufficient interest' under section 54. The State Coroner has stressed the importance of coronial confidentiality.
However, section 25 of the Act does allow the Director-General of Queensland Health to request a copy of the autopsy report from the pathologist, unless the State Coroner has given a notice prohibiting this. Queensland Health always welcomes authorisation from a coroner for a pathologist to convey autopsy findings to clinicians. Autopsy reports on babies are seldom available 'promptly' as such cases are complex. A reasonable turn around is three months.

Recommendation 4

In the case of deaths in the first year of life, the forensic pathologist should consult with the treating clinicians in an effort to agree on the cause of death.

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

Again, while it is not possible to implement the recommendation as stated due to the constraints of the *Coroners Act 2003*, pathologists and clinicians welcome Coroners' authorisation to consult with one another and improve clinico-pathological correlation,

within the limits of the legislation. Section 22 of the Coroners Act empowers coroners to ensure original medical records are available to pathologists, who should study them and include a summary of relevant aspects in the autopsy report. It is ultimately the pathologist's responsibility to form an independent opinion as to the cause of death, regardless of clinicians' views. Pathologists should ensure complex cases are reviewed by peers. These considerations apply equally to all ages of deceased.

Inquest into the death of Raleigh Hoy

Mr Hoy died on 6 January 2007 at the Tarampa After Care Centre where he had been a resident for two years. An ambulance was called when Mr Hoy experienced difficulty breathing but he was unable to be revived. Mr Hoy died from dilated cardiomyopathy.

Coroner MacCallum handed down findings on 5 May 2009.

Recommendation 1

Those matters which should be part of the regulation are as follows:

- the employment of sufficient and appropriately trained staff to ensure the comfort and safety of residents
- ensures that all staff employed in a Level three facility are trained and competent in both first aid and CPR
- ensures that medications are appropriately stored and distributed
- ensures that procedures are in place for advising doctors etc if the medications are not apparently taken
- ensures the appropriate training of staff in the particular facility is such that they are aware of emergency procedures and the whereabouts of emergency equipment
- depending on the size of the facility and type of residents whether the employment of a registered nurse is required to maintain accreditation
- the installation of an emergency phone in close proximity to each of the residences and/or panic/alert buttons.

Response and action
Under consideration
Responsible agency: Department of Employment, Economic Development and Innovation

The Coroner noted that this is a complicated area and that her recommendations might require more detailed consideration by the Department of Employment, Economic Development and Innovation.

The *Residential Services (Accreditation) Act 2002* and *Residential Service (Accreditation) Regulations 2002* currently provide for the general range of requirements recommended by the Coroner.

There are currently 48 level three personal care services in Queensland supporting nearly 2000 residents. Implementing the Coroner's recommendations will require careful consideration to ensure the approach adopted enhances the health and wellbeing of residents without unnecessarily risking existing accommodation and support arrangements by creating significant additional costs for services.

The sector is commercially driven and operates to provide a profit to service providers. Residential services receive no government funding to subsidise their operation and rely on

limited fixed income of residents to fund their operation. The vast majority of residents receive income support through Centrelink.

The Coroner suggests it may be necessary for the accreditation system to ensure a registered nurse is employed at larger services. Imposing this requirement would impose a significant financial burden on services operating as commercial enterprises. This could result in some service providers choosing to cease providing personal care services or closing. This in turn would have a significant impact on residents, making them homeless, and placing further pressure on the public housing sector, Mental Health Services and/or Department of Communities.

There is no current legislative basis on which the government can compel a service provider to provide particular personal care services.

If, however, a service provider chooses to provide 'personal care services' such as medication the government can place requirements on how these services are delivered in accordance with accreditation standards contained in the *Residential Services (Accreditation) Regulation 2002*. It should be noted consideration is currently underway to release guidelines relating to processes and procedures associated with assisting residents with medication management.

It should be further noted that if the service provider perceives that assisting with medication management is exposing them to significant additional costs, they may choose to cease providing assistance with medication management. This would leave vulnerable people in services without assistance in managing their medication and at increased risk of adverse health outcomes.

Alternatively, service providers may choose to evict residents perceived as having high care needs. This would have a significant adverse impact on the health and welfare of residents.

The Office of Fair Trading, Department of Employment, Economic Development and Innovation, is giving careful consideration to the Coroner's report and considering how the registration and accreditation of services can be carried out within the existing regulatory framework to give effect to the Coroner's recommendations.

Consideration is being given to the following:

- the staff ratio recommendation be rejected and instead be replaced with a minimum staff availability requirement.
- CPR and First Aid Training be mandated for all personal care staff in Level three services.
- services be supported to implement detailed emergency procedures to address adverse critical health incidents for residents.
- detailed guidelines be released on the department's expectations of services in relation to the process and procedures associated with assisting residents with medication management.

Consultation with industry will need to be undertaken.

Inquest into the death of Peter and Pauline Maczkowiack

Mr and Mrs Maczkowiack were killed when a removalist truck travelling in the opposite direction along the Bruce Highway crossed to the incorrect side of the road and collided into their vehicle.

Coroner Hennessy handed down findings on 14 May 2009.

Recommendation 2

Queensland Transport review the medical requirements in relation to licensing of commercial truck drivers with epilepsy with a view to requiring medical certificates to be issued by a neurologist rather than a general practitioner.

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

Drivers must meet the national standards contained in *Assessing fitness to drive* to ensure that their health does not interfere with road user safety.

Health professionals are encouraged to refer to these guidelines in assessing driver fitness. The guidelines and standards have been approved by the Australian Transport Council and endorsed by all national licensing authorities. *Assessing fitness to drive* makes provisions for general practitioners to assess commercial drivers' fitness to drive where access to specialists may be difficult and the department will accept medical certificates for commercial drivers where a general practitioner has assessed the fitness to drive including neurological conditions.

It is also noted that the Australian and New Zealand Association of Neurologists and the Epilepsy Society of Australia have indicated an intention to withdraw entirely from certifying a patient's fitness to drive. *Assessing fitness to drive 2003* is currently being reviewed and a revised version is anticipated in 2010.

Inquest into the death of June Woo

On 14 November 2002, Mrs Woo was admitted to the Princess Alexandra Hospital. She was moved to a respiratory ward and the following night she stopped breathing. As a 'not for resuscitation' order had been made the evening before, resuscitation was not attempted.

State Coroner Barnes handed down findings on 1 June 2009.

Recommendation 1

The Princess Alexandra Hospital policy governing the making of 'not for resuscitation' orders be reviewed to ensure compliance with the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*.

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

The Queensland Health Clinical Policy Unit is currently developing a statewide policy about withholding or withdrawing life-sustaining measures and a clinical form to document decisions to withhold cardiopulmonary resuscitation and associated interventions. A review of these matters was initiated following the Deputy State Coroner's recommendation from the inquest into the death of Margaret Bodell in November 2007. Consistent with those findings, it is considered desirable to develop consistent standards of practice and documentation across all Queensland hospitals. A draft policy on *Withholding or withdrawing life-sustaining measures* is currently in development, and clearly addresses the requirements of the *Guardianship and Administration Act 2000* and the *Powers of Attorney Act 1998*. Consultation with Queensland Health clinicians has highlighted a range of issues arising from contemporary clinical practice in the complex legal framework regulating the withholding of life-sustaining measures.

Further policy development and internal consultation is underway. Furthermore, a clinical form (Acute resuscitation plan) was piloted in May/June 2009 to provide hospitals with a consistent format to document 'not for resuscitation' orders. This pilot resulted in a revision of the form which will be further piloted within some health service districts for 4 months starting in January 2010. The form continues to comply with the law regarding consent and the withholding of life-sustaining measures. Full completion of the project is expected by December 2010.

Recommendation 2

Unless within 28 days of these findings being delivered, the family of Mrs Woo has made arrangements for her burial, the Chief Executive of the Department of Justice and Attorney-General take action pursuant to s3 of the *Burials Assistance Act 1965* to cause Mrs Woo's body to be buried.

Response and action
Agreed and partially completed

Inquest into the death of June Woo

Responsible agency: Department of Justice and Attorney-General

The burial of Mrs Woo is currently subject to Supreme Court action for injunction restraining burial. Mrs Woo remains held at John Tonge Centre pending the outcome of her family's application.

Inquest into the death of Cheyanne Ruby Downing

On 22 October 2006 Cheyanne was found drowned in a school swimming pool that adjoined her family home. It is unknown exactly how Cheyanne gained entry to the pool area, but the gate connecting the two properties was found non-compliant.

Coroner Black handed down findings on 1 June 2009.

Recommendation 1

Legislation should be passed to ensure:

a. As recommended by Coroner Spencer in 2005, Queensland adopt a single piece of legislation with uniform rules and regulations relating to the construction of pool fencing, irrespective of the date of construction of the pool. The legislation ought to make provision for safety inspection of all recorded swimming pools on a regular basis and, at least, on every occasion where the integrity of the pool fence has been compromised by any alteration.

Response and action
Agreed and partially completed
Responsible agency: Department of Infrastructure and Planning

Stage two of the Queensland Government's staged *Pool safety improvement strategy* will address this recommendation by the rationalisation of 11 current pool fencing standards to just one standard for all pools, both new and existing, when implemented as legislation.

Stage two of the Queensland Government's staged *Pool safety improvement strategy* will commence on 1 December 2010.

b. All common fences between contiguous properties, one of which contains a swimming pool, must be a 'pool fence' as defined by the prevailing legislation and not merely a 'boundary fence'. Further, any gate that intersects the pool/boundary fence must be self-closing and self-latching. The onus of ensuring compliance with the legislation ought to be that of the owner of the land on which the pool is sited. This death, as in the matter of Tognola, resulted from a boundary fence, as distinct from a pool fence, being modified.

Response and action
Agreed and completed
Responsible agency: Department of Infrastructure and Planning

This is currently a requirement of Queensland's existing swimming pool safety legislation.

c. That legislation enacted should require owners of properties adjoining a pool to keep the boundary fence clear of objects that would assist a young child to gain access to the pool (e.g. the planting of trees or the building a barbecue within about one metre of the boundary fence).

Response and action
Agreed and partially completed
Responsible agency: Department of Infrastructure and Planning

The issue of where changes occur to the adjacent land owner's property which renders the boundary fence not compliant will be considered as part of Stage 2 of the Queensland Government's staged *Pool safety improvement strategy*. For a dividing fence to be a pool fence, a non-climbable zone must be maintained free of any objects a young child can use to climb and access the pool area.
This zone can be on either side of the fence, but when used on the inside (pool side) of the fence, any changes the adjacent land owner makes to their property will not affect the compliance of the boundary fence.

Stage two of the Queensland Government's staged *Pool safety improvement strategy* will commence on 1 December 2010.

d. The legislation enacted should also provide that where a boundary fence of adjoining properties forms part of a pool fence, any inspection of the swimming pool fence should also entail an inspection of the property owner's boundary fence.

Response and action
Agreed and completed
Responsible agency: Department of Infrastructure and Planning

This is already an existing requirement for boundary fences being used as swimming pool fences under existing legislation.

e. As recommended by Coroner Spencer in 2005 the Parliament proclaim a single piece of legislation containing a uniform set of rules and regulations relating to the construction of pool fencing, irrespective of the date of construction of the pool. The legislation ought to make provision for safety inspection of all recorded swimming pools on a regular basis and, at least, on every occasion where the integrity of the pool fence has been compromised by any alteration.

Response and action
Agreed and partially completed
Responsible agency: Department of Infrastructure and Planning

Inquest into the death of Cheyanne Ruby Downing

Stage two of the Queensland Government's staged *Pool safety improvement strategy* will address this recommendation by the introduction of a mandatory point of sale and lease inspection system when implemented as legislation.

Stage two of the Queensland Government's staged *Pool safety improvement strategy* will commence on 1 December 2010.

Inquest into the death of Shane Robert Nielsen

On 1 January 2006 Mr Nielsen, aged 33 years, was found slumped in his lounge room chair with a gun across his lap and a gun shot wound to the left side of his head. The inquest examined whether Mr Nielsen discharged the firearm with an intention of taking his own life or whether some third party/parties were involved in inflicting the gunshot wound.

Coroner Lock handed down findings on 19 June 2009.

Recommendation 1

The Commissioner of Police note the findings made in this inquest and take appropriate action to address these deficiencies.

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

Policies and procedures for the investigation of sudden deaths, including suicides, are currently provided in the Queensland Police Service *Operational procedures manual* (in chapter 8: *Coronial Matters*). A summary of these policies and procedures is also provided in the Queensland Police Service *First response handbook*, a copy of which is provided to all officers to assist them in first response situations.

The Queensland Police Service also provides an on-line learning package in relation to coronial investigations training and a competency acquisition booklet in relation to death investigations under its Education and Training Support Program. These training packages are available to all officers.

In response to the Coroner's comment, an internal memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all members on 26 October 2009. This memorandum provided a reminder to officers concerning the relevant Service policies and procedures pertaining to the investigation of sudden deaths, including suicides. The memorandum also outlined the available training packages which are available for officers in relation to death investigations.

Recommendation 2

a. The Commissioner ensure there are suitable protocols or directives in place that establishes clear lines of communication and responsibility for similar investigations involving the CIB and uniform branches of the service.

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

The Queensland Police Service currently provides detailed policies and procedures concerning the responsibilities of officers investigating deaths, including suspected suicides. These policies and procedures are largely contained in chapter eight: *Coronial Matters* and

chapter two: *Investigative Process* of the Queensland Police Service *Operational procedures manual*. To remind officers of the relevant policies and procedures pertaining to the investigation of sudden deaths, an internal memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all members on 26 October 2009.

b. That in the event information becomes available which is relevant to the investigation it is exchanged and brought to the knowledge of the division in charge of the investigation.

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

In February 2006, the Queensland Police Service began the phased introduction of an integrated policing information and records management computer system called QPRIME. Since July 2006, all sudden death occurrences have been recorded on the QPRIME system. All relevant notes, information relating to a sudden death occurrence are now scanned and recorded on QPRIME and are readily available for those involved in the investigation.

c. The branch or officer responsible for the investigation be clearly identified for contact purposes.

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

In February 2006, the Queensland Police Service began the phased introduction of an integrated policing information and records management computer system called QPRIME. Since July 2006, all sudden death occurrences have been recorded on the QPRIME system and the details of the investigating officer and responsible station or establishment for the investigation of each death is clearly identified.

d. That should an inexperienced officer be responsible for such an investigation, procedures for formal supervision should be invoked.

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

Current Queensland Police Service policy (contained within section 8.4.24 of the Queensland Police Service *Operational procedures manual*) requires officers in charge of stations and establishments, district officers, officers in charge of local prosecutions corps and other nominated officers to review coronial files to ensure the contents are of a professional standard in terms of the investigation and any recommendations made.

On 26 October 2009, an internal memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all staff to remind supervisory officers of their

responsibility to ensure that the investigation of deaths is conducted expeditiously and in accordance with policy and procedures. The memorandum also reminded supervising officers that they are to ensure that any officer under their command who is investigating a death or who is responsible for supervising an officer investigating a death, is provided sufficient support and guidance during the course of the investigation, particularly where the investigating officer has limited experience.

Inquest into the death of Clay Hatch

Mr Hatch died in Maryborough on 2 May 2007 moments after being struck by a single bullet fired from the service pistol of a police officer.

Acting State Coroner Clements handed down findings on 19 June.

Comment 1, page 19

Sergeant Roff dispatched the two constables Rodgers and Frazer and also agreed to the police recruit Davies accompanying them. He clearly considered whether or not she should attend, but authorised it. He was aware recruits should not attend dangerous situations. In evidence it appears Sergeant Roff expected the unfolding scenario to be one where some people known to the police who carried knives for their own protection due to a disability, but who were considered harmless, were the subject of the report. Unfortunately, this was not the case.

Comment 2, page 20

It is important to recognise the very real, on the job risks that police officers face daily, and to be mindful of the instructions not to expose inexperienced and unarmed recruits to situations of potential danger.

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

Prior to deployment, all police recruits are instructed on the Queensland Police Service *Recruit station duty policy* which stipulates that supervising police are to ensure that recruits are not exposed to unnecessary risks or to potentially dangerous situations. In the event that a recruit is an observer in a police vehicle with a crew that is detailed to attend a foreseeable dangerous situation, current Service policy dictates that, if practicable, it may be necessary to leave the recruit at a safe location, prior to arriving at the scene of the job and to make arrangements to have the recruit picked up at a later time. This policy is also reinforced with the respective District Education and Training Office prior to recruit deployment.

As indicated in the findings of inquest, both Sergeant Roff and recruit Davies were aware of this policy at the time of this incident, although it is acknowledged on this occasion the policy was not followed. In response to this incident, the Queensland Police Service has reviewed its *Recruit station duty policy* and as from 8 September 2009, will now include the circumstances leading up to the unfortunate death of Mr Hatch as a case study in order to reinforce to officers the requirement to adhere to the policy.

Inquest into the death of Clay Hatch

Comment 3, page 20

The evidence from Constable Frazer in the inquest was of concern. She had survived the experience unscathed and had recently undergone training. Despite this she needed prompting upon re-examination before she could elicit the correct safe distance when faced with an assailant armed with a knife. Her estimates of distance were also at odds with other witnesses. I do not intend to be unduly critical of this except to support an opportunity for further training to increase her skills.

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

All Queensland police recruits receive training in safety distances, positions of safety, reaction times, threat assessment and other associated police operational skills and tactics during pre service training. All sworn members up to and including the rank of Senior Sergeant are also required to participate in operational skills and tactics training thrice yearly.

The operational skills and tactics curriculum is reviewed yearly, and to ensure relevance and currency of training, the Queensland Police Service conducts continuous research into all areas of operational skills and tactics. For example, when dealing with subjects armed with edged and blunt weapons, recent research has actually seen the previously recommended safety distance of seven metres extended to ten metres, so as to increase the decision making/reaction time available to officers. This change has been included as a curriculum item in operational skills and tactics training for 2010. The recruit operational skills and tactics curriculum has also been amended to ensure good practice.

Furthermore, in response to the Coroner's comment additional training to reinforce the issue of safety distances was provided to Constable Frazer on 8 September 2009.

Inquest into the death of Jarrod Barton Emerson

Shortly before midnight on 22 December 2006, Mr Emerson was walking along Fernvale Road Lowood. A vehicle, driven by an off duty policy officer, came upon Mr Emerson and struck him. Mr Emerson died at the scene.

Coroner McLaughlin handed down findings on 19 June 2009.

Recommendation 1

Where a police officer is under investigation by police in connection with a death, the investigating police should, as far as practicable, be officers from a region not connected with the officer under investigation.

