Inquest into the death of Samuel John Beresford

Mr Beresford died on 17 March 2011 as a result of severe head and upper body injuries after being struck on 9 March 2011 by the propeller blades of a gyroplane.

Mr Beresford lost control of his gyroplane when he attempted to start it from outside the cockpit. The engine went to high revolutions, dragging him in the direction of travel before moving forward of his position, resulting in the propeller blades striking his head and upper body.

The now Deputy State Coroner John Lock delivered his findings of inquest on 5 December 2013.

The Queensland Government responds to recommendations directed to government agencies at inquests by informing the community if a recommendation will be implemented or the reason why a recommendation is not supported. Further information relating the implementation of recommendations can be obtained from the responsible agency named in the response.

Recommendation 1

Whether there should be appropriate secure vehicle holding-yard facilities in the Cunnamulla area is a matter that should be considered by the Queensland Police Service.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Police Service.

Cunnamulla station has an approved property point consisting of a secure holding yard for the storage of vehicles. The yard is sufficient for Cunnamulla police normal storage requirements, but is not large enough to store aircraft.

A larger secure compound is available at Charleville, which is suitable for aircraft storage. The individual circumstances of an investigation are taken into consideration by officers when determining the use of secure vehicle holding yard facilities.

Recommendation 2

Sergeant Relf has advised that there have been a number of aviation fatalities in the area in recent years. He should be permitted to undertake an Australian Transport Safety Bureau aviation accident investigation training course when the next course vacancy is available.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Police Service.

Previously, the Australian Transport Safety Bureau sponsored Queensland Police Service personnel to attend their courses. However, from 2014 the Australian Transport Safety Bureau outsourced their training to an external provider and the Queensland Police Service is now responsible for the cost of attending the course in Canberra. It is currently unknown if the Queensland Police Service will be offered any places on the next available aircraft accident investigation fundamentals course. Regional assistant commissioners will assess invitations for training from the Australian Transport Safety Bureau on a case by case basis.

Sergeant Relf completed a human factors component as part of his forensic crash qualifications which is applicable to the Human factors for transport safety investigations course offered by the Australian Transport Safety Bureau.

Recommendation 3

The Queensland Police Service should identify and ensure there is a trained pool of officers to specialise in aviation accident investigations. Such officers could then be available to provide initial advice to on-scene investigating officers and could be assigned as the primary investigator for aviation incidents wherever possible.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Police Service.

Six Forensic Crash Unit investigators were trained in 2009-2012 at the Australian Transport Safety Bureau course. Participants were selected from the Brisbane, Wide Bay and Sunshine Coast forensic crash units.

A further 41 officers throughout the state ranging from general duties, Forensic Crash Unit investigators, Criminal Investigations Branch, Child Protection Investigation Unit and Scenes of Crime Unit completed the course. The eastern sea-board of Queensland is covered from Cairns to the Gold Coast, Toowoomba and west to Emerald. This provides a spread of trained Australian Transport Safety Bureau officers available for advice to first response police officers.

The Australian Transport Safety Bureau outsourced their training to another provider in 2014 and attendance at such courses is now on an invitation-only basis. When invitations are received from the Australian Transport Safety Bureau they will be assessed on a case by case basis by individual regional assistant commissioners.

As this is a Commonwealth course, the Queensland Police Service is unable to manage the risks associated with the potential lack of training spots and costs associated with this training, other than by expressing interest in attending a course.

Recommendation 4

The Queensland Police Service should review section 8.5.12 of the Queensland Police Service *Operational procedures manual* entitled 'Aircraft incidents resulting in death' to remove any ambiguity relating to release of aircraft procedures where the incident is not being investigated by the Australian Transport Safety Bureau.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Police Service.

Section 8.5.12: 'Aircraft incidents resulting in death' of the *Operational procedures manual* was amended to remove the ambiguity regarding the release of the aircraft to other investigating authorities, by requiring the investigating officer to first contact the coroner's office prior to release.

The amendments to the *Operational procedures manual* were published in June 2014 and all members were informed via a statewide email.

Recommendation 5

Workplace Health and Safety Queensland should review its procedures to ensure that relevant agencies are notified about the outcome of their investigations at the conclusion of their investigations.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Treasury.

Following a review of current policies and procedures, it is considered that current processes are sufficient to meet the intent of this recommendation.

In accordance with current operational procedures and in conjunction with the effective application of the memoranda of understanding, relevant agencies are, or can be notified upon request, of the outcome of any investigation completed by Workplace Health and Safety Queensland or the Electrical Safety Office.

Recommendation 6

Workplace Health and Safety Queensland should ensure machinery is not released or disposed of without the coroner's permission where the investigation relates to a 'reportable death' under the Coroners Act.

Response and action: the recommendation is implemented.

Responsible agency: Queensland Treasury.

On 1 January 2013 the Office of Fair and Safe Work Queensland implemented an operational procedure that specifies that the relevant coroner must be consulted prior to releasing any evidence related to a work place death. The operational procedure is used for training inspectors and is readily available to all staff on the departmental intranet site.