QUEENSLAND COURTS

Coroners Court of Queensland
Inquest List for November 2017

at 30 October 2017

Name of deceased	Inquest date and location	Coroner	Issues to be considered	NPO
Ackerman, James William	Findings scheduled for 09 Nov 2017 at 10:00am in Court 4 BRISBANE	John Lock	1. The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death. 2. The circumstances surrounding the on field incident involving Francis Molo and James Ackerman during the InTrust Super Cup match between the Norths Devils and Sunshine Coast Falcons on 20 June 2015. 3. Actions taken by Queensland Rugby Football League Ltd, the Queensland Police Service and Workplace Health and Safety Queensland in response to James' death. 4. Actions taken by Brisbane Broncos Rugby League Club Ltd and Francis Molo to manage the risk to player safety associated with shoulder charges, both prior and subsequent to James' death. 5. Actions taken by Queensland Rugby Football League Ltd and, where applicable, National Rugby League Ltd to improve player safety in relation to the risks associated with shoulder charges. 6. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003.	No
Appleton, Garry Ronald (combined with MALONE)	Inquest adjourned DTBF for findings	Terry Ryan	1. The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death; 2. The adequacy of the health care (including mental health care) provided to the deceased after his arrival at Brisbane Correctional Centre ("BCC") on 1 May 2015; and 3. The availability of razor blades to prisoners in Queensland correctional facilities.	No
Beale, Tracy Ann	Inquest adjourned DTBF for hearing	David O'Connell	1. The findings required by section 45(2) of the Coroners Act 2003, including: (a) Who was the deceased person? (b) How did the person die? (c) When did the person die? (d) Where did the person die? 2. Was Ms Beale's death due to: (a) Asphyxia; (b) Vasovagal attack (or reflex cardiac arrest); (c) A combination of (a) and (b); or (d) Other cause, or causes? 3. What is the probability that: (a) dilated cardiomyopathy and/or, (b) consumption of alcohol, contributed, in some degree, to Ms Beale's death? 4. Is there a need for a program of education to raise public awareness as to the dangers inherent in some forms of neck compression or restraint? 5. Should a recommendation be made to the Attorney-General that consideration be given to: (a) Whether neck compression or restraint which causes death should receive legislative attention in the same or a similar way as "One punch" strikes to the head or neck? (cf section 314A Criminal Code)? (b) Whether neck compression, in and of itself, in a domestic setting, should receive legislative attention (cf section 315A Criminal Code)?	No
Brown, Holly Winta	Inquest scheduled for 29 Jan - 1 Feb 2018 at 11:00 am in Court TBA at CAIRNS	Nerida Wilson	1. The identity of the deceased, when where and how she died and what caused the death. 2. The adequacy or otherwise of the planning for the 2015 Laura Races, Camp draft and Rodeo, including the planning for provision of emergency medical care. 3. The adequacy or otherwise of the medical care received by the deceased on the day of her death.	No
Brown, Samuel Timothy	Inquest scheduled for 19 to 23 Mar 2018 at 10.00am in Court TBA at SOUTHPORT	James McDougall	1. The findings required by s.45 (2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how they died and the cause of their death. 2. The circumstances surrounding the death, including the mechanism by which the injuries were inflicted, and the involvement of another party. 3. The response of the Queensland Police Service to the death, including the basis for decisions about prosecution actions. 4. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances.	No