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

The Queensland Police Service is committed to ensuring consideration is given to impartiality and the appearance of impartiality in the conduct of investigations.

Current Queensland Police Service policy (contained in Commissioner's Circular 19/2009), requires the Assistant Commissioner, Ethical Standards Command to take full responsibility for the management of investigations into deaths arising from police related incidents in consultation with the State Coroner and Crime and Misconduct Commission.

The Assistant Commissioner is also responsible for the appointment of a suitable investigator from Ethical Standards Command to carry out the investigation. In making the appointment the Assistant Commissioner must consider impartiality and the appearance of impartiality, in the conduct of the investigation, including any relationship between the investigating officer and the parties involved in the incident which may give rise to an actual or apparent conflict of interest.

Recommendation 2

The chain of command in such matters should be clearly set out in a protocol document, including the role and authority of the Ethical Standards Unit of the Queensland Police.

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

On 1 July 2008 an updated Memorandum of understanding between the Queensland Police Service, State Coroner and the Crime and Misconduct Commission commenced in relation to the investigation of deaths arising from police related incidents. The Memorandum of understanding includes provisions outlining the role and authority of Ethical Standards Command within the Queensland Police Service with respect to the investigation of such incidents.

The contents of the Memorandum of understanding were subsequently incorporated into current Queensland Police Service policy on 24 April 2009 (in Commissioner's Circular 1/2009: *Fatalities or serious injuries resulting from incidents involving members (police related incidents)*). This policy requires the Assistant Commissioner, Ethical Standards Command to take full responsibility for the management of investigations into deaths arising from police related incidents, in consultation with the State Coroner and Crime and Misconduct Commission.

The Assistant Commissioner is also responsible for the appointment of a suitable investigator to carry out the investigation and in making the appointment the Assistant Commissioner must consider impartiality and the appearance of impartiality, in the conduct of the investigation, including any relationship between the investigating officer and the parties involved in the incident which may give rise to an actual or apparent conflict of interest.

Inquest into the death of Vanessa Louise Kingston

Ms Kingston, aged 31 years, died on 29 March 2006 in a motor vehicle accident on the Warrego Highway near Dalby.

Ms Kingston's passenger side wheels left the sealed roadway as a heavy rigid truck, travelling in the opposite direction, approached her. She lost control of the vehicle and collided with another truck travelling approximately 500m behind the first truck.

Coroner Cornack handed down findings on 24 June 2009.

Recommendation 1

The Main Roads Department examine the roadway along this major trucking route in the near future and at regular intervals to ensure that the drop or lip along the edge of the roadway does not erode into the width of the fog line and does not extend to a depth likely to cause danger to motorists.

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

The Warrego Highway is inspected under the Roads Maintenance Performance Contract to the standards required by the contract.

Shoulder drop-offs are repaired in accordance with agreed intervention levels and response times as stated in the departments *Roads maintenance performance contract guidelines for undertaking routine maintenance*, volume 3. Defects are backlogged onto a forward list of works upon reaching an initial intervention level and works programmed for completion by the time they reach a nominated general intervention level. For edge breaks with traffic volumes less than 2.500 vehicles per day and seal widths of 6-8 metres, as in this case, the intervention levels are set at 75mm and 100mm respectively.

Recommendation 3

The volume of traffic generally and heavy vehicle traffic be monitored in this area to ensure improvements to the roadway are carried out as required.

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

The Warrego Highway is part of the National Network and the Federal Government is responsible for funding all works on this road. Funding for rehabilitation and widening of this road has been repeatedly sought without success. A design to upgrade this section of highway has been completed. The department will continue to monitor this section of the highway.

This section of road will continue to be put forward for upgrade funding as per normal departmental program development processes.

Recommendation 4

All edges are repaired regularly to ensure safety of motorists.

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

The Warrego Highway is inspected under the Roads Maintenance Performance Contract to the standards required by the contract.

Shoulder drop-offs are repaired in accordance with agreed intervention levels and response times as stated in the departments *Roads maintenance performance contract guidelines for undertaking routine maintenance*, volume 3. Defects are backlogged onto a forward list of works upon reaching an initial intervention level and works programmed for completion by the time they reach a nominated general intervention level. For edge breaks with traffic volumes less than 2.500 vehicles per day and seal widths of 6-8 metres, as in this case, the intervention levels are set at 75mm and 100mm respectively.

Recommendation 5

A review be conducted of the roadway to determine if the roadway needs to be widened to accommodate the growing level of heavy vehicle traffic.

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

The Warrego Highway is part of the National Network and the Federal Government is responsible for funding all works on this road. Funding for rehabilitation and widening of this road has been repeatedly sought without success. A design to upgrade this section of highway has been completed and the Department of Transport and Main Roads will continue to monitor this section of the highway.

This section of road will continue to be put forward for upgrade funding as per normal departmental program development processes.

Comment 1, page 3

The findings of an investigation by the Main Roads department concerning the path of the sedan prior to the collision are at odds with eye witness accounts. It would appear prudent for police to forward

copies of witness statements to investigators from Main Roads to help them determine what happened in the crash.

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

Although it is impractical for the Queensland Police Service to automatically forward copies of every traffic crash witness statement to the Department of Transport and Main Roads, if they are investigating an incident and request copies of witness statements, they will be supplied in accordance with existing policies and procedures.

Queensland Police Service policy for the release of information, including statements, to other Government agencies is currently provided in section 1.10: *Release of information* of the Queensland Police Service *Operational procedures manual*.

Comment 2, page 3

There has been an unacceptable delay in this coronial investigation. A full police investigation was requested by the Dalby Coroner on 2 May 2006. The first report from the investigating officer was received at Dalby Police Station in December 2006. The report was reviewed by the local prosecutor and returned to the investigating officer with further investigations requested by him prior to referral to the Coroner. In February 2007 a further report was received from the investigating officer. This material was delivered to Dalby Coroner in March 2007. Further investigations were promptly requested by the Coroner. This request was not sent on to the investigating officer until May 2008. The Dalby Coroner requested urgent follow up in July 2007, January 2008, April 2008 and March 2009.

The investigating officer had been transferred but once he received the request he promptly responded in July 2008. This material was sent to the Coroner at Dalby at the end of July 2008. However there was a further delay before this material was considered by the Coroner. An inquest was held in April 2009. It is clear the review and improvement of communication between the Dalby Police Prosecution office and investigating officers could greatly assist to reduce delay in future matters.

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

Inquest into the death of Vanessa Louise Kingston

A review of the circumstances surrounding the delays associated with this coronial investigation has been conducted within the Dalby Police District. As a result of this review, local procedures have been implemented in Dalby Police District to ensure that all correspondence received from the Coroner is correctly recorded, managed and monitored to prevent unacceptable delays in future coronial investigations.

It is current Queensland Police Service policy (contained in section 8.4.19 of the Queensland Police Service *Operational procedures manual*) that when a Notice of inquest is received from a Coroner, the investigating officer should submit the finalised coronial file and a covering report showing the results of inquires into the death within twenty-eight days, to the officer in charge of their station or establishment. The completed coronial file is then reviewed to ensure it has been investigated fully and it is then referred to the relevant coroner.

In the event that a finalised report is unable to be furnished within twenty-eight days, the investigating officer is required to furnish a supplementary report detailing the progress of the investigation, including whether any person has been charged with any offence surrounding the death and the result of any court proceedings. The investigating officer must also furnish an additional supplementary report every twenty-eight days thereafter, until the matter is finalised. These supplementary reports are also forwarded to the relevant coroner.

Since the death of Ms Kingston, the Queensland Police Service has introduced an integrated policing information and records management computer system called QPRIME. Since July 2006, all sudden death occurrences have been recorded on the QPRIME system and it is current policy (in section 8.4.24 of the Queensland Police Service *Operational procedures manual*) that officers in charge are to ensure sudden death occurrences for the relevant division are checked on QPRIME every day and that any appropriate actions are taken.

The Office of the State Coroner has also established a system which enables coroners throughout the state to send directions in relation to death investigations via email. These directions are received by the Queensland Police Service Coronial Support Unit, are entered promptly onto the QPRIME system and are then forwarded to the relevant station or establishment for attention of the investigating officer. This system has assisted in reducing the time taken in responding to coroners directions.

In addition, to remind officers of the relevant Service policies and procedures pertaining to the investigation of sudden deaths, an internal memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all staff on 26 October 2009. This memorandum included a reminder to supervising officers of their responsibility to ensure that the investigation of deaths is conducted expeditiously.

Inquest into the death of Randall John Coleman

Mr Coleman died on 18 January 2007 at the Kingaroy Hospital after knowingly ingesting a quantity of strychnine while in custody at the Kingaroy watch house.

Acting State Coroner Clements handed down findings on 10 July 2009.

Comment 1, page 8

Officer Coloquhorn failed to ask the required questions about medical and psychiatric conditions at the time of his admission to the watchhouse. He explained this was due to Mr Coleman's appearance of extreme tiredness, which Mr Coleman explained was a side effect of his medication. He did not return to this task later explaining the failure was due to driving the other officer back to Nanango before returning to other duties which then claimed his attention. He did not delegate the task to anyone else and said he then forgot about his responsibility until the next morning when he completed the computer custody register at about 5.30am.

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

The actions of Senior Constable Colquhoun in this matter were investigated by Ethical Standards Command and were dealt with in accordance with existing Queensland Police Service disciplinary procedures. This matter was finalised on 15 July 2009.

The Queensland Police Service currently provides detailed policies and procedures in relation to the health assessment of persons in police custody. Existing Service policy (contained in chapter 16: *Custody Issues* of the Queensland Police Service *Operational procedures manual*), requires that officers complete an assessment of all prisoners and persons in police custody to determine whether such persons may require medical attention, treatment or medication. This assessment includes a number of checklists (including a Health questionnaire and observations checklist) to be completed prior to a person being lodged in a watchhouse.

To assist officers in understanding their duties in regard to custody issues and the lodgement of prisoners in a watchhouse, the Queensland Police Service currently provides an on-line learning package which is available to all officers.

On 3 November 2009, a memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all staff reminding them of their responsibilities in relation to custody issues and of the training which is currently available.

The local Standing operational procedures for the Kingaroy Watchhouse were also modified in November 2009, in response to the Coroner's comments and include requirements in relation to the health assessment of incoming prisoners.

Inquest into the death of Randall John Coleman

Comment 2, page 12

The investigation found that there had been non compliance with Queensland Police Service policies relating to search procedure and record keeping.

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

The issues identified by the Coroner have been investigated by Ethical Standards Command and were dealt with in accordance with existing Queensland Police Service disciplinary procedures. This matter was finalised on 15 July 2009.

Comment 3, page 14

It remains a concern that Officer Colquhoun left the station to return Senior Constable Sutton to Nanango without delegating the task of completing the health form to another officer, particularly when his evidence indicated Mr Coleman was affected by medication. This is in the context of the Kingaroy police station not having a designated watchhouse keeper but instead it being a shared responsibility of all general duties officers to monitor prisoners in the cells.

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

The actions of Senior Constable Colquhoun in this matter were investigated by Ethical Standards Command and were dealt with in accordance with existing Queensland Police Service disciplinary procedures. This matter was finalised on 15 July 2009.

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Inquest into the death of Randall John Coleman

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The local Standing operational procedures for the Kingaroy Watchhouse were also modified in November 2009, in response to the Coroner's comments and include requirements in relation to the health assessment of incoming prisoners.

Comment 4, page 16

While it is unrealistic to expect police officers to identify a risk of suicide during police incarceration, perhaps a heightened awareness of risk should be considered when bail is refused. Certainly Department of Corrective Service facilities automatically assess all new prisoners and conducts assessments for risk of suicide. While this is beyond the scope of direct police training and responsibility there are other appropriate experts who could perform this task.

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

Current Queensland Police Service policy (contained in section 16.13.1 of the Queensland Police Service *Operational procedures manual*) stipulates that officers must immediately assess and re-assess as appropriate, the level of supervision and health requirements for prisoners whose personal circumstances may have changed whilst in custody, including:

- being refused bail or sentenced to a period of imprisonment;
- death or serious illness of someone meaningful to the prisoner;
- break-up of a personal relationship or conflict with family members; or
- loss of employment or other significant economic stress; and
- where any of the above issues are evident, the prisoner must be closely monitored until they are, released; discharged; assessed by a medical person; or removed to a hospital or other medical facility.

On 3 November 2009, a memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all staff to remind them of their responsibilities in relation to prisoners in a watchhouse.

The local Standing operational procedures for the Kingaroy Watchhouse were also modified in November 2009, in response to the Coroner's comments and include procedures in relation to the management of suicidal prisoners.

Inquest into the death of David John Duggan

Mr Duggan was admitted to the Caloundra Hospital on 10 January 2007 for the management of severe back pain. Mr Duggan died on 19 January 2007 prior to his planned transfer to the Royal Brisbane Hospital. The cause of death was determined as hypertensive heart disease.

Coroner Fingleton handed down findings on 13 August 2009.

Recommendation 1

Queensland Health reviews its pain management and risk protocols generally but, in particular, the protocols applicable to primary care level one hospitals.

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

On consultation with the relevant Queensland Health business areas, it is apparent that pain management is not governed by any one statewide body, and that it is managed on a local level and depends on the type of pain involved, e.g. chronic pain, acute post surgery pain, palliative, etc. As such, a memorandum has been distributed to all District Executive Directors of Medical Services requesting them to review their local policies/protocols in the area of pain management, bearing in mind the Coroner's concerns.

Recommendation 2

Queensland Health investigates the introduction of Nurse Advocates into the hospital system to assist communication between patients' relatives and medical staff.

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

The national competency standards for the registered nurse are the core competency standards by which their performance is assessed to obtain and retain their licence to practise as a registered nurse in Australia.

As a registered nurse, these core competency standards provide them with the framework for assessing their competence, and are used by state/territory Nursing and Midwifery Regulatory Authorities to assess competence as part of the annual renewal of license process, to assess nurses educated overseas seeking to work in Australia and to assess nurses returning to work after breaks in service. They are also used to assess nurses involved in professional conduct matters.

The Nursing and Midwifery Regulatory Authorities may also apply the competency standards in order to communicate to consumers the standards that they can expect from nurses. Education providers also use the standards when developing nursing curricula, and to assess student and new graduate performance. Standard 2.3 of the national competency

standards requires that a registered nurse practises in a way that acknowledges the dignity, culture, values, beliefs and rights of individuals/groups (Australian Nursing and Midwifery Council, 2005). The standard includes a performance criterion that compels registered nurses to 'advocate(s) for individuals/groups when rights are overlooked and/or compromised' (Australian Nursing and Midwifery Council, 2005). In addition, standard 2.4 requires registered nurses to – 'Advocate(s) for individuals/groups and their rights for nursing and health care within organisational and management structures'. This includes:

1) identify when resources are insufficient to meet care needs of individuals/groups
2) communicate skill mix requirements to meet care needs of individuals/groups to management
3) protect the rights of individuals and groups and facilitate informed decisions
4) identify and explain policies/practices which infringe on the rights of individuals or groups
5) clarify policies, procedures and guidelines when rights of individuals or groups are compromised
6) recommend changes to policies, procedures and guidelines when rights are compromised.

As such, a specific nurse advocate position may not be necessary, as it is within the professional responsibilities of all registered nurses. Reference was made in the Coroner's report that nurse advocate positions exist within New South Wales and Victoria. On advice from the Chief Nurses of these jurisdictions, it was confirmed that no such specific positions exist. As is the case in Queensland, nurse unit managers and other senior nursing staff in New South Wales and Victoria play a key role in advocating for patients and their families. In addition, patient liaison officers exist within most acute health services who deal with complaints and the concerns of patients and their loved ones.

Recommendation 3

Evidence given by the police officer who investigated the death of Mr Duggan suggested an inadequacy in the training of himself and others to successfully complete coronial enquiries. These shortcomings included:

- the lack of seniority of officers given the investigation of a complex hospital death and lack of adequate supervision by more senior officers throughout the investigation
- no pictures were taken of the death scene
- no blood sample was taken within four hours of death;
- death by natural causes was assumed even though an autopsy would be taken place
- no statements taken from hospital staff or the defacto partner of the deceased.

The Coroner recommended that the Queensland Police Service review the adequacy of the investigations police undertake in relation to

hospital deaths for coroners and the training for officers who carry them out.

Comment one, page 13

Evidence given by the police officer who investigated the death of Mr Duggan suggested an inadequacy in the training of himself and others to successfully complete coronial enquiries. These shortcomings included:

- the lack of seniority of officers given the investigation of a complex hospital death and lack of adequate supervision by more senior officers throughout the investigation
- no pictures were taken of the death scene
- no blood sample was taken within four hours of death
- death by natural causes was assumed even though an autopsy would be taken place
- no statements taken from hospital staff or the defacto partner of the deceased.

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

The Queensland Police Service currently provides detailed policies and procedures (in chapter 8 of the Queensland Police Service *Operational procedures manual*) in relation to the conduct of coronial investigations. These policies and procedures include provisions that address the specific issues identified by the Coroner.

To remind officers of the existing Service policies in relation to the conduct of coronial investigations, a memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all staff on 26 October 2009. This memorandum outlined the relevant Service policies and procedures pertaining to the investigation of sudden deaths. The memorandum also provided officers with information concerning the training which is currently available to all officers in relation to coronial investigations.

A review of existing training programs and packages has also been undertaken by the Queensland Police Service and additional information has been included in the Police Recruit Operational and Vocational Education (PROVE) Program in relation to death investigations. Proposed changes to other training programs and products are also being considered.

It is anticipated any required changes to current training programs and products will be completed by mid 2010.

Inquest into the death of Caitlyn Hanrick

On 4 December 2006, Caitlyn Hanrick, a grade eight student at Redcliffe State High School suffered fatal injuries outside her school after being struck by a stolen car being pursued by police. At the time of the incident Caitlin was traversing a pedestrian crossing on Oxley Avenue that dissected the school grounds.

State Coroner Barnes handed down findings on 17 July 2009.

Miss Hanrick's death is one of 10 deaths that occurred in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests have been held into each of those deaths.

The *Coroners Act 2003* authorises a coroner conducting an inquest to comment on anything connected to the death that relates to public health or safety the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. To maximise the evidence base, the State Coroner postponed making any such comments in these cases until all 10 deaths had been heard. At that stage a further hearing was convened and evidence heard in relation to the Queensland Police Service's pursuit driving policy.

The State Coroner handed down thirteen recommendations on 31 March 2010 relating to the Queensland Police Service's pursuit driving policy. The government's response to the State Coroner's recommendations will be included in the report *Queensland Government's response to coronial recommendations 2010*.