Brown, Stephen Ross	Inquest scheduled for 30 to 31 Jan 2018 at 10.00 in Court TBA at BRISBANE	John Lock	1. The findings required by s.45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death. 2. The circumstances leading up to the single vehicle accident on 27 August 2014. 3. Whether the deceased's employer took reasonable steps to ensure the deceased's safety when driving the vehicle involved in the accident, particularly with regards to maintenance and repair of the vehicle. 4. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003.	No
Chan, Shui Ki	Findings scheduled for 02 Nov 2017 at 11:30 in Court at BRISBANE	John Hutton	1. The findings required by section 45 (2) of the Coroners Act 2003; namely the identity of the deceased person, how, when and where he died, and what caused his death; and 2. Whether any recommendations can be made to reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public safety or the administration of justice.	No
Cheney, Danny George	Inquest adjourned DTBF for findings	Kevin Priestly	The circumstances of Mr Cheney's death and its implications for the effectiveness of the safety management system, in particular: 1. What were the safe operating procedures; 2. Was there compliance with the procedures and if not, why? 3. What training was provided to Mr Cheney and crew about the task being performed, and how effective was that training? 4. How compliance with the safe working procedure was monitored and how effective was that monitoring? 5. Was that procedure subject to auditing and review, and if so, how effective was that process? 6. Was there an accident and incident reporting and investigation process in place, were there similar incidents in the past, if so - how were they investigated and the lessons learnt translated in remedial action within the safety management system? 7. How effective was the emergency response plan as executed?	No
Double fatality Walkerston - Glennon, Lardeen Bernadette & Glennon, Matthew David	Inquest scheduled for 21 Nov 2017 to 23 Nov 2017 at 10:00am in Court 3 at MACKAY	David O'Connell	1. The findings required by section 45(2) of the Coroners Act 2003, namely the identity of the deceased persons, when, where and how they died, and what caused their deaths? 2. (a) Was the signage (including the posted speed limit of 100kph) adequate to protect the safety of the travelling public on that section of the Peak Downs Highway? (b) Was there any feature of the Peak Downs Highway which contributed, either wholly or in part, to the circumstances of this collision? 3. What was the speed, immediately before and at the time of the collision, of – (a) the vehicle driven by Mrs Lardeen GLENNON; and (b) the vehicle driven by Mr Adam WISLEY? 4. Did Mrs Glennon signal her intention to turn right off the highway? 5. What caused the collision between the two vehicles; and in particular, was speed, or excessive speed, a factor contributing to the collision? 6. (a) Whether the law relating to the reception of evidence provided by Airbag Control Modules (Event Data Recorders) should be reviewed, by reference to their potential admissibility in proceedings arising from the driving or operation of motor vehicles?; and (b) Whether the duties of overtaking drivers, as contained in the Road Rules (eg s.140), should be reviewed?	No
Finlayson, Eric Davis	Inquest adjourned DTBF for findings	Kevin Priestly	The circumstances surrounding the death of Eric Finlayson and the approach to recreational diving/snorkelling. In particular; fitness to snorkel, group management of snorkelling, effectiveness of lookouts, emergency response and regulators expectations and effectiveness of enforcement.	No
Gudge, Shawn Bradley Joseph	Inquest adjourned DTBF for findings	Kevin Priestly	1. The immediate circumstances surrounding death; 2. Clinical management and risk mitigation used relevant to the risk of suicide; 3. Management of environmental hazards relevant to the risk of inpatient suicide at Townsville Hospital Mental Health Unit, including implementation of previous coronial recommendations; and 4. Opportunities to improve management of the risk of suicide.	No

Hitchins, Steven John	Inquest adjourned DTBF for findings	Kevin Priestly	1. The immediate circumstances surrounding death; 2. Clinical management and risk mitigation used relevant to the risk of suicide; 3. Management of environmental hazards relevant to the risk of inpatient suicide at Townsville Hospital Mental Health Unit, including implementation of previous coronial recommendations; and 4. Opportunities to improve management of the risk of suicide.	No
Hou, Xiangxiong	Inquest adjourned DTBF for hearing	Nerida Wilson	Fair and Safe Work Queensland's engagement with accommodation providers about the safety of resort swimming pools following Mr Hou's death.	No
House, William John **Smith, Jodie Anne** **White, Vanessa Joan** **Milne, Daniel Keith**	Inquest adjourned DTBF for findings	James McDougall	1. The findings required by s.45(2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how they died and the cause of their death. 2. The prescribing of drugs of dependence by a number of different General Practitioners to each of the deceased, often at concurrent times. 3. The provision of drugs of dependence by treating Hospitals to the deceased. 4. The sufficiency of monitoring currently available in relation to the prescribing and dispensing of drugs of dependence in Queensland. 5. The adequacy of current practices in relation to the sharing of information between Hospitals, General Practitioners and the agencies responsible for monitoring the prescribing of drugs of dependence medicine, in relation to the overall management of shared patients. 6. What further actions could be undertaken to prevent doctor shopping and the inappropriate prescribing of drugs of dependence in Queensland? 7. What further actions could be undertaken to ensure that an integrated approach by all relevant participants is provided to patients, who are prescribed drugs of dependence?	No
Jacobs, Roy Rodney	Inquest adjourned DTBF for findings	Ainslie Kirkegaard	1. the findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death 2. the adequacy of the management of Mr Jacob's multiple emergency department presentations and subsequent admission to the Cherbourg Hospital over the period 28-31 August 2016 3. the appropriateness of the response of the Darling Downs Hospital and Health Service to the circumstances of Mr Jacobs' death including measures to enhance the management of patients presenting with apparent intoxication, recognition and response to clinical deterioration and medical officer staffing at Cherbourg Hospital	No
Jones, Anthony John	Inquest adjourned DTBF for findings	Terry Ryan	Scope of Inquest - The findings required by s.43(4) – (a) so far as has been proved — (i) the cause and circumstances of the disappearance of such missing person; and (ii) whether such missing person is alive or dead; and (iii) if such missing person is alive or likely to be alive—the whereabouts of such missing person at the time of the inquiry; and (b) the persons (if any) committed for trial. The scope of the inquest is as follows: — (a) whether or not a person has died; (b) the identity of the deceased person; (c) when, where, and how the death occurred; (d) the persons (if any) to be charged with murder, manslaughter, the offence of dangerous driving of a motor vehicle causing death as set forth in the Criminal Code, section 328A, or any offence set forth in the Criminal Code, section 311.	Yes
Kennedy, Dale Daniel	Inquest adjourned DTBF for findings	Kevin Priestly	The circumstances surrounding the death of Mr Kennedy including: 1. Compliance with the Wiring Rules at installation; 2. Management of the risk of electrocution in the ceiling space; and 3. Regulatory framework, standards, oversight and enforcement.	YES
Khazaei, Hamid	Inquest adjourned DTBF for findings	Terry Ryan	1. The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death.	No