The Queensland Police Service is developing a whole of government response, collaboratively with the Department of Education and Training and the Department of Transport and Main Roads, to the issues raised in the Coroner's report including the Coroner's comments about policing matters and crossings at split-campus schools. The government response will also include a response to the State Coroner's findings in relation to the Queensland Police Service pursuits policy which were handed down on 31 March 2010.

A whole-of-government response to this inquest will be finalised in the near future. The response will include information about the action taken to date and further action required.

Inquest into the death of Ronald Thomas Oram

Mr Oram, aged 49 years, died on 6 January 2008 while in custody at the Capricornia Correctional Centre. An autopsy determined the cause of death to be coronary artery occlusion due to, or as a consequence of coronary artery atheroma.

State Coroner Barnes handed down findings on 21 August 2009.

Recommendation 1

The Department of Community Safety review its policy governing responses to medical emergencies to ensure it mandates an appropriate response as soon as an emergency may reasonably be thought to exist and take steps to ensure all staff are aware of the need to do so.

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

The Department of Community Safety reviewed its policy governing the response to medical emergencies. It has now amended the nightshift procedure to specifically provide that *'*when a medical emergency is thought to exist by the night shift officers, a code blue must immediately be called*'*.

On 30 September 2009, all prison general managers were advised by memorandum that the procedure was being amended but that the change was effective immediately.

This procedure was published internally within Queensland Corrective Services on 1 December 2009.

Recommendation 2

The Department of Community Safety review the policy that stipulates cell doors can not be opened at night except in the presence of the officer in charge.

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

The Department of Community Safety reviewed its policy regarding access to cells during medical emergencies and the Custodial Operations Directorate has amended the nightshift procedure accordingly.

This procedure was published internally within the Department of Community Safety on 1 December 2009.

For security reasons the details of the amendment are not detailed in this document.

Inquest into the death of Jason George Elliott Blee

Mr Blee, aged 33 years, died on 9 April 2007 while employed as in an underground coal mine. He died from a pelvic crush injury when he was trapped by a coal shuttle car.

Coroner Hennessy handed down findings on 10 September 2009.

Recommendation 1

The department resolve the outstanding issue of notification to next-of-kin with Queensland Police Service as a matter of priority. Reference should be had in those negotiations to the principles set out herein and a protocol developed and communicated to coal mine operators as to the circumstances in which the Queensland Police Service will conduct the notifications, for example in the case of a fatality. Where the Queensland Police Service are required to make the notification, I strongly recommend that the task should be given priority over all matters other than those involving a life threatening emergency or a crime in progress. The Queensland Police Service should have reference in these circumstances to alternative resources being employed to ensure that the notification is treated with priority.
I further recommend that coal mine operators adopt the following guiding principles in relation to the important task of notifying next-of-kin of coal mine workers in the event of a serious injury or fatality:

- each mine's safety and health management system should include a protocol for the notification of next-of-kin in the event of a serious injury to or fatality of a coal mine worker
- the protocol should assign specific responsibility to a person to ensure that the notification is made as a matter or priority and in accordance with the protocol
- the protocol should require each employer at the mine to maintain a register, to be updated annually, of next-of-kin details and the name and contact details for a support person who may assist the next-of-kin. Where the employer is a contractor, the contractor should be required to immediately provide relevant details to the mine operator as and when required. If an injured worker is capable of instructing how notification should occur then the worker's instructions should be complied with when it is practical to do so
- if a worker is unable to provide instructions or is deceased, the next-of-kin should be advised as soon as possible after the incident occurred and the worker has been positively identified by at least two people well known to the worker, preferably one of whom would be the worker's immediate supervisor

- notifications should be carried out by or on behalf of the employer in person by at least two appropriately trained people, and wherever possible one person should be female. To the extent possible, details of what has occurred should be able to be provided at the time of the notification
- in the event of the Queensland Police Service conducting the notification in the first instance, additional support services should be provided by the employer as quickly as possible and in accordance with the needs of the next-of-kin
- consideration should be given to how the notification will be made in circumstances where the next-of-kin resides a great distance from the employer, including interstate and overseas.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Queensland Mines Inspectorate has engaged in ongoing discussions with the Queensland Police Service and coal mine operators regarding this recommendation.

A Memorandum of understanding between the Queensland Mines Inspectorate and the Queensland Police Service is proposed. Work on the draft Memorandum of understanding occurred prior to the coroner handing down recommendations in this case.

The Chief Inspector of Coal Mines wrote to site Senior Executives of all coal mines in Queensland and drew their attention to these recommendations. He advised he intends to introduce a Guidance note that will incorporate all of these recommendations. The Guidance note will be provided to the Mining Safety and Health Advisory Councils (for coal mines and for metalifferous mines) for discussion and comment before release to the industry.

After obtaining Mining Advisory Councils' comments on the draft Guidance note, the Queensland Mines Inspectorate will issue the Guidance note to the site Senior Executives of all coal mines in Queensland.

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

Current Queensland Police Service policy (in section 8.4.7: *Advising relatives* of the Queensland Police Service *Operational procedures manual*) provides that where a death has occurred, the Queensland Police Service will provide reasonable assistance to advise a deceased's family member of the death.

In June 2007, as a result of Coroner Hennessy's findings into the deaths of Shane William Davis and Rodger Bruce Browne, a memorandum under the hand of the Deputy Commissioner was disseminated reminding officers of their obligations when investigating a sudden death, to provide advice to the deceased's of next of kin. This memorandum emphasised that where a death has occurred as a result of a workplace incident, some private

companies may follow their own internal procedures to notify a deceased employee's next of kin of the event. However, the existence of such circumstances does not absolve an investigating officer from fulfilling their obligations under the Queensland Police Service *Operational procedures manual*.

The Queensland Police Service agrees that where a death has occurred, next of kin should be advised expeditiously, where possible. Accordingly, a memorandum under the hand of the Deputy Commissioner (Specialist Operations) was prepared and distributed to all staff on 8 January 2010. This memorandum outlined the existing Service policies in relation to death notifications. The memorandum also required the development of local standing operating procedures, if necessary, to ensure that when requests for death notifications are received, these tasks are prioritised for response before other matters not involving injury or present threat of injury to persons or property, where practicable.

Recommendation 2

The Minister for Mines give serious consideration to amendment of the *Coal Mining Safety and Health Act 1999* to provide for tripartite investigations involving the employer/coal mine operator, department and industry safety and health representative, into serious accidents involving grievous bodily harm and all fatal incidents. Further, consideration be given to amending the Act to ensure that all material generated as a result of such investigation including but not limited to all statements, reports, diagrams, digital images and recordings be privileged such that they cannot be used by any person (including the department) in any proceeding under the Act, any other statute or the common law, other than a Coronial hearing.

Response and action
Not agreed and not being implemented
Responsible agency: Department of Employment, Economic Development and Innovation

This recommendation is not supported by the Queensland Mines Inspectorate, the coal mining industry or the unions.

All concerned parties are already involved in an investigation, but only until the point is reached where the Queensland Mines Inspectorate decides that their further involvement might compromise the objectivity and independence of its investigation.

The recommendation to go even further in relation to establishing formal tripartite investigations is not supported. There is little prospect of the industry and unions working cooperatively in the manner suggested.

The Queensland Mines Inspectorate does not consider there is any deficiency in the current process that the implementation of this recommendation would address.

Further, making any investigation documents privileged could hinder or prevent the successful prosecution of those who have failed to comply with the Act. Given the inherently hazardous nature of the industry, this would not be beneficial or appropriate.

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and has drawn their attention to these recommendations. The Chief Inspector of Coal Mines advised them it is not proposed to implement these recommendations.

Recommendation 3

All coal mines include in alcohol and other drug policies a requirement for all workers involved in fatal incidents or those involving serious bodily injury, be tested for the presence of drugs and alcohol. The results of such tests should be provided to the department and Queensland Police Service as soon as they are available. The Queensland Mines Inspectorate manual and Queensland Police Service Operation procedure manual should be updated to include the requirement that the investigating inspector and investigating officer require the site senior executive to ensure that the tests are carried out and the results are obtained in a timely manner. In the event of suspicious circumstances, Queensland Police Service should conduct their own testing for evidentiary purposes.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Queensland Mines Inspectorate's investigation manual has been comprehensively updated and approved by the chief inspectors. This recommendation is included in the revised manual.

All inspectors will be trained to ensure this recommendation is addressed in all matters that involve grievous bodily injury or a fatality.

This recommendation will also be included in the Memorandum of understanding between the Queensland Mines Inspectorate and the Queensland Police Service.

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations. He advised of his intention to issue a Directive under s.168 of the *Coal Mine Safety and Health Act 1999* to all coal mines to review their safety and health management systems to include, if not already mandated, the requirement to drug and alcohol test everyone involved in an incident that involves a fatality or serious bodily injury.

The Directive will be issued on or before 31 March 2010. Implementation of this directive will necessarily involve negotiations between the coal mine operators, the union and the workers.

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

In response to the issue raised by the Coroner, draft amendments have been prepared to section 8.5.5 of the Queensland Police Service *Operational procedures manual* to highlight that investigating officers should consider any existing legislative provisions which permit the taking (by any agency) of specimens of breath, blood, urine or saliva from mine employees involved in the incident for alcohol and/or drug testing purposes. In addition, the proposed amendments indicate that investigating officers should ascertain whether the mine has undertaken drug and alcohol testing of relevant employees, advise the relevant Coroner if they have and if necessary, obtain a Coroner's search warrant to obtain the results of these tests.

The Queensland Police Service does not support police officers being required to compel the site senior executive to ensure tests are carried out. There is no legislative authority for police to do that. Moreover, the Queensland Mines Inspectorate is often the principal investigating authority for the incident.

The Queensland Police Service partly supports the recommendation that in the event of suspicious circumstances, it should conduct its own testing for evidentiary purposes. The position of the Police Service is that it should conduct the testing only in those circumstances where there is legislative power to do so (for example, an incident involving dangerous operation of a vehicle). Service policy requires police investigators to consider powers available under the *Transport Operations (Road Use Management) Act 1995* and the *Police Powers and Responsibilities Act 2000* to conduct drug and alcohol testing. The Police Service does not consider that it should become the principal investigating authority for all mining incidents.

It is anticipated these draft amendments will be published by mid 2010.

Recommendation 4

Underground coal mines review arrangements in relation to the interaction between pedestrians and machinery and, following a suitable risk assessment process, revise and to the extent necessary, establish No Go and Restricted Zones to govern the interaction. Where this occurs, coal mine workers should be trained in them and they should be enforced. To assist, where appropriate, the No Go and Restricted Zones should be represented in pictorial form and made available in crib rooms and other such locations to act as a reminder for coal mine workers. Ultimately, operators of mobile equipment must ensure that it is safe to move equipment before they do so.

Response and action
Agreed and completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations. He advised of his intention to issue a Directive under s.168 of the *Coal Mining Safety and Health Act 1999* directing all coal mines undertake this review. The Directive will be issued on or before 31 March 2010.

Recommendation 5

Coal mining operations equip each underground district with airbags of sufficient capacity to move or lift the heaviest equipment in the district. Operations should conduct a risk assessment to establish the most likely causes of trauma to coal mine workers, which as a minimum contain a trapping which may result in a crush injury. Once the type of traumas has been identified the Senior Site Executive should ensure that a number of personnel are trained and available to deal with such trauma until a higher level of medical care is available. Trauma care kits should be readily available such that the correct first aid equipment is available to treat those that have suffered a crush injury or other trauma. The Mines Inspectorate should have discussions with Queensland Mines and Rescue Service to develop training programs for Queensland Mines and Rescue Service trainees to undertake exercises in the extrication of persons trapped by heavy machinery and objects underground.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations. He advised of his intention to issue a Directive under s.166 of the *Coal Mining Safety and Health Act 1999* directing all coal mines undertake this review. The Directive will be issued on or before 31 March 2010.

The Chief Inspector has discussed the development of an agreed training package with the Queensland Mines and Rescue Service for release to industry.

Recommendation 6

Coal mining operations urgently audit the efficacy of their management of change standard and if one does not exist, it should be immediately developed.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

Inquest into the death of Jason George Elliott Blee

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations. He advised of his intention to issue a Directive under s.168 of the *Coal Mining Safety and Health Act 1999* directing all coal mines undertake this review. The Directive will be issued on or before 31 March 2010.

Recommendation 7

Coal mining operations and the department (as the approval body) move quickly with manufacturers and other appropriate bodies to have developed, tested and approved proximity detection devices for use in underground coal mines to detect the presence of pedestrians in and around mobile equipment including shuttle cars.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations.

The Queensland Mines Inspectorate conducted four industry-wide seminars on this subject.

Legislation will be introduced to make this a requirement for all coal mining operations, except for underground coal mine areas classified as hazardous. Implementation in relation to areas deemed hazardous may take longer, as manufacturers will need to develop systems that can be approved as intrinsically safe or flame proof.

Recommendation 8

The department move to ensure that any uncertainty which may exist in the legislation, that there be one safety and health management system at a coal mine, be removed.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations.

He advised that while the Queensland Mines Inspectorate doesn't consider there is any ambiguity, legislative amendments will be introduced to make it clear there can only be one safety and health management system on a mine site, that this system is the responsibility of the site senior executive, and that there can only be one *Standard operating procedure* or documented way in which a task may be undertaken.

Recommendation 9

A working party comprising the department, coal mine operators, workers, union representatives and other interested organisations form to meet with manufacturers of shuttle cars to review and discuss, with the intention of designing out or improving the design of some of the concerns related to the ergonomic and/or safety factors and control surfaces of shuttle cars.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations.

The Chief Inspector convened a committee with a wide cross section of expertise to consider these issues. Discussions will take place with manufactures to discuss the design of shuttle cars.

Recommendation 10

Manufacturers of coal mining machinery and stakeholder groups investigate whether the regulations and regulatory bodies governing modification to design of machinery are unnecessarily prohibiting or delaying the implementation of innovation within the reasonable time frames.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations.

The Chief Inspector convened a committee (see response to recommendation 9) to consider these issues.

Consideration will be given to the views of the committee, before a decision is made about what further action should be taken.

Recommendation 11

The department liaise with emergency service providers (police, ambulance, fire, rescue service providers and where appropriate medical personnel) to establish an ongoing program to familiarise emergency services personnel who are based in mining communities with mining operations. Where practicable, this may include relevant

personnel receiving generic inductions to mining operations. Mining companies should take all reasonable steps to assist in the successful implementation of such a program.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations.

The Queensland Mines Inspectorate's Rockhampton and Mackay district inspectors and the regional inspector for the southern district are charged with holding discussions with appropriate emergency services and for ensuring the familiarisation program is undertaken. Cooperation will be sought from mining companies when needed.

A familiarisation program has commended and will eventually cover all centres.

Recommendation 12

The coal mining industry adopt a system (whether through a central database or otherwise) whereby a coal mine worker, on departure from an operation, is provided with a full copy of their competencies, tickets and authorisations achieved whilst employed on that site. Further, that those documents be required to be placed on the record at subsequent operations the worker might be employed at in order to provide a ready cross reference of previous experience. The department should consider legislative amendment or other requirement being issued for this system to be implemented across the industry.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations.

Currently, most employees are provided with their training records when they leave an employer. However, the Queensland Mines Inspectorate has recently discovered some forged records.

Legislative amendments will be implemented to address this issue.

Inquest into the death of Jason George Elliott Blee

Recommendation 13

A Memorandum of understanding be established between the Queensland Mines Inspectorate and the Queensland Police Service which incorporates the provisions of section 8.5.5 of the Queensland Police Service *Operation procedures manual* and also includes the assistance of the Queensland Police Service forensic science facilities and staff should they be required in determining the nature and cause of any mining related deaths in Queensland.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations.

This will be included in the proposed Memorandum of understanding with the Queensland Police Service.

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

It is agreed that assistance can be provided by forensic services staff during investigations into mining accidents causing deaths. It is not agreed that a Memorandum of understanding is required in this instance as existing policy already provides call out procedures for the use of forensic services.

In response to the issue raised by the Coroner in this instance, amendments have been prepared to section 8.5.6: *Workplace or electrical incidents causing or likely to cause grievous bodily harm or death* of the Queensland Police Service *Operational procedures manual*, to clarify that investigating officers should during the initial stages of investigation into the death resulting from mining and other incidents that the relevant regional forensic services coordinator should be consulted regarding the method of examination to be performed at the site and the possible forensic services required for the investigation.

It is anticipated these draft amendments will be published by mid 2010.

Recommendation 14

That the department review and if amended, reissue, Safety Alert MDA 148/06 in light of this incident to enhance the alert with respect to these factual circumstances.

Response and action
Agreed and completed
Responsible agency: Department of Employment, Economic Development and Innovation

Inquest into the death of Jason George Elliott Blee

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to this recommendation. An amended safety alert has been issued.

Recommendation 15

The Minister for Mines give serious consideration to the amendment of the relevant legislation to require all coal mine operators to submit to the District Inspector of Mines electronically (in an approved format) a copy of the Safety and Health Management System for the operation. The document is to be updated annually by the coal mine operator and any amendments submitted by the required date upon the written request of the Chief Inspector to the Senior Site Executive.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations.

Legislative amendments are proposed to address these issues.

Recommendation 16

That the Standards Review Committee formed as a subcommittee reporting to the Coal Mining Safety and Health Advisory Council thoroughly review the 'place change' system of mining with a view to establishing best practice guidelines to be recommended to the Health Advisory Council for consideration of developing a Recognised Standard for promulgation to the minister. The Standard should include the guidelines and seek to ensure that risk assessments are conducted to the highest possible standard to ensure the lowest level of risk.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations.

This recommendation is under consideration by the Standards Review Committee.

Recommendation 17

The department make the Safety in Mines Testing and Research Station (SIMTARS) simulation prepared for this matter available for use as a training tool.

Response and action
Agreed and completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Chief Inspector of Coal Mines wrote to site senior executives of all coal mines in Queensland and drew their attention to these recommendations.

Site senior executives of all underground coal mines have been provided with this DVD and asked to show it to all coal mineworkers and for training to be provided, based on this simulation, as to No Go Zones and general awareness around operating machines in an underground environment.

Copies have also been sent to the New South Wales Chief Inspector of Mines, as that state has a number of underground coal mines.

Recommendation 18

In all industrial deaths, particularly mining deaths, the autopsy on the deceased person be conducted by a forensic pathologist and that the autopsy should include a full internal and external examination of the body including the taking of photographs (and x-rays and other tests if warranted in the circumstances of the death) to ensure that such deaths are treated with the same level of attention as suspicious deaths in order to ensure that the circumstances of the death are able to be fully understood from a medical viewpoint.