Malone, Terrence Michael (combined with APPLETON)	Inquest adjourned DTBF for findings	Terry Ryan	1. The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death; 2. The adequacy of the health care (including mental health care) provided to the deceased after his arrival at Brisbane Correctional Centre ("BCC") on 7 November 2014; and 3. The availability of razor blades to prisoners in Queensland correctional facilities	No
MANN, Renae Jean	Inquest scheduled for 13 Dec 2017 at 10.00am in Court TBA at SOUTHPORT	James McDougall	1. The findings required by s.45 (2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how she died and the cause of her death. 2. The specific circumstances surrounding Ms Mann's death. 3. The adequacy and appropriateness of the care and treatment provided to Ms Mann by Hospital staff following her admission, including her medical clearance and nursing care. 4. The appropriateness of utilising assessment pods for patients in the Hospital. 5. The sufficiency of the changes made to relevant Hospital policies and procedures following Ms Mann's death. 6. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances.	No
Martin, Christopher Leslie	Pre inquest conference scheduled for 10 November 2017 at 10:00 in Court 4 at BRISBANE	Terry Ryan	1. The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death; 2. The adequacy and appropriateness of the decision to restrain the deceased in the lead up to his death; 3. The adequacy and appropriateness of the manner by which the deceased was restrained in the lead up to his death; and 4. Whether any further recommendations can be made to prevent a death in similar circumstances from happening in the future.	No
Osborne, Warren Andrew	Inquest scheduled for 4 to 8 December 2017 at 10:00am in Court 4 at BRISBANE	Terry Ryan	1. The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death; 2. The adequacy and appropriateness of the decision to request for the deceased to be restrained in the lead up to his death; 3. The adequacy and appropriateness of the manner by which the deceased was restrained in the lead up to his death; 4. The adequacy and appropriateness of the manner by which the deceased's vital signs were checked during the restraint; 5. The adequacy and appropriateness of the training provided to employees of the Caboolture Hospital with respect to physically restraining a person; 6. Whether any further recommendations can be made to prevent a death in similar circumstances from happening in the future.	No