Response and action
Agreed and completed
Responsible agency: Queensland Health

The Chief Forensic Pathologist, Queensland Health, supports the recommendation and supports coroners determining the type of autopsy examination to be conducted and directing the order for autopsy to a doctor 'with the necessary skills to conduct the autopsy having regard to the particular circumstances' in keeping with section 19 of the *Coroners Act 2003*. The existing practice of coroners, where appropriate, annotating orders for autopsy with any special requirements (e.g., toxicology, x-rays) is also supported.

This practice complements pathologists' proper exercise of their professional judgement in the conduct of autopsies, in keeping with their training. The Chief Forensic Pathologist also supports coroners instigating the practice of directing police to take photographs at autopsies where these may be useful but in the past may not have been taken (e.g. industrial accidents). This might assist in the conduct of investigations and inquests and in the

preparation of reports and second opinions by pathologists as well. Even with the most careful exercise of judgement, however, it is not possible for coroners or pathologists to anticipate accurately in every case the autopsy examinations or tests that subsequent information shows would have been desirable, or indeed the particular medical skills required for the type of autopsy.

The State Coroner's existing guidelines on *Doctors approved to conduct particular types of autopsy* shows that pathologists who are not 'forensic' should only perform more complex cases 'if within expertise' and 'should avoid high profile cases' involving 'reportable deaths of public interest e.g., industrial accidents'. The Chief Forensic Pathologist is happy to work with the State Coroner to amend the guidelines should he wish to make them clearer or more prescriptive. Coroners currently consult the forensic pathologists at the John Tonge Centre if in doubt as to the type of autopsy to be performed and the doctor who should perform it. It is believed that this arrangement is useful to coroners and should continue.

Inquest into the death of Irene Clare Leach

Mrs Leach, aged 94 years, died from injuries sustained when the water lift installed in her house malfunctioned.

Coroner Black handed down findings on 15 September 2009.

Recommendation 1

It would be in the public interest and would benefit the safety of aged, infirmed persons to require that water lifts of the nature discussed in these proceedings be again required to be registered with workplace health and safety authorities.

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

The registration of plant does not make it safe. However, it is acknowledged that it is a useful mechanism for knowing where particular types of plant exist. Registration in itself would not result in all of these pieces of plant being inspected by Workplace Health and Safety Queensland – the volume of registered plant is substantial and the resources of Workplace Health and Safety Queensland could not extend to conducting such audits. There appears to be some recognition of this given the second recommendation of the coroner with respect to 'appropriately qualified persons' conducting audits of the 'registered plant'.

The Coroner's recommendation would require the owner of the plant to bear the responsibility for registering and then engaging a third party to conduct the inspections. This responsibility would come with considerable cost to the owner with an underlying message that non-compliance could result in prosecution action.

Such an outcome is considered counter to what the coroner is trying to achieve through the recommendations.

Consequently, Workplace Health and Safety Queensland propose to meet with officers of the Office of Fair Trading to develop and implement a strategy for:

- alerting owners of these types of lifts to the incidents that have occurred in the past
- encouraging the lift owners to engage suitably qualified people at regular intervals to confirm that the plant is in serviceable condition.

The above approach is considered to complement the existing arrangement, which does not prevent the owner of a water-lift from engaging a suitably qualified person to undertake such audit.

Aside from the issues raised above, any decision to adopt registration for this type of plant would take Queensland once again outside of the approach adopted across Australia (national consistency is achieved through the establishment of a national plant standard that outlines the type of plant requiring registration for its use and the type plant for which its design must be registered. This would present a challenge to current attempts to achieve national harmonised occupational health and safety law.

Inquest into the death of Irene Clare Leach

Recommendation 2

The devices be subjected to a regular, if not annual audit by appropriately qualified persons to ensure the continued compliance with the Australian Standard and Design Guide.

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

The registration of plant does not make it safe. However, it is acknowledged that it is a useful mechanism for knowing where particular types of plant exist. Registration in itself would not result in all of these pieces of plant being inspected by Workplace Health and Safety Queensland – the volume of registered plant is substantial and the resources of Workplace Health and Safety Queensland could not extend to conducting such audits. There appears to be some recognition of this given the second recommendation of the coroner with respect to 'appropriately qualified persons' conducting audits of the 'registered plant'.

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Inquest into the death of Jean-Marie Jeremie Yannick Zaza

Jean-Marie Zaza, aged two years and nine months, died in the family swimming pool on 23 February 2008.

Coroner Fingleton handed down her findings on 21 September 2009.

Recommendation 1

The Queensland Government, as part of its response to its *Review of Queensland's swimming pool safety laws*, implement a mandatory ongoing periodic inspection system, so that pools are inspected at least once every four years for safety compliance.

Response and action
Agreed and partially completed
Responsible agency: Department of Infrastructure and Planning

Stage two of the Queensland Government's staged *Pool safety improvement strategy* will introduce a mandatory inspection at point of sale or lease instead of a cyclic pool inspection program. This system of inspection supports research findings that young children are at a greater risk of drowning within the first six months of installing a new pool or moving to a property with a swimming pool.
The requiring of a point of sale or lease mandatory inspection provides a greater incentive for individual pool owners to maintain compliant pool fencing as the sale or lease of the property could not proceed without an inspection compliance certificate.

Recommendation 2

The Queensland Government embark on an immediate advertising blitz as summer fast approaches, urging pool owners to check that their fences and gates are safe and compliant with building regulations and that such checks should be made by owners several times each year. Advertisements should focus on the major risk factors – gates/latches/hinges/gaps in fences. Pool owners should be referred to the Royal Lifesaving Association of Australia's checklist for pool safety.

Response and action
Agreed and completed
Responsible agency: Department of Infrastructure and Planning

As part of the Summer Safety Campaign the Queensland Government conducted in 2009/2010, advertising campaigns leading up to summer included 'Hannah's Story', 'Carson's Story' and used campaigns such as the ABC for pool safety:

Always supervise your children near a pool - Begin swimming lessons for your children - Close the pool gate and keep your fence maintained.

The Queensland Government has more than tripled spending on its pool safety campaign.

Recommendation 3

The Queensland Government ensures that there is a viable monitoring process in place for pools to be inspected upon sale or upon leases being entered into, as this provides a good opportunity for such inspections.

Response and action
Agreed and partially completed
Responsible agency: Department of Infrastructure and Planning

Stage two of the Queensland Government's staged *Pool safety improvement strategy* will address this recommendation and includes the following:

- rationalisation of 11 current pool fencing standards to just one standard for all pools, both new and existing
- a mandatory point of sale and lease inspection system
- phase-out of child-resistant doors used as pool barriers for existing pools
- wider application of state laws to include indoor pools and pools associated with hotels, motels, caretaker residences and caravan parks
- a swimming pool register
- fencing for all portable pools deeper than 300 millimetres
- narrowing the ability for councils to create local pool laws where state laws apply
- councils to gain greater powers of entry for safety inspections
- model local law for councils who wish to cover pools outside state laws.

Stage two of the Queensland Government's staged *Pool safety improvement strategy* will commence on 1 December 2010.

Recommendation 4

Building certifiers be forced to follow up on pool fencing approvals, as opposed to owners being obliged to call for final inspections.

Response and action
Agreed and completed
Responsible agency: Department of Infrastructure and Planning

Stage one of the Queensland Government's staged *Pool safety improvement strategy* addressed this recommendation and applies to new building work and new residential swimming pools and includes:

- simplification of pool fencing laws to the latest pool fencing standards
- provisions to allow temporary fencing for pools under construction
- ensuring all new swimming pools undergo mandatory final inspections
- CPR signage that meets current best practice
- development of an electronic model swimming pool register

- better reporting of immersion incidents from Queensland police
- more than tripling the spend on the Queensland Government's pool safety campaign.

Stage one of the Queensland Government's staged *Pool safety improvement strategy* commenced on 1 December 2009.

Recommendation 8

The Regional Council compile a register of all pools in its area, in both owned and rented residential properties, including those in existing properties, with a view to regular inspections being carried out.

Response and action
Agreed and partially completed
Responsible agency: Department of Infrastructure and Planning

As noted in recommendation four, Stage two of the Queensland Government's staged *Pool safety improvement strategy* will address this recommendation by developing a register of swimming pools.

Stage two of the Queensland Government's staged *Pool safety improvement strategy* will commence on 1 December 2010.

Inquest into the death of Leon Streader

Mr Streader died on 22 February 2004 at Pinjarra Lodge, a privately owned level three care facility.
The Coroner found that Mr Streader died due to the effects of coronary atherosclerosis worsened by heat stroke.

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

Recommendation 1

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

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

The Department of Justice and Attorney-General is currently considering the recommendation to prohibit doctors issuing cause of death certificates for residents of a level three accredited facility in which the doctor has a financial interest, or alternatively, requiring the co-signing of the certificate by another doctor.

Recommendation 2

A review be undertaken by the accrediting authority for level three accommodation to consider an appropriate ratio of residents to staff, and an appropriate level of training of staff and procedures.

Response and action
Under consideration
Responsible agency: Department of Employment, Economic Development and Innovation

The Coroner noted that this is a complicated area and that her recommendations might require more detailed consideration by Department of Employment, Economic Development and Innovation.

The Act and Regulations currently provide for the general range of requirements recommended by the Coroner.

There are currently 48 level three personal care services in Queensland supporting nearly 2000 residents. Implementing the Coroner's recommendations will require careful consideration to ensure the approach adopted enhances the health and wellbeing of residents without unnecessarily risking existing accommodation and support arrangements by creating significant additional costs for services.

The sector is commercially driven and operates to provide a profit to service providers. Residential services receive no government funding to subsidise their operation and rely on

limited fixed income of residents to fund their operation. The vast majority of residents receive income support through Centrelink.

Imposing additional costs on services operating as commercial enterprises may result in some service providers choosing to cease providing personal care services or closing. This in turn would have a significant impact on residents, making them homeless, and placing further pressure on the public housing sector, Mental Health Services and/or Department of Communities.

There is no current legislative basis on which the government can compel a service provider to provide particular personal care services.

If however, a service provider chooses to provide 'personal care services' such as medication the government can place requirements on how these services are delivered in accordance with accreditation standards contained in the *Residential Services (Accreditation) Regulation 2002*. It should be noted consideration is currently underway to release guidelines relating to processes and procedures associated with assisting residents with medication management.

It should be further noted that if service provider/s perceive assisting with medication management is exposing them to significant additional costs, they may choose to cease providing assistance with medication management. This would leave vulnerable people in services without assistance in managing their medication and at increased risk of adverse health outcomes.

Alternatively, service providers may choose to evict residents perceived as having high care needs. This would have a significant adverse impact on the health and welfare of residents.

The Office of Fair Trading, Department of Employment, Economic Development and Innovation, is giving careful consideration to the Coroner's report and considering how the registration and accreditation of services can be carried out within the existing regulatory framework to give effect to the Coroner's recommendations.

Consideration is being given to the following:

- The staff ratio recommendation be rejected and instead be replaced with a minimum staff availability requirement.
- CPR and first aid training be mandated for all personal care staff in Level three services.
- Services be supported to implement detailed emergency procedures to address adverse critical health incidents for residents.
- Detailed guidelines be released on the department's expectations of services in relation to the process and procedures associated with assisting residents with medication management.

Consultation with industry will need to be undertaken.

Inquest into the death of Leon Streader

Recommendation 3

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

Response and action
Under consideration
Responsible agency: Department of Employment, Economic Development and Innovation

This is now a requirement under the accreditation standards, although it wasn't at the time of Mr Streader's death.

As discussed above, consideration is being given to releasing detailed guidelines on the department's expectations of services in relation to the process and procedures associated with assisting residents with medication management.

Consultation with industry will need to be undertaken.

Comment 1

The standard of Dr Nyst's medical record keeping be referred to the Medical Board for their advice and consideration.

Response and action
Agreed and partially completed
Responsible agency: Medical Board of Queensland

On 8 October 2009, a preliminary assessment of the matter was undertaken to determine whether the Medical Board should take immediate action to suspend or impose conditions on Dr Nyst's registration and if not, to prioritise the matter for further assessment.

The matter was assessed as not requiring immediate action and awaits further assessment.

Inquest into the death of John Arthur Harvey

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

Coroner Springer handed down findings on 1 October 2009.

Recommendation 2

Queensland Transport seek legislative change to require:

a. the tare mass weight to be included on the registration label of vehicles designated to transport loads (other than passenger cars) in addition to the gross vehicle mass(GVM)
b. the actual load carrying capacity to be clearly visible on the vehicle.

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

This recommendation will need to be further considered by the Department of Transport and Main Roads. Research has shown that many states are considering the need for registration labels on light vehicles (up to 4.5 t GVM). Western Australia has recently made the decision to take registration labels off light vehicles (up to 4.5t GVM).

In regard to heavy vehicles above 4.5tonnes GVM, there is a national agreement in place to develop the requirements for a national heavy vehicle regulator which is expected to be in place in the next year. There will be a national heavy vehicle registration regulator which means the Department of Transport and Main Roads will lose powers over these vehicles and therefore will not be responsible for labels or information on the labels (this is approximately two years away).

The certificate of registration (that has the label attached to it) does currently have the tare, GVM and GCM printed on it.

Further research will be undertaken on:

- legislative provisions
- national registration jurisdictions in regard to the future of registration labels and their contents
- the position of the national heavy vehicle regulator.

This information will then be considered as part of the review of the recommendation.

Inquest into the deaths of Constable Brett Irwin and Craig Anthony Semyrah

On the evening of 18 July 2007, Constables Irwin and Edwards attended a residence intending to execute a warrant on Mr Semyraha. There was a verbal exchange between Constable Irwin and Mr Semyraha, a brief struggle and a shot was fired. At 1:16am the sound of a gunshot was heard. SERT officers entered the premises and found Mr Semyraha with a self inflicted gunshot wound to his head. Constable Irwin was found deceased.

State Coroner Barnes handed down findings on 6 October 2009.

Recommendation 1

The Queensland Police Service review its policies and training to ensure all officers appreciate the potential danger involved in apprehending suspected offenders and the need for a conscious and explicitly articulated threat assessment and the development of at least a verbal operational plan whenever circumstances permit.

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

A review of current policies and training is being conducted by the Queensland Police Service in response to this recommendation.

It is anticipated any amendments to Queensland Police Service policies or training arising from this recommendation will be finalised by the end of 2010.

Recommendation 2

The Queensland Police Service review its policies and training to ensure all officers recognise the paramountcy of safety and their obligation to raise any safety concerns and the obligation of supervisors to support and encourage junior officers who do so.

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

A review of current policies and training is being conducted by the Queensland Police Service in response to this recommendation.

It is anticipated any amendments to Queensland Police Service policies or training arising from this recommendation will be finalised by the end of 2010.

Recommendation 3

The Queensland Police Service utilise the powerful learning potential of the circumstances of this sad case by creating a training scenario

that explicitly recognises the mistakes that were made and their consequences.

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

In response to the Coroner's recommendation, the Queensland Police Service is in the process of developing a suitable training scenario for use as part of its pre-service and on-going operational skills and tactics training programs to educate staff of the lessons learned from this particular incident.

It is anticipated this training scenario will be finalised in 2010.

Recommendation 4

An officer experienced in managing such operations who was not involved in the response to the shooting of Constable Irwin, review all aspects of it to identify whether it could have been handled more effectively.

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

The Queensland Police Service has appointed an experienced senior officer to conduct a review of all aspects of this incident to determine whether or not it could have been handled more effectively.

It is anticipated any recommendations arising from this review will be forwarded to the Queensland Police Service senior executive for consideration by mid 2010.

Inquest into the death of Talisha Hildebrandt

Baby Talisha was stillborn 7 January 2007 at the Ayr Hospital, the cause of death was meconium aspiration.

Coroner Smid handed down findings on 7 October 2009.

Recommendation 1

Queensland Health consider the acquisition of a second CTG scanner for the Ayr Hospital. The provision of a second CTG monitor would provide a critical safety factor and obviate the need for a single machine to be needed for multiple presentations at the one time.

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

The Ayr Hospital supports the recommendation to consider acquisition of a second CTG monitor and is currently exploring avenues to fund the equipment. The Health Technology and Equipment Replacement program is also being explored as a means to acquire a second CTG monitor. A decision should be made by June 2010.

Recommendation 2

Queensland Health provide recurrent funds to the Ayr Hospital and other rural and primary hospitals such as the Ayr Hospital to enhance the primary health care approach in our antenatal clinics with a particular emphasis on the implementation of screening for smoking, alcohol and drug use to improve access for mothers. In particular, antenatal information provided to expectant mothers should include a warning that a change in foetal movement, be it a decrease or increase in movement, be promptly reported to the doctor.

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

Queensland Health has committed significant ongoing funding to implement the Universal Postnatal Contact Service Initiative. The overarching goal of the initiative is to ensure all mothers receive a follow up contact from a health professional after the birth of a baby. Funding is being allocated to Health Service Districts to implement strategies to ensure the best outcomes for birthing families. In addition to postnatal contact, the Universal Postnatal Contact Service Initiative will:

- expand, upgrade and integrate the Child Health Line with 13HEALTH
- implement universal antenatal assessment and screening for key risk factors that impact on the health of both mother and baby including tobacco, drug and alcohol use, psychosocial wellbeing, domestic violence and depression

- develop and enhance community partnerships and service networks to ensure appropriate referral for families identified at risk
- establish newborn and family drop-in services to ensure families have access to local, flexible health care options after the birth of a baby
- improve integration of maternity and child health services and information sharing, for enhanced continuity of care between hospital and community settings.

The Primary, Community and Extended Care Branch is responsible for the project rollout which will be fully implemented by June 2012.

Queensland Health (through the Clinical Practice Improvement Centre) is also currently developing a standardised statewide hand held pregnancy record. This document will contain information for the woman about when to contact her health provider which will include changed foetal movements.

Recommendation 3

Queensland Health review the current practice of emergency callout to include codes to clearly signify the degree of urgency. The Coroner refers to the evidence that medical practitioners and nurses had to be called from their home on a Sunday and that the degree of urgency perhaps could be more clearly conveyed if proper coding was in place.

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

Queensland Health currently has two systems in place for emergency situations. The first supports the organisational response to an emergency, and includes fire and other external emergencies as well as 'medical' emergencies. Anyone in the hospital can call a medical emergency which is responded to by a Code Blue Response Team. The second system is specifically for medical emergency situations for hospital patients and is referred to as a Medical Emergency Team call. The team is made up of appropriately trained and competent health care providers who will respond to identified medical emergencies within a hospital 24hrs a day 7 days a week. Any staff members may make a Medical Emergency Team call for any person within the hospital (including visitors) if the situation meets set criteria, i.e. threatened airway; respiratory/cardiac arrests etc.

Queensland Health believes the issue raised by the coroner is best addressed through appropriate clinical assessment and handover to enable effective clinical decision making as to the urgency of a situation by medical practitioners. The Patient Safety Centre has oversight for the Clinical Handover Program which is examining current processes for the effective and efficient transfer of information and responsibility for patient care between health care professionals, examining current best practice models, identifying gaps and making recommendations on a statewide strategy to address these gaps. The strategy options paper was endorsed for wider consultation by the Patient Safety and Quality Executive Committee in early November 2009. Once feedback is received by the relevant stakeholders, a statewide standardised *Clinical handover policy* will be developed. The draft

policy will also require consultation and feedback, and is expected to be completed by December 2010.

Recommendation 4

That Queensland Health and the Queensland Police Service review any existing Memorandum of understanding or protocol to ensure the efficacy and timeliness of coronial investigation undertaken by police on behalf of the Coroner. I endorse the recommendation advanced and I refer to Exhibit 24 on the part of Dr Row and Ms Vicary whose respective functions are Director of Medical Services and Director of Nursing at the Ayr Health Service to implement the K2 program for all endorsed midwives and doctors so that a regular CTG implementation updates can be electronically updated and completed.

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

The Queensland Police Service and Queensland Health meet regularly with Coroners during a bi-monthly Interdepartmental Working Group meeting regarding coronial matters.

The recommendation was discussed at the November Interdepartmental Working Group meeting with the outcome being to progress a protocol or guideline through the State Coroner as this position has final oversight for the whole coronial system, including issues associated with information exchange between police and health staff. The State Coroners guidelines are currently being reviewed in line with recent changes to the *Coroners Act 2003*, and therefore the revision will include this issue. The State Coroner's guidelines require substantial revision and therefore they are expected to be completed by December 2010.

Responsible agency: Queensland Police Service

The Queensland Police Service currently provides detailed policies and procedures (in chapter eight of the *Operational procedures manual*) in relation to the conduct of coronial investigations. These policies and procedures include specific provisions relating to the appropriate timeframes for completing coronial investigations and the responsibilities of supervisors to ensure coronial investigations have been carried out to a professional standard. They also include specific provisions relating to the investigation of deaths which occur during a health procedure.

To remind officers of the existing Service policies in relation to the conduct of coronial investigations, a memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all staff on 26 October 2009. This memorandum included a reminder to supervising officers of their responsibility to ensure that the investigation of deaths is conducted expeditiously.

In addition, since August 2007, a Memorandum of understanding between the Queensland Police Service; Health Quality and Complaints Commission; Office of Health Practitioner Registration Boards; Queensland Nursing Council, Chief Health Officer; Queensland Health; State Coroner; Crime and Misconduct Commission; Queensland Ombudsman and the Commission for Children and Young People and Child Guardian has existed in relation to the coordination of responses to serious adverse health incidents and in response to this particular recommendation. The Queensland Police Service is in the process of liaising with the other parties concerning a review of this Memorandum of understanding.

It is anticipated any review of this particular Memorandum of understanding, will be completed in 2010.

Comment 1, page 4

The Coroner endorsed the recommendation on the part of Dr Row (Director of Medical Services, Ayr Health Service) and Ms Vicary (Director of Nursing, Ayr Health Service) to implement the K2 program for all endorsed midwives and doctors so that regular CTG implementation updates can be electronically updated and completed.

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

The Ayr Hospital is currently progressing the implementation of this rollout through gaining access to Townsville Hospital's software license for the K2 program. This should be completed by June 2010.

Inquest into the death of Edward Alexander McBride

Mr McBride died on 7 February 2007 at an Energex Sub-station from electrocution as a result of intentionally placing himself in a position on the substation tower such that he would receive a high voltage electric charge.

Coroner Lock handed down findings on 15 October 2009.

Recommendation 1

The Commissioner of Police include in any future training or further in service education of police, information concerning the importance of recording at the scene any evidence gathered in an examination of electronic devices (such as a PDA) in case that data is subsequently lost. There should be included in such training information pointing out the potential loss of such data as occurred in this particular case.

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

In February 2003, the Australasian Centre for Policing Research published a best practice guide for seizing computers and other electronic evidence. A copy of this document is currently provided for the information of all officers in the Queensland Police Service *Operational procedures manual* (in Appendix 2.30).

To remind officers of the existence of this best practice guide and to highlight the issues surrounding this particular case, a draft memorandum under the hand of the Deputy Commissioner (Specialist Operations) has been prepared and is currently being considered for publication and distribution to all staff.

Draft amendments to section 2.28.5: *Seizing electronic evidence* of the Queensland Police Service *First response handbook* have also been prepared in relation to this issue. These handbooks are provided to all officers and contain a summary of essential policing powers and first response actions for a number of operational situations.

In addition, the Queensland Police Service Human Resource Development Branch has conducted a review of current training materials and the issue identified by the Coroner is being incorporated into several in-service training programs.

It is anticipated that the memorandum under the hand of the Deputy Commissioner will be distributed to all staff in early 2010. The proposed amendments to the *First response handbook* are expected to be published within edition 8 of the handbook by mid 2010 and the inclusion of appropriate information into relevant training materials will be completed by late 2010.

Inquest into the death of Andrew Scott Anderson

Master Anderson died on 25 July 2005 from a self inflicted gunshot wound to the head.

Deputy State Coroner Clements handed down findings on 16 October 2009.

Comment 1, page 17

At a structural level the department must create a system and allocate responsibility to ensure that where a child is 'mobile' between different offices that the child's needs are properly met. Identification that this problem has arisen must attract mandatory review and responsibility by a more senior level of practitioner to address how the child's needs are met.

The department has responded to this issue with a suggested time frame in which a transfer should occur. The responsibility to make this happen must be accepted initially by the relevant case worker. There should be a requirement for that officer to formally advise their line manager as soon as circumstances arise indicating the need for transfer. There should then be a joint responsibility to ensure the transfer happens within the required time frame, ensure delivery of services and continuation of essential case work services during the transition by whatever are the appropriate mechanisms.

A deadline should be set by which time the line manager must escalate any problem with the transfer to higher management within both offices.

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

The *Child safety practice manual* outlines a detailed set of principles and processes which includes time frames for the case transfer of children subject to ongoing intervention, which includes children subject to child protection orders. It states:

- Acceptance of case transfers for a child subject to a child protection order must be approved by the manager of the Child Safety Service Centre.
- A process for the resolution of disagreements in respect of case transfers – those disagreements must be resolved within two weeks and can be sent to a regional director for final resolution.
- The receiving Child Safety Service Centre should allocate a child safety officer to the case and ensure that contact is made with the child/young person and family occurs within one week of their arrival to the area.
- This Child Safety Service Centre must also undertake case work tasks prior to the transfer of the case and coordinate referrals to community agencies in the new area where required.

- In essence, the new Child Safety Service Centre is to begin required case work tasks immediately when they are advised that the child/young person is in their area.
- Case management remains with the transferring Child Safety Service Centre until they receive written confirmation (email or written correspondence) that the transfer has been accepted. This written communication must include an agreement about the likely timeframe for planned case transfer.
- As the originating office retains case management until the transfer is accepted, responsibility to ensure that any case work tasks are followed up would be a shared responsibility.

Timeframes for the electronic transfer of files for a child subject to a child protection order occurs after three months in the placement to allow for both the placement and child to stabilise.

Comment 2, page 18

The guidelines for responding to this situation must be reviewed within the regime of the Suspected child abuse and neglect process so that there is a timely decision made about what is to happen. Doing nothing should not be an option and a review of how the department works with Queensland Police should be considered.

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

Suspected child abuse and neglect processes, policies and procedures are currently being reviewed in partnership with Suspected child abuse and neglect core member agencies, including the Queensland Police Service, as part of the implementation of a refocused Suspected child abuse and neglect system. Implementation of the revised system will occur in second half of 2010.

Departmental policy 391-4 *Critical incident reporting outlines responsibilities of staff if a child or young person is reported as missing*, specifically including where there are serious concerns in relation to their vulnerability, for example suicide risk. The Queensland Police Service must also be informed. If the child or young person is not located within a reasonable timeframe, regular updates are to be provided of the steps being undertaken to locate the missing child or young person.

The revised Suspected child abuse and neglect system processes, policies and procedures are in draft and will be progressed to the Child Safety Directors Network for approval prior to end of May 2010.

Statewide joint training will then be delivered to support implementation of the refocused Suspected child abuse and neglect system in the second half of 2010.

Responsible agency: Queensland Police Service

The Suspected child abuse and neglect system is established under the provisions of the *Child Protection Act 1999* (chapter 5A, part 3). The purpose of the system is to enable a coordinated response to the protection needs of children.

Referrals to the Suspected child abuse and neglect system are made by the core member agencies which include the Department of Communities, Queensland Health, the Department of Education and Training, the Queensland Police Service and, in the case of a child being an Aboriginal or Torres Strait Islander, a recognised Aboriginal or Torres Strait Islander agency or individual.

In this particular instance, the Queensland Police Service was not notified that Andrew Anderson was missing and the Service was not in a position to refer this matter to the Suspected child abuse and neglect system.

Interagency policy and procedures in relation to the suspected child abuse and neglect system are currently being developed by the Department of Communities with input from the core agencies including the Queensland Police Service. It is anticipated the issue identified by the Deputy State Coroner will be addressed once the new –interagency policy and procedures are finalised.

It is anticipated the interagency policy and procedures will be finalised by late 2010.

Comment 3, page 18

It is noted that the Placement Services Unit now manages the assessment and placement of a particular child in a suitable residential arrangement. The provision of information from the case worker into that placement decision is now provided for but it is recommended that the assessment report, which is signed off by the child safety manager, is copied and returned directly to the case worker.

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

Email communiqué was sent to Child Safety Service Centre managers and Placement Services Unit directors to inform them that a copy of the carer assessment report is to be provided to the child safety officer with case responsibility for the child.

A teleconference was held with Placement Services Unit staff to inform them of the recommendation and the requirement to address any training and support needs in the carer assessment report.

Comment 4, page 18

a. Where a qualified approval is given subject to the provision of conditions or supports, the department must meet its responsibility to provide these supports and continue to

monitor suitability. Where a placement is made with a relative carer, it is recommended the assessing report writer observes interaction between the child and proposed carer, and the child's wishes are taken into account in accordance with their age as appropriate.

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

The Kinship Carer assessment form has been amended to include comments on the interaction between a potential kinship carer and the child, where practicable. A space exists to record the child's views.

Email communiqué has been sent to Child Safety Service Centre managers and Placement Services Unit directors to inform them of the update.

b. The evidence in this inquest showed the potential availability and suitability if supported, of another 'relative carer', namely a step mother. This was not considered and it was suggested the department does not consider step parents as possible relative carers. If this is indeed the policy it should be reconsidered to also include step parents as possible suitable relative carers.

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

No further action required as current legislative requirements and practice procedures enable a step parent to apply to become a kinship carer.

Comment 5, page 18

Discussion and policy papers have been written in response to the department's review to guide practitioners in how to deal with difficult children and their family members. What has not happened yet is the development of training for case workers around these polices directly available. This should be a priority.

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

Dealing with difficult children and families is covered in phases one, two, three and five of mandatory child safety officer training. Example modules include:

- working with involuntary clients
- conflict resolution
- dealing with difficult clients
- interviewing parents
- engaging adolescents
- identifying levels of aggression
- engaging young people.

Comment 6, page 19

In the course of the inquest there was mention of early intervention resources to assist families at a time when it is first identified there are problems. Andrew's family attempted to the best of their ability and resources to access professional help and advice to guide them in managing Andrew as a young child. Their efforts were unsuccessful and the family unit fractured before the final crisis which precipitated Andrew being taken into care. There must be greater priority for identifying and supporting families when the first indication of potential child safety issues arise.

There was mention of the positive benefits available through the Evolve program which was piloted in limited areas. Subject to proper evaluation confirming the benefit to families of this program, resources should be made available to make this accessible state wide.

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

The Evolve performance report 2008 indicated benefit for children and carers. Additional Evolve Therapeutic and Behaviour Support Services are being established in Brisbane South and Ipswich. Evolve Behaviour Support provided through Disability Services is also being established in Toowoomba. These additional Evolve services will be fully operational in May 2010. This will provide coverage across the state with the exception of remote areas and regional centres in western Queensland.

Consideration to be given to future funding bids to increase capacity of the program.

The Department of Communities is currently considering improvements to early intervention services to increase their capacity to provide support to vulnerable families and prevent the need for a child safety out-of-home care response. Initiatives under this project will aim to assist families, including those with complex needs, to access integrated and specialist support services.

Inquest into the death of Andrew Scott Anderson

Comment 7, page 19

The department with responsibility for families and children in care must receive priority funding. This must focus on early intervention and support to families where there is a risk identified to children as well as support to children in the care.

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

Protecting Children is Everyone's Business – National Framework for Protecting Australia's Children 2009–2020, is an initiative of the Council of Australian Governments, endorsed on 30 April 2009. The national framework's three year action plan provides an integrated perspective on protecting children. There is a significant focus on early intervention services targeted at vulnerable families and children, as well as strengthening responses within the statutory system such as developing national standards for out-of-home care. The current work being undertaken by the Department of Communities to improve early intervention services will significantly contribute to Queensland's commitments under the national framework.

Current child protection funding initiatives within the Department of Communities include:

- establishing four Therapeutic Residential Services to provide intensive services to support young people's recovery from the impact of trauma experienced through abuse and neglect
- from 1 July 2010, the department will re-allocate $8.5M of funding currently budgeted for statutory information and advice on Indigenous children and families, to actual family support services for Aboriginal and Torres Strait Islander children and their families. The majority of the clients of these services will be children and families who come to the attention of the department but do not meet the statutory threshold of being 'in need of protection'. The family support intervention will range from practical in-home support to counselling to referrals to specialist agencies with a view to preventing re-notification to the department
- establishing Safe Houses in Aboriginal and Torres Strait Islander communities to provide on-community placement and support services for children and families subject to statutory intervention
- continuing the Foster and Kinship Care Support Line which provides practical information and parenting tips relating to behavioural problems, counselling and support, carer resources and information about child protection services. This service is available after hours also
- the Foster and Kinship Carer recruitment campaign, aimed at recruiting an additional 500 carers to enhance placement options for children in care
- establishing Placement Services Units to enhance the coordination of placements for children/young people in care and better match carers to children to improve placement stability
- expanding the Family Intervention Services to deliver specialist services for families and children subject to ongoing statutory child protection intervention, by

increasing the family's protective factors and enhancing attachment to prevent re-entry into the statutory child protection system.

Providing early support to children and families and those children in care is supported.

Queensland's commitment to the *Implementing the first three year action plan, 2009– 2012* for the National Framework for Protecting Australia's Children provides a process for guiding the appropriate allocation of resources and policies, alongside of Queensland's own priorities.

Comment 8, page 19

The department is addressing disciplinary issues with a team leader involved in the supervision of Andrew's care. The only remark made is that the department's actions in suspending the person did not occur until immediately before the inquest commenced. This was four years after Andrew's death. It is hoped there is a conscientious and careful review of what actions the department might take to prevent another death such as Andrew's. Issues of training and supervision of staff are paramount to ensuring our most vulnerable children are protected whilst in the state's care.

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

The department has undertaken the following actions to ensure effective case management of children and young people:

- The department has updated the policy in relation to transfer so that the timelines and expectations around transfers are clearly articulated and officers are fully informed as to how the transfer of files between offices is to be enacted.
- Previously, Child Safety Service Centres were using both the AAA spreadsheet and integrated client management system simultaneously as tracking tools and this proved challenging to maintain data integrity. Child Safety Service Centres now use only one tracking system and rely solely on ICMS for reporting. This is proving to be more effective for team leaders to track progress of cases.
- Case discussion panels have been implemented within the Toowoomba South Child Safety Service Centre for any child under consideration for reunifying or taking to permanency. In preparation for these panels, the senior practitioner undertakes a comprehensive case review of all facets which are fully discussed between panel members. Any gaps in case work that are identified are then resolved as part of actions either undertaken during or after the panel.
- Toowoomba South has also strengthened links with Child and Youth Mental Health Service, particularly in Toowoomba. For the past 12 months, the senior practitioner has attended monthly meetings with Child and Youth Mental Health Service to build relationships and to offer and receive training. This has increased the responsiveness between Child and Youth Mental Health Service and the department to children in need.

- An Evolve service and a Therapeutic Residential Service have also been established in the region which has greatly increased the capability of the region to respond to children with high and complex needs.

Training of staff has been reviewed within the Toowoomba South Child Safety Service Centres and as a result, staff now have increased access to training and supervision opportunities within the office which has sought to increase their knowledge base around issues that are pertinent to child protection. Initiatives include:

- In partnership with the Training and Specialist Support Unit, specialist skills training workshops are now offered regionally as Lunchbox Sessions. Prior to this program, workers would be required to attend workshops in Brisbane requiring at least one day out of the office.
- In partnership with the Training and Specialist Support Unit, the Toowoomba South Management Team is participating in a Team Management System pilot project which utilises the Team Management System by Dr Dick McCann and Dr Margerison. The pilot project provides professional leadership coaching to assist in forming a cohesive and united management and leadership team and to implement predictive planning processes throughout the office.
- In addition the senior practitioner, as part of a statewide program, runs internal training on a bi-monthly basis on issues relating to best practice in child protection.
- One team within Toowoomba South has implemented weekly reflective practice workshops, with one or two team members bringing a complex case to the table for discussion between the senior practitioner, the team leader and all of the child safety officers on that team. All members participate, meaning that diverse and innovative case management approaches of these complex cases are discussed.
- Orientation of new staff members has been reviewed and changes made to ensure that inexperienced staff members are supervised and developed appropriately. Initiatives include:
    - Under an Executive Management Team directive, child safety officers are to remain on restricted duties until the completion of phase 2 training. Restricted duties relates to not exercising their delegations under the Child Protection Act. This translates as child safety officers being able to do casework, but not make decisions about removal/change of placements, not undertaking investigations and assessments as primary workers, and not taking any Child Protection Orders as applicants.
    - Orientation of new staff members has also been reviewed with the senior practitioner overseeing the origination of all new staff members to the Toowoomba South Child Safety Service Centres to ensure consistency during induction.
    - It is a departmental requirement that all staff complete core training relevant to their position. Core training is scheduled regularly throughout the year to ensure it is accessible to all staff. Training is undertaken over 12 months and is divided into 5 phases. Two phases (two and four) are face-to-face at Warilda, the remaining phases are undertaken on the job. At the completion of 28 modules and 12 competencies workers will be deemed competent and also attain a Vocational Graduate Certificate in Community Service Practice (Statutory Child Protection). Child Safety Services is the only organisation in Australia with this qualification. Assessment of evidence for the competencies is undertaken by Training and Specialist Support Unit,

verification of evidence is still signed off by team leaders. During the 12 months, a child safety officer will complete activities in the workplace, intensive face-to-face workshops and workplace simulations, workplace learning documents, a case study and a research project.