Shoal water Helicopter Crash Redfern, Haydn Jonathan & Schofield, Wayne Patrick	Pre inquest conference scheduled for 07 Nov 2017 at 11:00am in Court 3 at MACKAY	David O'Connell	1. The information required by section 45(2) of the Coroners Act 2003, namely: (a) when, where, and how Mr Schofield died, and what caused his death; and (b) when, where, and how Mr Redfern died, and what caused his death? 2. Whether the collision with terrain by Eurocopter helicopter VH-RDU on the 8th September 2011 was caused by, or contributed to by: (a) the failure of the aircraft's hydraulic pump drive belt; or (b) any other mechanical or technical fault in the aircraft? 3. (a) Whether the said collision was caused by, or contributed to by, pilot error? and (b) Whether the said collision was caused by, or contributed to by, adverse weather event? (c) Whether the experience of the pilot was adequate to the flight tasked to him? 4. Whether any feature of the helicopter landing site (HLS) at Double Mountain South was a contributing factor to the said collision? 5. What preventive measures (if any) relating to:- (i) remote mountaintop landing sites; (ii) as to assessed or demonstrated pilot experience, can be implemented in order to: (a) prevent such fatal events in the future; or (b) reduce the risk of re-occurrence of any event or state of affairs which may have contributed to these deaths?	NO
Robertson, Charlie Mark John	Inquest adjourned DTBF for findings	Terry Ryan	1. The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death; 2. The adequacy and appropriateness of the manner in which various police officers dealt with the (then unconscious) deceased man while in attendance at his residence on the morning of 13 June 2015; and 3. The adequacy of training provided to QPS officers with regard to recognising symptoms of a drug overdose.	No
Robinson, Breeana Elaine Stewart	Inquest scheduled for 27 Nov 2017 to 01 Dec 2017 at 10.00am in Court TBA at SOUTHPORT	James McDougall	1. The findings required by s.45 (2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how they died and the cause of their death. 2. The specific circumstances surrounding Breeana's death, particularly how she came to fall to her death. 3. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances.	No
Ross, Matthew Trent	Inquest scheduled for 20 Nov 2017 to 01 Dec 2017 at 10:00am in Court 4 at BRISBANE	John Lock	1. The findings required by s45(2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death. 2. The circumstances surrounding the death and, in particular, the chain of events leading to the deceased's death by electrocution. 3. The adequacy and timeliness of investigations conducted by police, work health and safety and electrical safety authorities in relation to the death. 4. What actions have been taken since the death to prevent deaths from happening in similar circumstances in the future. 5. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003.	No
Smit, Bernardus Johan	Inquest scheduled for 20 to 22 Dec 2017 at 10:00am in Court 4 at BRISBANE	John Lock	1. the findings require by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death; 2. The circumstances of the traffic incident on 8 September 2015 that resulted in the deceased's death; 3. Whether the driver involved was fit to hold a Queensland driver's licence at the time of the traffic incident on 8 September 2015; 4. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003.	No

Statis, Joshua	Inquest scheduled for 20 to 24 Nov 2017 at 10:00 in Court 5 at BRISBANE	Ainslie Kirkegaard	1. the findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death 2. the adequacy of Joshua's cardiac surgical and post-operative management at the Lady Cilento Children's Hospital during his admission from 26 October – 16 November 2015 including whether the sternal wound infection could have been identified sooner and whether Joshua should have been taken to theatre for emergency cardiac surgery sooner after his sudden deterioration in the early hours of 16 November 2015 3. what caused the CardioCel RVOT pericardial patch to rupture 4. the appropriateness of the response of the Lady Cilento Children's Hospital to the circumstances of Joshua's death including measures to enhance the recognition and response to clinical deterioration and management of patient deterioration requiring urgent direct ward to theatre transfer for urgent cardiac surgical intervention after hours	No
Thwaites, Andrew John	Inquest adjourned DTBF for findings	Christine Clements	• The findings required by section 45 of the Act, that is the identity of the deceased, how he died, when he died, where he died and what caused him to die; • Whether the organisation/coordination of the dive trip was appropriate; • The role and responsibilities of Keswick Island Charters Pty Ltd and Get Wet Scuba Adventures in relation to the dive trip; • Whether the conduct of the dive trip was appropriate. Particularly in relation to: ? Experience and qualifications of boat crew and other key personnel; ? Dive site and/or boat safety briefings; ? Dive site risk assessment; ? Site supervision; ? Number and location of supervisory personnel; ? First aid and emergency equipment; ? Dive buddy protocols; ? Emergency procedures and recovery efforts; • When and how did the contamination enter the deceased's SCUBA cylinders? • The Ingersol Rand 15T4 compressor owned and operated by the Underwater Research Group of Queensland ('URGQ') for the production of breathing air: ? Adequacy of servicing and maintenance; ? Adequacy of training provided to club members in the compressor's use; ? Adequacy of records in relation to SCUBA cylinders that were filled using the compressor; ? Adequacy of policies and procedures in place in relation to the compressor; ? The applicability of the current regulatory regime to URGQ in relation to the compressor and the filling and handling of SCUBA cylinders; • Whether there is a need to regulate persons, non-commercial groups or organisations that are involved in, or intend being involved in the supply, filling, storage and handling of SCUBA cylinders; • Recommendation pursuant to section 46; and • Referrals pursuant to section 48.	No
Vance, Jason John	Findings scheduled for 09 Nov 2017 at 11:00am in Court 4 at BRISBANE	John Lock	1. The findings required under section 45(1) & (2) of the Coroners Act 2003, namely; whether or not Jason John Vance is in fact deceased and, if so, how, when and where he died and what caused his death; 2. The circumstances surrounding the death; and 3. Whether any recommendations may be made to reduce the likelihood of deaths occurring in similar circumstances in the future or otherwise contribute to public health and safety or the administration of justice.	Yes