- Under the Child safety practice manual section 12.1 Professional supervision and policy no. 404-2: *Professional supervision*, all permanent, temporary, part-time and casual departmental officers will have scheduled, planned and regular supervision with their supervisor. The frequency of supervision is based on the level of experience, skills and knowledge of the supervisee, and takes into account the role and nature of the work the supervisee is undertaking. The minimum requirement is one scheduled hour of supervision per fortnight. More frequent supervision is recommended for staff that are new to the department or in circumstances where a manager or team leader considers it is required.

Inquest into the death of Joshua Leslie Hopkinson

Mr Hopkinson died on the 21 July 2005 from chest injuries while employed as an apprentice fitter and turner. His injuries were the result of an uncontrolled release of stored nitrogen gas which occurred as he was in the process of dismantling a nitrogen charged cylinder.

Coroner Risson handed down findings on 19 October 2009.

Recommendation 1

Coal mine operators critically review the effectiveness and implementation of their mine safety and health management systems in accordance with section 41(1)(f) of the *Coal Mining Safety and Health Act 1999* in relation to stored energy to ensure that:

- procedures for the safe discharge of energy are effective and comply with any equipment manufacturer's instructions
- the discharge is validated by an independent person by the removal of any plug, valve or hose thereby ensuring an open circuit or zero energy state.

Response and action
Agreed and completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Queensland Mines Inspectorate has engaged in ongoing discussions with coal mine operators and the Queensland Resources Council about this recommendation. A directive has been issued to site senior executives of all coal mines in Queensland to review their systems and ensure these issues are adequately addressed.

The Queensland Mines Inspectorate will continue to routinely audit coal mine operators' compliance with their obligations under section 41(1)(f) of the *Coal Mining Safety and Health Act 1999*.

Recommendation 2

Coal mine operators and others involved in the maintenance and repair of stored energy equipment used in coal mining operations in dispatching and transporting any such equipment ensure that the nature of the item and the hazards associated with it are appropriately documented and displayed for the benefit and safety of both transport operators and those receiving the equipment.

Response and action
Agreed and completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Queensland Mines Inspectorate has engaged in ongoing discussions with coal mine operators and the Queensland Resources Council about this recommendation. A directive

has been served on all coal mines from the Senior Mechanical Inspector to ensure they comply with this recommendation.

The Queensland Mines Inspectorate will continue to routinely audit coal mine operators' compliance.

Recommendation 3

Coal mine operators and others involved in the maintenance and repair of stored energy equipment used in coal mining operations review procedures for the equipment to ensure that no dismantling of any such equipment is commenced before it is confirmed, by independent validation if necessary, that it is fully discharged.

Response and action
Agreed and completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Queensland Mines Inspectorate has had ongoing discussions with coal mine operators and the Queensland Resources Council about this recommendation. Coal mine operators have been requested to review their systems and ensure these issues are adequately addressed.

The Queensland Mines Inspectorate will continue to routinely audit coal mine operators' compliance.

Recommendation 4

Recommend that coal mine operators and others involved in the maintenance and repair of stored energy equipment used in coal mining operations review their procedures to ensure that all apprentices and others without formal trade qualifications are appropriately supervised at all times when working on such equipment.

Response and action
Agreed and completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Queensland Mines Inspectorate has had ongoing discussions with coal mine operators and the Queensland Resources Council about this recommendation. Coal mine operators have been requested to review their systems and ensure these issues are adequately addressed.

The Queensland Mines Inspectorate will continue to routinely audit coal mine operators' compliance.

Inquest into the death of Joshua Leslie Hopkinson

Recommendation 5

Departments responsible for the administration of the *Coal Mining Safety and Health Act 1999* and the *Workplace Health and Safety Act 1995* are clear as to who is responsible for any investigation and prosecution in relation to any accident relating to coal mining operations which occurs elsewhere than at a coal mine and that any legislative amendment be sought if thought necessary.

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

There is understanding between the Department of Justice and Attorney-General and the Department of Employment, Economic Development and Innovation as to the operation of the *Coal Mining Safety and Health Act 1999* and the *Workplace Health and Safety Act 1995* to operations at workplaces other than those at a coal mine.

The determination by Workplace Health and Safety Queensland to investigate incidents relating to coal mining operations is guided by the *Memorandum of understanding* between the Department of Justice and Attorney-General and the Department of Employment, Economic Development and Innovation.

Inspectors of the departments work cooperatively to apply the *Memorandum of understanding* to ensure the ability of one department to investigate and prosecute is not impeded by the other department.

The *Memorandum of understanding* is currently undergoing review. This review will continue to seek an outcome of joint understanding of the scope for the departments to investigate matters relating to operations at workplaces other than those at a coal mine.

Response and action
Agreed and completed
Responsible agency: Department of Employment, Economic Development and Innovation

Discussions have occurred between the Queensland Mines Inspectorate and Workplace Health and Safety Queensland about this recommendation.

The circumstances of Mr Hopkinson's case were unusual, in that two workplaces were involved that were regulated by different Acts. This caused some initial confusion about the jurisdiction of the Queensland Mines Inspectorate and Workplace Health and Safety Queensland. However, this didn't prevent the Queensland Mines Inspectorate and Workplace Health and Safety Queensland from working cooperatively together to investigate all of the events that led up to the death of Mr Hopkinson. That cooperative working relationship continues.

The Queensland Mines Inspectorate's jurisdiction is not limited to activities that occur on a coal mine or that only affect the safety and health of person at a coal mine. For example:

- Section 41(1)(b) of the *Coal Mining Safety and Health Act 1999* provides that a coal mine operator has an obligation 'to ensure the operator's own safety and health and the safety and health of others is not affected by the way the operator conducts coal mining operations'
- Section 42 of the *Coal Mining Safety and Health Act 1999* provides that a site senior executive for a coal mine 'has the following obligations in relation to the safety and health of persons who may be affected by coal mining operations … (a) to ensure the risk to persons from coal mining operations is at an acceptable level'.

The Queensland Mines Inspectorate's view is that there is no legislative deficiency that requires amendment. However, in working with Workplace Health and Safety Queensland on inter-related matters, the Queensland Mines Inspectorate will continue to discuss and assess any jurisdictional point raised. The Queensland Mines Inspectorate will ensure that any outcomes requiring formal recognition will be dealt with the Memorandum of understanding and review process between the departments.

Recommendation 6

The Mining Inspectorate liaises with other departments, industry and professional bodies to ensure that awareness of the hazards of uncontrolled release of stored energy in equipment used in coal mining activities and the need for training for those exposed to the hazards is disseminated across all industries and applications of the equipment.

Response and action
Agreed and completed
Responsible agency: Department of Employment, Economic Development and Innovation

The Queensland Mines Inspectorate has finalised discussions with the following organisations regarding this recommendation:

- Queensland Resources Council
- Construction, Forestry, Mining and Energy Union
- Australian Petroleum Producers and Explores Association
- Petroleum and Gas Inspectorate, Department of Employment, Economic Development and Innovation
- Workplace Health and Safety Queensland, Department of Justice and Attorney-General.

Inquest into the death of Peter Edward Ash and Nicole Florence Ash

Mr and Mrs Ash died on 18 July 2008 when their vehicle was struck by a Magna travelling at high speed, causing Mr Ash to lose control of his vehicle. The Magna was being followed by a police vehicle who attempted to intercept the vehicle but the driver sped off, overtaking two other vehicles before crashing into the back of the Ash's car.

State Coroner Barnes handed down findings on 3 November 2009.

The Ash's deaths are two of 10 deaths that occurred in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests have been held into each of those deaths.

The *Coroners Act 2003* authorises a coroner conducting an inquest to comment on anything connected to the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. To maximise the evidence base, the State Coroner postponed making any such comments in these cases until all 10 deaths had been heard. At that stage a further hearing was convened and evidence heard in relation to the Queensland Police Service's pursuit driving policy.

The State Coroner handed down thirteen recommendations on 31 March 2010 relating to the Queensland Police Service's pursuit driving policy. The Government's response to the State Coroner's recommendations will be included in the report *Queensland Government's response to coronial recommendations 2010*.

Inquest into the death of Matthew Raymond Cullen

On 26 July 2008 Mr Cullen ignored a police direction to stop at a Random Breath Test point and a police officer attempted to intercept him. The pursuit lasted 13-18 seconds during which time Mr Cullen lost control of his motorcycle, crashed and died.

State Coroner Barnes handed down findings on 5 November 2009.

Mr Cullen's death is one of 10 deaths that occurred in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests have been held into each of those deaths.

The *Coroners Act 2003* authorises a coroner conducting an inquest to comment on anything connected to the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. To maximise the evidence base, the State Coroner postponed making any such comments in these cases until all 10 deaths had been heard. At that stage a further hearing was convened and evidence heard in relation to the Queensland Police Service's pursuit driving policy.

The State Coroner handed down thirteen recommendations on 31 March 2010 relating to the Queensland Police Service's pursuit driving policy. The Government's response to the State Coroner's recommendations will be included in the report *Queensland Government's response to coronial recommendations 2010.*

Inquest into the death of Annette Lee Spencer

Ms Spencer died on 20 November 2008, she suffered fatal injuries as a result of the collapse of a balcony deck at a residential premises.

Coroner Lock handed down preliminary recommendations on 12 November 2009.

Recommendation 2

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

Response and action
Agreed and partially completed
Responsible agency: Building Services Authority

The Building Services Authority has implemented an awareness strategy which includes:

- a weblink on the Building Services Authority website to the findings into Ms Spencer's death, available to Building Services Authority licensees, stakeholders and the general public who access the Building Services Authority website
- a two page spread/article featured in the December 2009 edition of the Building Services Authority *Building Links* magazine which became available online in December 2009.

The Department of Public Works will further progress implementation of Coroner Lock's recommendation by holding 13 contractor super shows throughout Queensland from April to July 2010, as well as a number of trade contractor shows in smaller regional areas throughout the year. All of the seminars will include education sessions on timber decks in response to the coroner's recommendations

The Building Services Authority published handouts which are being distributed at the seminars, and information has been published on the Building Services Authority website for consumers and contractors.

All Building Services Authority licensees are encouraged to attend the seminars but particularly those licensed to carry out pre-purchase inspections and those newly licensed with a builder licence class.

Inquest into the death of Michael James Miller

On 25 May 2008, two water police officers approached Mr Miller to enquire about the registration of the boat he was on. Mr Miller satisfied the police officers and they departed. However, the officers soon returned, having been unable to find in police records the alias Mr Miller had given them. Faced with the prospect of arrest for an outstanding warrant, Mr Miller took his own life.

State Coroner Barnes handed down findings on 9 December 2009.

Recommendation 1

The Queensland Police Service remind officers of the provisions of *Operational procedures manual* section 14.9 and consider whether guidelines should be developed to assist officers with the power to direct subordinates not to wear firearms as how they should exercise that discretion.

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

In response to the State Coroner's recommendation, a memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all staff on 31 December 2009. The draft memorandum was designed to remind officers of the provisions of s.14.9: *Carriage of firearms - generally* of the Queensland Police Service *Operational procedures manual* and to remind supervising officers of their responsibility for ensuring that where a direction is given not to carry firearms in relation to a particular incident or occurrence, that this direction is justified in the circumstances and is clearly communicated to the officers involved.

Inquest into the death of John Martin Heywood

Mr Heywood died on 20 July 2009 whilst a prisoner housed in the Secure Unit of the Princess Alexandra Hospital where he was admitted 13 days prior for loss of appetite, weight loss and elevated adrenal hormones.

An autopsy determined Mr Heyward died from natural causes, namely an abnormal heart rhythm precipitated by coronary atherosclerosis and phaeochromocytoma.

The State Coroner handed down findings on 3 December 2009.

Comment, page 4

In this case the following shortcomings were observed in the police report when it was received by this office:

- there were no statements from the nurses who found Mr Heywood dead, nor from the doctor who issued the life extinct certificate
- there was no statement from the nurse who did the routine check at approximately 3:00am detailing her observations which enables the conclusion to be drawn that the deceased was alive and sleeping at that time
- there was no statement from the first police officer to arrive at the scene her detailing her observations about its state upon her arrival
- the four other prisoner/patients who were in the unit at the time were not interviewed as to anything they heard or saw at the time of Mr Heywood's death.

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

The Queensland Police Service currently provides detailed policies and procedures (in chapter 8 of the Queensland Police Service *Operational procedures manual*) in relation to the conduct of coronial investigations. These policies and procedures include provisions that address the specific issues identified by the Coroner.

To remind officers of the existing Service policies in relation to the conduct of coronial investigations, a memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all staff on 26 October 2009. This memorandum outlined the relevant Service policies and procedures pertaining to the investigation of sudden deaths. The memorandum also provided officers with information concerning the training which is currently available in relation to coronial investigations.

The current training products available in relation to coronial investigations include an on-line learning package and a competency acquisition booklet. These products are provided under the Education and Training Support Program and are available to all officers. In

response to similar comments made in a previous inquest, a review of these training packages is currently being undertaken.

In addition, the Coroner's comments have been referred to the Queensland Police Service State Crime Operations Command for consideration regarding the development of internal procedures to ensure that death in custody investigations conducted by the Corrective Services Investigation Unit (which is part of the Queensland Police Service) are conducted and overviewed to a professional standard.

It is anticipated the review of relevant training products and any required changes will be completed by late 2010.

It is also anticipated any required changes to internal Corrective Services Investigations Unit procedures will be finalised by mid 2010.

Inquest into the death of Daniel Scott Grace and Raymond John Heffler

Messrs Grace and Heffler died at the scene of the single vehicle truck crash on the Bruce Highway on 4 April 2007 when Mr Grace failed to safely negotiate a sweeping right hand bend.

Coroner Hennessy handed down findings on 14 December 2009.

Recommendation 1

The Department of Transport and Road Transport industry continue to support the development of an early warning tip device for trailers being hauled by prime movers to alert drivers to potential rollover due to movement of the trailer.

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

Electronic stability control, also referred to as electronic stability program, is an active safety system that reduces the risk of a driver losing control of the vehicle. Electronic stability control uses a number of intelligent sensors that identify when a vehicle has deviated from the driver's direction and then stabilises the vehicle by selectively braking individual wheels and reducing torque to bring the vehicle back on course. In the case of heavy vehicles yaw sensors are utilised to measure the vehicle's rotation around a vertical axis, while at the same time measuring the acceleration at right angles to the driving direction. By electronically evaluating the measured values, the sensor is able to differentiate between normal cornering and vehicle skidding movements and can apply braking selectively to individual wheels and reduces engine power to bring the vehicle back to a stable operating condition. This system offers benefits in maintaining the stability of the vehicle on the road.

The issue of mandating electronic stability control / electronic stability program for heavier commercial vehicles (over 3.5 tonne) is being explored as part of the National Heavy Braking Strategy, a comprehensive review by the Department of Infrastructure, Transport Regional Development and local government (Australian Government) and the National Transport Commission to improve all aspects of heavy vehicle braking.

The strategy recognises that the United Nations Economic Commission for Europe has decided to amend Regulation 13 to require electronic stability control on heavy vehicles in a staged introduction between 2010 and 2016. Australia currently has a policy of harmonising vehicle design rules with the Economic Commission for Europe.

Therefore it is acknowledged by the Australian Government and the National Transport Commission that Australia should, subject to regulatory impact statement, in-time mandate electronic stability control for heavy vehicles.

The Australian Government recently provided a timetable for the development of Australian Design Rules relating to heavy vehicle braking to the Australian Design Rules Technical Liaison Group, which includes states, territory and industry representatives, for comment.

Inquest into the death of Daniel Scott Grace and Raymond John Heffler

The Department of Transport and Main Roads continues to support the development of vehicle safety technologies to improve the safety of heavy vehicles as part of the national process for the development of heavy vehicle standards.

The proposed timeframes indicated by the Australian Government and the National Transport Commission for the implementation of the Australian Design Rules for electronic stability control on heavy vehicles is 2015.

Inquest into the death of Robert Hayes Myers

Robert Hayes Myers died of natural causes while in the custody of the Department of Corrective Services on 14 October 2005.

State Coroner Barnes handed down findings on 16 December 2009.

Recommendation 2

The Department of Community Safety review its policy *Managing traumatic events at work* to ensure that when Corrective Services Investigation Unit officers are investigating an incident, staff undertake interviews with those officers prior to participating in critical incident stress de-briefing or incident de-briefing.

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

Queensland Corrective Services amended the *Managing Traumatic Events at Work* procedure on 9 February 2010. The amendments implemented the coroner's recommendation but also provided some flexibility if Corrective Services Investigation Unit investigation officers are unable to interview staff members within a reasonable timeframe.

This recommendation and Queensland Corrective Services' response was reviewed by the Incident Oversight Committee at its April 2010 meeting. The committee acknowledged the changes made by the amendment and agreed implementation of the recommendation was finalised.

Inquest into the death of Yvonne Alice Davidson

Mrs Davidson died on 9 September 2007 when complications developed during a tracheostomy and she failed to recover.

Coroner Hennessy handed down findings on 16 December 2009.

Recommendation 1

That Rockhampton Hospital (and where appropriate, all other hospitals under the management of Queensland Health) ensure that:

a. Formal orientation for locum doctors be conducted prior to their commencing duty, including procedures and policies for the unit/s in which they are working and that those doctors be given an understanding that there is an expectation that those policies and procedures be adhered to.

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

Rockhampton: the Director of Intensive Care Unit has developed an orientation program specifically for Intensive Care Unit Locums. The orientation includes the high risk clinical procedures specific to the area. Locums read and sign off that they will adhere to the procedures prior to their first shift. All other clinical departments have orientation handbooks and commenced the sign-off procedure in February 2010.

Statewide: the process of orientation to local facility and unit policies, procedures and practices is a process that occurs locally. Where statewide clinical policies exist these are located with and maintained by Queensland Health's Clinical Policy Unit. The Patient Safety Centre will write to all Health Service Districts to ensure locums are included in any orientation programs in place and that orientation programs are to include reference to relevant policies and procedures.

b. The percutaneous tracheostomy protocol require the use of a fibre-optic bronchoscope (with video screen) as highly desirable for patient safety.

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

Rockhampton: three 'difficult intubation' trolleys are now located in the Rockhampton Hospital. These trolleys include a channelled bronchoscope, light source and a working end-tidal carbon dioxide monitor and a supplemental resuscitation trolley is located within the operating rooms. This mitigates the risk of equipment failure/ breakdown or the reliance on loan equipment while repairs or servicing is undertaken. A resuscitation trolley checking schedule has been implemented to monitor all emergency equipment.

Statewide: under consideration.

c. Ensure a working End-tidal Carbon Dioxide monitor and Bronchoscope.

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

Rockhampton: three 'difficult intubation' trolleys are now located in the Rockhampton Hospital. These trolleys include a channelled bronchoscope, light source and a working end-tidal carbon dioxide monitor and a supplemental resuscitation trolley is located within the operating rooms. This mitigates the risk of equipment failure/ breakdown or the reliance on loan equipment while repairs or servicing is undertaken. A resuscitation trolley checking schedule has been implemented to monitor all emergency equipment.

Statewide: under consideration.

d. Percutaneous tracheostomies be performed in normal working hours, unless urgent, to enable sufficient staff including skilled personnel to manage airway (surgical and/or ENT expertise) to be available to perform the procedure in accordance with the protocol and as safely as possible.

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

Rockhampton: the Intensive Care Unit policy clearly directs staff to perform tracheostomies with two consultant level staff present and requires that the procedure be undertaken within working hours unless absolutely necessary.

Statewide: under consideration.

e. Develop an escalation process regarding treatment concerns for all staff in ICU to access including graded assertiveness training.

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

Rockhampton: nursing and clinical directors have discussed with all Intensive Care Unit staff the need for escalation of concerns when they are faced with high risk clinical situations they are uncomfortable with. A formal hospital-wide escalation policy will be finalised by 31 March 2010. All staff continue to be given the assurance that they will be supported if they escalate problems to their nursing directors or clinical directors. A formal graded assertiveness training program is underway (completion by 30 June 2010).

Statewide: the issue of recognition and management of deteriorating patients has been identified as a priority for national action by the Australian Commission on Safety and Quality in Healthcare. In Queensland, the Patient Safety Centre has published a discussion paper on this issue, with reference to the need for communications training to enable effective clinical handover, the escalation of concerns and challenging of actions which could lead to patient harm (e.g. graded assertiveness or PACE). Graded assertiveness training is currently provided as part of the Human Error and Patient Safety training in Queensland. This training program is offered regularly in every Health Service District across the state through the patient safety officer. It is anticipated that Queensland Health will progress a statewide strategy on the recognition and management of the deteriorating patient to the Executive Management Team by June 2010. This strategy will align with the Health Ministers' agreed national approach.

f. The professional standards published by the relevant medical colleges are adhered to in performance of percutaneous tracheostomies.

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

Rockhampton: the Intensive Care Unit Protocol for Percutaneous Tracheostomy refers to the relevant College standards.

Statewide: under consideration.

Recommendation 2

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

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

Statewide implementation of the recommendation is currently under consideration.

Inquest into the death of Peter Shishko

Mr Shishko died while on remand and under an involuntary treatment order in isolation room at The Park Centre for Mental Health at Wacol on 18 June 2006.

He died of an abnormal heard rhythm (arrhythmia) induced by atherosclerosis while suffering from sleep apnoea, morbid obesity and while heavily sedated with prescription drugs.

The State Coroner handed down findings on 16 December 2009.

Comment, pages 1 - 2

Detective Sergeant B A Swift and Plain Clothes Senior Constable Mark Kickbusch attended Mr Shishko's room at the PCMH at about 3.00am. From their observations they could not find anything that suggested an external influence on the causation of Mr Shishko's death.

Sergeant Dennis Ryan of the South Brisbane Scenes of Crime office attended at the scene and in the presence, and at the direction of Detective Sergeant Swift, took a number of photographs of the seclusion room and of the deceased.

Thereafter the investigation languished. When, after numerous requests and directions, Sergeant Swift finally provided a report two years and two months after the death, it was seriously inadequate, containing only scant statements from two witnesses and no analysis of obvious issues such as the quality of the care provided to the patient/prisoner while he was in custody.

I readily appreciate the difficulty police officers may face when attempting to investigate deaths that occur in a medical setting which is why staff of this office are always available to assist with suggestions and the nomination of independent experts. I have seen no evidence in this case that technical challenges caused the unacceptable delay. I conclude Sergeant Swift failed to give the matter appropriate attention. I acknowledge the apology received from the Assistant Commissioner, Metropolitan South, and take heart from his advice that the progress of coronial files in the region shall henceforth be audited and monitored.

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

The comments of the State Coroner in this instance are acknowledged and an apology was provided by the Assistant Commissioner, Metropolitan South Region, concerning this matter.

It is current Queensland Police Service policy (contained in section 8.4.19 of the Queensland Police Service *Operational procedures manual*) that when a Notice of Inquest is received from a Coroner, the investigating officer should submit the finalised coronial file and a covering report showing the results of inquires into the death within 28 days, to the officer in charge of their station or establishment. The completed coronial file is then reviewed to ensure it has been investigated fully and it is then referred to the relevant coroner.

In the event that a finalised report is unable to be furnished within 28 days, the investigating officer is required to furnish a supplementary report detailing the progress of the investigation, including whether any person has been charged with any offence surrounding the death and the result of any court proceedings. The investigating officer must also furnish an additional supplementary report every 28 days thereafter, until the matter is finalised. These supplementary reports are also forwarded to the relevant coroner.

Since the death of Mr Shishko, the Queensland Police Service has introduced an integrated policing information and records management computer system called QPRIME. Since July 2006, all sudden death occurrences have been recorded on the QPRIME system and it is current policy (in section 8.4.24 of the Queensland Police Service *Operational procedures manual*) that officers in charge are to ensure sudden death occurrences for the relevant division are checked on QPRIME every day and that any appropriate actions are taken.

The Office of the State Coroner has also established a system which enables coroners throughout the State to send directions in relation to death investigations via email. These directions are received by the Queensland Police Service Coronial Support Unit, are entered promptly onto the QPRIME system and are then forwarded to the relevant station or establishment for attention of the investigating officer. This system has assisted in reducing the time taken in responding to Coroners directions.

In addition, to remind officers of the relevant service policies and procedures pertaining to the investigation of sudden deaths, an internal memorandum under the hand of the Deputy Commissioner (Specialist Operations) was distributed to all staff on 26 October 2009. This memorandum included a reminder to supervising officers of their responsibility to ensure that the investigation of deaths is conducted expeditiously.

Inquest into the deaths of Hayden Eric Duncan, Glen Russell Duncan and Reginald Roy Fisher

Hayden Duncan, his brother Glen and their cousin Reginald Fisher died on 11 March 2006 when they were hit by a train whilst in the rail corridor between the Redbank and Goodna train stations.

The State Coroner handed down findings on 23 December 2009.

Recommendation 1

Queensland Rail review Notice to traincrew no. 134/2008 to ensure its consistency with Module EP – 1-20 *Persons on Queensland Rail right of way*.

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

The Notice has been updated in accordance with the recommendation.

Recommendation 2

Queensland Rail develop and use in all its policies and notices to employees a standardised meaning for the terms ‘proceed with caution’ and ‘proceed with extreme caution’.

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

Queensland Rail notes that the recommendation involves terminology used across the network and will involve resolution and consultation with third party operators using the Queensland Rail network.

A technical peer review took place in March 2010 of proposed new terminology.

Consultation with third party operators and other stakeholders to take place.

Agreed changes to be communicated and current references within the Queensland Rail policies, procedures and other work/business instructions to be updated.

Changes to be implemented in first quarter of 2010-11 financial year.

Comment 1, page 19

The Coroner will refer the material gathered by the inquest to the CEO of the employing company to enable him to consider whether disciplinary action should be taken against the driver of the train.

Inquest into the deaths of Hayden Eric Duncan, Glen Russell Duncan and Reginald Roy Fisher

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

Queensland Rail accepts the Coroner's recommendation to Queensland Rail's CEO that he consider whether or not disciplinary action should be taken against the driver of the train for failing to comply with Queensland Rail's Code of Conduct. However, in the circumstances of the particular case, when taking into account all relevant factors, Queensland Rail has determined that it is not appropriate to take disciplinary action against the driver.

Recommendations profiled in the *Queensland Government's Response to Coronial Recommendations 2008*

The following recommendations appeared in the *Queensland Government's response to coronial recommendations 2008*. At the time, the Government was considering whether to implement the coroners' recommendations. Further information is now available and the relevant departments have provided the following responses.

Inquest into the death of Janet Louise Young

Mrs Young died from multiple injuries as a result of a traffic accident in 10 May 2006. A semi-trailer, loaded with bricks, rolled over as it turned through a 90 degree bend in the road and collided with Ms Young's vehicle.

Coroner Lock handed down findings on 23 January 2008.

Recommendation 2

Queensland Transport investigates the Electronic Stability Program systems and if it is regarded as suitable and viable take up with the industry and the National Transport Commission its more widespread use.

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

The issue of mandating Electronic Stability Control/Electronic Stability Program systems for heavier commercial vehicles (over 3.5 tonne) is being explored as part of the *National heavy braking strategy*, a comprehensive review by the Department of Infrastructure, Transport Regional Development and local government (Australian Government) and the National Transport Commission to improve all aspects of heavy vehicle braking.

The strategy recognises that the United Nations Economic Commission for Europe has decided to amend Regulation 13 to require ESC on heavy vehicles in a staged introduction between 2010 and 2016. Australia currently has a policy of harmonising vehicle design rules with the Economic Commission for Europe.

Therefore it is acknowledged by the Australian Government and the National Transport Commission that Australia should, subject to regulatory impact statement, in-time mandate ESC for heavy vehicles.

The Australian Government recently provided for comment a timetable for the development of Australian Design Rules relating to heavy vehicle braking to the Australian Design Rules Technical Liaison Group, which includes states, territory and industry representatives.

The proposed timeframes indicated by the Australian Government and the National Transport Commission for the implementation of the rule is 2015.

Inquest into the death of Samantha Anne Maslen

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

Ms Maslen's death is one of 10 deaths that occurred in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests have been held into each of those deaths.

The *Coroners Act 2003* authorises a coroner conducting an inquest to comment on anything connected to the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. To maximise the evidence base, the State Coroner postponed making any such comments in these cases until all 10 deaths had been heard. At that stage a further hearing was convened and evidence heard in relation to the Queensland Police Service's pursuit driving policy.

The State Coroner handed down thirteen recommendations on 31 March 2010 relating to the Queensland Police Service's pursuit driving policy. The Government's response to the State Coroner's recommendations will be included in the report *Queensland Government's response to coronial recommendations 2010*.

State Coroner Barnes handed down findings on 28 August 2008.

Comment 1, page 21

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

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

Response and action
Under consideration
Responsible agency: Queensland Police Service

Beginning with a trial in two districts from 1 October 2006 and expanding to a statewide trial from 1 January 2008, the Queensland Police Service has introduced a rigorous and more restrictive safe driving policy to address the risks involved in urgent duty and pursuit driving. The new policy was complemented by new offence provisions to deal with motorists who seek to evade police. The policy introduced the concept of non-pursuit matters and gives detailed guidance on when a pursuit may be commenced, what risk factors must be considered and when a pursuit must be abandoned. Training was delivered to all staff (including civilian radio operators) up to and including the rank of inspector, in all

districts and branches between 1 July and 31 December 2007. In addition, consistent with recommendations from the Crime and Misconduct Commission and the State Coroner, from semester one 2008, police pursuits have formed part of ongoing operational skills and tactics training.

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Inquest into the death of Elise Susannah Neville

In January 2002, while on holidays, Elise Neville fell from the top bunk she was sleeping in. Her parents took her to the Caloundra Hospital and she was discharged back into the care of her parents. Later in the morning an ambulance was called to their unit and Elise was transported by ambulance back to the hospital and then air lifted to the Royal Children's Hospital in Brisbane. Elise's neurological condition continued to deteriorate following surgery and on 9 January 2002 a decision was made to cease life support.

Coroner Lock handed down findings on 12 September 2008.

Recommendation 9

The warning label on bunk beds as provided by the Australian Standard be reviewed by the Office of Fair Trading and other relevant authorities as soon as possible with a consideration that if there is to be a label for bunk beds it should not be age specific or at the very least increasing the age categories for the warning to up to age 14.

Response and action
Agreed and partially completed
Responsible agency: Department of Employment, Economic Development and Innovation

This matter is under consideration by the Australian Standards Technical Committee for bunk beds. The committee last met on 7 and 8 December 2009.

The Standards Technical Committee responsible for bunk beds met in March 2009. The outcome was that there was agreement for the age warning on bunk beds to state that bunk beds are 'not suitable for children under 12'.

It was first thought this change would go through unopposed, however there has since been significant industry opposition to changing the age warning. This objection has mainly come from the camping and holiday camp industry who allege that such a requirement (even if it only remains a recommendation) would decimate their industry. Eighty of the 103 comments received in relation to the draft standard objected to the increase in the age warning.

The outcome from the committee meeting on 7-8 December 2009 was that the warning would be changed to:

'*WARNING: TOP BUNKS AND ELEVATED BEDS ARE DANGEROUS AND ARE NOT RECOMMENDED FOR CHILDREN UNDER THE AGE OF 9*'.

There would also be a new requirement – the information leaflet to be provided with the bunk beds would be required to state:

'*WARNING: TOP BUNKS AND ELEVATED BEDS ARE DANGEROUS AND ARE NOT RECOMMENDED FOR CHILDREN UNDER THE AGE OF 9*

Children at the age of 11 and 12 years who sleep in elevated beds are estimated to have a three-times greater risk of hospital-treated injury than those who sleep in standard-height

beds. This estimate increases to a seven-times greater risk for children aged 9 and 10 years, and a ten-times greater risk for children aged seven and eight years. Children younger than seven years are at even higher relative risk from elevated beds. A fall from an elevated bed onto a covered concrete floor can be fatal'.

It was also agreed that a Standards Australia handbook be published to provide guidance to the accommodation industry on providing safe bunk beds.

The revised Australian Standard for bunk beds is expected to be published by the end of April 2010.

The Australian Standards handbook is currently being progressed by a Standards Australia working group. This work should be completed by August 2010.

Inquest into the death of Joseph Douglas Duncan

Mr Duncan died on 9 January 2006 from injuries sustained in a car crash when the car he was a passenger in was involved in a police pursuit.

Mr Duncan's death is one of 10 deaths that occurred in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests have been held into each of those deaths.

The *Coroners Act 2003* authorises a coroner conducting an inquest to comment on anything connected to the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. To maximise the evidence base, the State Coroner postponed making any such comments in these cases until all 10 deaths had been heard. At that stage a further hearing was convened and evidence heard in relation to the Queensland Police Service's pursuit driving policy.

The State Coroner handed down thirteen recommendations on 31 March 2010 relating to the Queensland Police Service's pursuit driving policy. The Government's response to the State Coroner's recommendations will be included in the report *Queensland Government's response to coronial recommendations 2010*.

State Coroner Barnes handed down findings on 24 October 2008.

Comment 1, page 15

At the completion of the seven inquests connected to police pursuits, the Coroner will address the policy issues thrown up by these cases.

In this case there seemed a degree of uncertainty about when the pursuit controller assumed control of the pursuit. The policy is silent on that issue and on whether the transfer of control should be communicated to the pursuing officer.

Response and action
Under consideration
Responsible agency: Queensland Police Service

Beginning with a trial in two districts from 1 October 2006 and expanding to a statewide trial from 1 January 2008, the Queensland Police Service has introduced a rigorous and more restrictive safe driving policy to address the risks involved in urgent duty and pursuit driving. The new policy was complemented by new offence provisions to deal with motorists who seek to evade police. The policy introduced the concept of non-pursuit matters and gives detailed guidance on when a pursuit may be commenced, what risk factors must be considered and when a pursuit must be abandoned. Training was delivered to all staff (including civilian radio operators) up to and including the rank of inspector, in all districts and branches between 1 July and 31 December 2007. In addition, consistent with recommendations from the Crime and Misconduct Commission and the State Coroner, from semester one 2008, police pursuits have formed part of ongoing operational skills and tactics training.

Inquest into the death of Joseph Douglas Duncan

The State Coroner has indicated that at the completion of the seven inquests connected to police pursuits, the policy issues arising from the inquests would be addressed. Accordingly, the specific recommendations arising from this and the other inquests will be considered by the Queensland Police Service once the State Coroner's final report is delivered.

Finalisation of any policy recommendations made as a result of this and other related inquests will be subject to the timing of the State Coroner's final report.

Inquest into the death of Kristina Ann Tynan

Ms Tynan was a passenger in a car which was the subject of a police pursuit on 22 May 2006. Ms Tynan died from injuries sustained when the car crashed into a lagoon after the pursuit was terminated.

State Coroner Barnes handed down findings on 27 November 2008.

Ms Tynan's death is one of 10 deaths that occurred in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests have been held into each of those deaths.

The *Coroners Act 2003* authorises a coroner conducting an inquest to comment on anything connected to the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. To maximise the evidence base, the State Coroner postponed making any such comments in these cases until all 10 deaths had been heard. At that stage a further hearing was convened and evidence heard in relation to the Queensland Police Service's pursuit driving policy.

The State Coroner handed down thirteen recommendations on 31 March 2010 relating to the Queensland Police Service's pursuit driving policy. The Government's response to the State Coroner's recommendations will be included in the report *Queensland Government's response to coronial recommendations 2010*.

Comment 1, page 2

There are two aspects of the investigation which raise some concern: Neither officer in the pursuing vehicle was required to undertake a breath test following the pursuit.

The driver of the crashed vehicle, Mr Keyworth, was initially interviewed, both at the roadside and later in hospital, by Senior Constable Behne – the senior officer in the pursuit vehicle.

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

This matter was fully investigated by the Queensland Police Service with Ethical Standards Command oversight. The investigation was finalised on 30 November 2006.

It is noted that the State Coroner stated that he was not suggesting that these two lapses undermined the integrity of the investigation. He stated that the investigation was thorough and professionally conducted.

The Queensland Police Service believes that current policy as set out below adequately addresses these types of issues.

Queensland Police Service policy (contained in section 21.14.17: *Critical incident testing* of the Human *resource management manual*) provides that alcohol and drug testing should be conducted on members involved in critical incidents, including vehicle pursuits in which a

person dies, or because of which a person is admitted to hospital for treatment of injuries. This policy reflects the legislative provisions currently provided in part 5A: *Alcohol and drug tests* of the *Police Service Administration Act 1990*.

Additionally, it is Queensland Police Service policy that wherever practicable, members who are involved in an incident causing death or serious injury, or who are witnesses to the incident, do not undertake or continue to perform duties associated with the investigative process or other duties at the scene. This policy is currently provided in section 1.17.2 of Commissioner's Circular 19/2009: *Investigation of deaths in custody or as a result of police operations – Amendments to Coroners Act 2003*.

Inquest into the death of Craig Robert Shepherd

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

State Coroner Barnes handed down findings on 12 December 2008.

Mr Shepherd's death is one of 10 deaths that occurred in Queensland during or following a police pursuit between June 2005 and July 2008. Inquests have been held into each of those deaths.

The *Coroners Act 2003* authorises a coroner conducting an inquest to comment on anything connected to the death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. To maximise the evidence base, the State Coroner postponed making any such comments in these cases until all 10 deaths had been heard. At that stage a further hearing was convened and evidence heard in relation to the Queensland Police Service's pursuit driving policy.

The State Coroner handed down thirteen recommendations on 31 March 2010 relating to the Queensland Police Service's pursuit driving policy. The Government's response to the State Coroner's recommendations will be included in the report *Queensland Government's response to coronial recommendations 2010*.

Comment 1, page 21

The Coroner is of the view that Queensland Police Service policy was breached when the pursuit was not terminated when the motorcycle entered onto Beechmont Road. The State Coroner is of the view the policy was breached when the police communications centre was not advised the pursuit was underway.

Comment 2, page 25

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

Response and action
Under consideration
Responsible agency: Queensland Police Service

All disciplinary matters referred to the Queensland Police Service are dealt with in accordance with existing policy and relevant legislation. The Queensland Police Service has a comprehensive complaint management and discipline process, designed to satisfy the requirements of the *Police Service Administration Act 1990, Police Service (Discipline) Regulations 1990* and *Crime and Misconduct Act 2001*. Queensland Police Service policy in relation to complaint management is contained in chapter 18 of the *Human resource management manual*. The Queensland Police Service also provides clear guidelines concerning the standards of conduct expected of its members. These guidelines are largely

contained in chapter 17: *Professional Conduct* of the Queensland Police Service *Human resource management manual*.

The conduct of the four officers involved in this particular incident is currently being investigated in accordance with the Queensland Police Service discipline process.

It is anticipated the discipline process in relation to this matter will be finalised by mid 2010.

Inquest into the death of Rhonda Joy Steggall

On 21 December 2006, Mrs Steggall was involved in a single vehicle accident on a country road near Rockhampton. Mrs Steggall lost control of her vehicle on a bend in the road which had been subject to road works in the preceding days by Rockhampton Regional Council.

Coroner Hennessy handed down findings on 17 December 2008.

Recommendation 1

The Department of Main Roads consider changes to the *Manual of uniform traffic control devices* (part 3 – 2007 *Works on roads*) in order to require signage to remain in place until the hazard ceases to exist or warn of a change in road conditions including changed lane width, changed grade or physical attribute of the road surface including roughness or slipperiness of surface.

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

Revision of the *Manual of uniform traffic control devices* has been completed. This revision included new practices with respect to the use of road condition signs. The practice allows for advisory speed signs to be used with road condition signs in situations where a reduction in speed is desirable for traffic safety reasons.

Inquest into the death of John Ernest Venturato

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

Coroner Brassington handed down findings on 22 December 2008.

Recommendation 1

A traffic safety management plan be developed and distributed to all escort members before the escort takes place and that plan be required as part of the permit process where the wide load effectively blocks the road to other road users.

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

The Queensland Police Service currently provides policy guidance (in chapter 10 of the Queensland Police Service *Traffic manual*) on the issue of excess dimension vehicle permits and the conduct of escorts of such vehicles. This policy emphasises that the safety of all road users is the primary responsibility of Queensland Police Service officers. In early 2008 the Queensland Police Service introduced a training course specifically for officers undertaking such escorts. The training course includes theoretical and practical components. As from 27 February 2009, only officers who have completed the relevant training are permitted to conduct such escorts.

The Queensland Police Service is currently participating in a working group chaired by the Department of Transport and Main Roads which is reviewing the performance guidelines for the movement of oversize vehicles. At the conclusion of this review it is anticipated that amendments to Queensland Police Service policy will be progressed to require the development and distribution of a traffic safety management plan as part of the police excess dimension vehicle permit issuing process.

The expected completion date for the review and the development of any necessary amendments to Queensland Police Service policy is late 2010.

Response and action
Agreed and being implemented by the Queensland Police Service
Responsible agency: Department of Transport and Main Roads

Approval to move vehicles wider than 5.5m is solely a matter for the Queensland Police Service. Transport and Main Roads have worked with the Queensland Police Service to identify improvements to systems and processes in relation to risk identification and conditions.

The Queensland Police Service has advised that a traffic safety management plan is to be developed and submitted for over dimensional loads which require police officers as escorts

and that this will be a condition of police issued permits for loads in excess of 4.5 metres wide on critical roads and loads in excess of 5.5 metres wide on all roads.

The requirement for a traffic safety management plan will be included in the Queensland Police *Traffic manual* following the completion of the review of the Guidelines for excess dimension vehicles carrying indivisible articles and special purpose vehicles (Form 4). The Working Group for the review is chaired by the Department of Transport and Main Roads.

The Queensland Police Service has advised that the expected completion date for the review and inclusion in the *Traffic manual* is late 2010.

Recommendation 2

The procedures and permit conditions from Main Roads and Queensland Police Service be more explicit when describing the risk of transporting a wide load on a two lane road.

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

The Queensland Police Service currently provides policy guidance in chapter 10 of the Queensland Police Service *Traffic manual* on the issue of excess dimension vehicle and/or load permits and the conduct of escorts of such vehicles and/or loads. This policy emphasises that the safety of all road users is the primary responsibility of Queensland Police Service officers. In early 2008 the Queensland Police Service introduced a training course specifically for officers undertaking such escorts. The training course includes theoretical and practical components. As from 27 February 2009, only officers who have completed the relevant training are permitted to conduct such escorts.

The Queensland Police Service is currently participating in a working group chaired by the Department of Transport and Main Roads which is reviewing the performance guidelines for the movement of oversize vehicles. The Queensland Police Service has consulted with stakeholders at this working group and it has been agreed to include a more explicit warning in the guidelines for oversize load movements on two lane roads. Once the review of these guidelines is finalised, it is anticipated that similar amendments will be incorporated into Queensland Police Service policy.

The expected completion date for the review and the development of any necessary amendments to Queensland Police Service policy is late 2010.

Response and action
Agreed and being implemented by the Queensland Police Service and the Department of Transport and Main Roads
Responsible agency: Department of Transport and Main Roads

Approval to move vehicles wider than 5.5m is solely a matter for the Queensland Police Service. The Department of Transport and Main Roads have worked with the Queensland Police Service to identify improvements to systems and processes in relation to risk identification and conditions.

The Queensland Police Service have advised that conditions on permits will be made more explicit. The Working Group reviewing the Guidelines for excess dimension vehicles carrying indivisible articles and special purpose vehicles (Form 4), chaired by the Department of Transport and Main Roads, has consulted with the Queensland Police Service and has agreed a more explicit warning be included in the guidelines for oversize load movements on two lane roads.

Expected completion date for the review and inclusion of this requirement is mid 2010.

Recommendation 4

More attention be given to the appropriate spacing between the first pilot vehicle, police vehicles and the wide load while the escort is underway. This aspect should be included in any training given to police officers.

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

The Queensland Police Service introduced mandatory training for officers performing excess dimension/mass vehicle escorts as of 27 February 2009. The Service policy regarding this training is contained in chapter 10 of the Queensland Police Service *Traffic manual*. This training consists of theoretical and practical components. In light of the Coroner's recommendation in this instance, as of June 2009, the content of this training course has been updated to provide greater emphasis on the need to maintain the appropriate spacing of escort vehicles while the escort is underway and of the environmental and road conditions that may impact upon this.

Recommendation 5

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

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

The Queensland Police Service currently provides guidance, (in chapter 10 of the Queensland Police Service *Traffic manual*) to officers issuing permits for the movement of excess dimension vehicles/loads, on the type of lighting required. In response to the Coroner's recommendation, a review of this information is currently being undertaken.

The National Transport Commission has advised that a current proposal to allow the use of light emitting diode lights as warning lights is under consideration nationally. This will also take into consideration glare issues. The findings of the National Transport Commission will be considered as part of the Queensland Police Service review of its existing guidelines.

Finalisation of any required amendments to Queensland Police Service guidelines will be subject to the timing of the National Transport Commission's findings.

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

The requirement for utilising warning lights on oversize vehicles in all jurisdictions is a reflection of National Model Law which falls under the responsibility of the National Transport Commission. The matter of adopting alternative lights for use in oversize vehicles is a complex issue. Previously the use of strobe lights has been rejected.

The National Transport Commission has advised that any consideration to review national rules relating to movement of oversize vehicles, including alternative lights may be considered as part of the National Heavy Vehicle Regulator Reform as agreed by the Council of Australian Governments.

The National Regulator is to be in operation in 2012.

Comment 1, page 38

The Department of Transport's submission states the guidelines governing the operation of oversize vehicles are developed for loads under 5.5m while for loads over 5.5m with a police escort the police officer issuing the permit is actually responsible for setting the appropriate conditions that may apply to ensure the safe movement of the vehicle. Queensland Transport does acknowledge that it is not the practice for the permits to depart from the performance guidelines issued by the department. This is understandable given the individual Queensland Police Service officers issuing permits may lack the requisite expertise to depart from the guidelines. Nevertheless the present system of guidelines and police permits does not comprehensively assign responsibility to who determines signage for wider loads than 5.5 m. The present Queensland Transport review may wish to consider this issue.

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

Approval to move vehicles wider than 5.5m is solely a matter for the Queensland Police Service. The Department of Transport and Main Roads has worked with the Queensland Police Service to identify improvements to systems and processes in relation to risk identification and conditions.

The Department of Transport and Main Roads and the Queensland Police Service have consulted and agreed on a number of improvements to the Guidelines for excess dimension vehicles carrying indivisible articles and special purpose vehicles (Form 4) in particular

more explicit conditions on permits issued by the Queensland Police Service and the introduction of traffic management plans for loads requiring Queensland Police Service escort.

Warning signs are regulated nationally via the National Transport Commission's Oversize and Overmass Regulations. Queensland has adopted these national regulations. The issue of appropriate warning signs was considered when the national regulations were developed and 'wide load' was considered the most appropriate warning sign. This sign is now used uniformly across Australia. Therefore, amending the current wide load warning sign is not supported by Department of Transport and Main Roads.

Comment 2, page 41

Given the complex issues relating to these recommendations the Coroner considers it more appropriate to refer the issue to the Queensland Police Service and Queensland Transport for consideration as to whether review of existing notification procedures should be considered.

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

It is current Queensland Police Service policy that clear directions are given to all road users. It is important that road users quickly understand what the escorting officer is trying to convey to them so that they may take evasive action before the excess dimension vehicle passes. It is also stated in Queensland Police Service policy that adequate warning is to be given to motorists with as little inconvenience as possible to minimise danger when it is necessary for excess dimension vehicles and/or loads to contravene road rules.

The Queensland Police Service has tabled this issue at the Department of Transport and Main Roads chaired working group reviewing the performance guidelines for the movement of oversize vehicles and it has been agreed that in certain circumstances motorists should be required to come to a complete stop in order for an over dimensional load to negotiate an obstacle or traverse an area or roadway deemed at risk. However, there was no support for the notion that motorists should be compelled to come to a complete stop while the load is in motion in most instances. The requirement for a traffic safety management plan as outlined in recommendation 1, will identify areas of risk and appropriate methods of traffic control.

At the conclusion of the review of the performance guidelines for the movement of oversize vehicles, it is anticipated that amendments to Queensland Police Service policy will be progressed to require the development and distribution of a traffic safety management plan as part of the police permit issuing process.

The expected completion date for the review and the development of any necessary amendments to Queensland Police Service policy is late 2010.

Response and action
Agreed in part and being implemented by the Queensland Police Service
Responsible agency: Department of Transport and Main Roads

Approval to move vehicles wider than 5.5m is solely a matter for the Queensland Police Service. The Department of Transport and Main Roads has worked with the Queensland Police Service to identify improvements to systems and processes in relation to risk identification and conditions.

The Department of Transport and Main Roads, in consultation with the Queensland Police Service through the Working Group, reviewing the Guidelines for excess dimension vehicles carrying indivisible articles and special purpose vehicles (Form 4), have agreed that in certain circumstances motorists will be required to come to a complete stop in order for an over dimensional load to negotiate an obstacle or traverse an area of roadway deemed at risk.

However, there was no support for the notion that motorists should be compelled to come to a complete stop whilst the load is in motion in most instances. The requirement for a traffic safety management plan as outlined in recommendation 1 will identify areas of risk and appropriate methods of traffic control.

The expected completion date for the review and inclusion in the Queensland Police *Traffic manual* is late 2010.

Comment 5, page 46

Professor Troutbeck recommends that the Queensland Police Service and Queensland Transport (the department) review the procedures of transporting wide indivisible loads on two lane rural roads. He also recommends that the Queensland Police Service risk matrix make a distinction between wide loads carried on two lane roads and those carried on roads with more than two loads (lanes). However, information has been provided that such a review is already underway. These recommendations may be more appropriately considered in that review. These findings may provide some assistance to that review.

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

The Queensland Police Service is currently participating in a working group chaired by the Department of Transport and Main Roads which is reviewing the performance guidelines for the movement of oversize vehicles. Once the review of these guidelines is finalised, amendments to the Queensland Police Service *Minimum requirement for over dimensional load vehicle escorts matrix* will be progressed to address the issue raised by the Coroner.

The expected completion date for the review and the development of appropriate amendments to Queensland Police Service policy is late 2010.

Inquest into the death of John Ernest Venturato

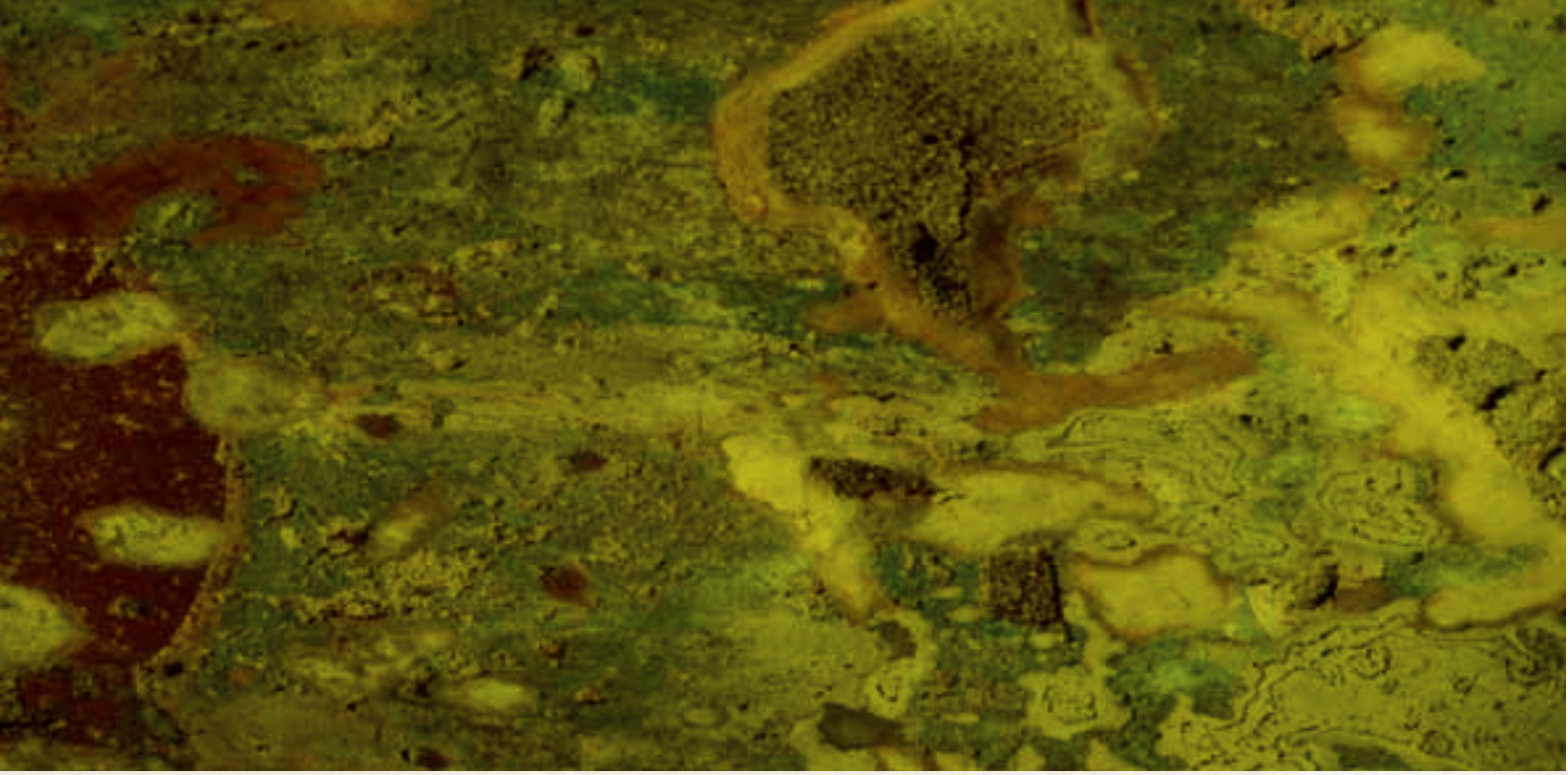
Response and action
Agreed and being implemented by the Queensland Police Service
Responsible agency: Department of Transport and Main Roads

Approval to move vehicles wider that 5.5m is solely a matter for the Queensland Police Service. The Department of Transport and Main Roads has worked with the Queensland Police Service to identify improvements to systems and processes in relation to risk identification and conditions.

The Queensland Police Service advises the matrix in the Queensland Police *Traffic manual* to the effect that loads with a width of between 5.5 metres and 6.5 metres will include a requirement for an additional pilot vehicle during the hours of darkness on roads other than multi-lane roads.

This will form part of the amendments already identified by the Department of Transport and Main Roads Working Group reviewing the Guidelines for excess dimension vehicles carrying indivisible articles and special purpose vehicles (Form 4).

The expected completion date for the review and inclusion in the Police *Traffic manual* is late 2010.



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