QUEENSLAND COURTS

# Coroners Court of Queensland
# Inquest List for May 2018
**at 24 April 2018**

| Name of deceased | Inquest date and location | Coroner | Issues to be considered | NPO |
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| **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 |
| **Banjo, Neil Richard** | Pre inquest conference scheduled for 16 May 2018 at 10:00 am in Court 5 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. | No |
| **Blair, Colin Wayne** | Inquest scheduled for 30 Apr 2018 to 03 May 2018 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;<br><br>2. The adequacy of the mental health treatment provided to the deceased in the lead up to his death, and whether a referral to the Prison Mental Health Service should have been made earlier;<br><br>3. The adequacy of the decisions made at the Risk Assessment Team meeting on 12 November 2015;<br><br>4. The adequacy of the observations regime of the deceased in his cell on the day of his death;<br><br>5. The adequacy of the response by Arthur Gorrie Correctional Centre and the Brisbane Correctional Centre to the recommendations made as a result of the investigations conducted by the Office of the Chief Inspector; and<br><br>6. The adequacy of the cells within the dependency unit of Brisbane Correctional Centre with regard to hanging points and the availability of aids to suicide | No |
| **Brown, Holly Winta** | Inquest adjourned DTBF for findings | Nerida Wilson | • The identity of the deceased, when where and how she died and what caused the death.<br>• 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.<br>• 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 21 May 2018 to 22 May 2018 at 10.00am in Court 16 at SOUTHPORT | James McDougall | I. 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.<br><br>II. The circumstances surrounding the death, including the mechanism by which the injuries were inflicted, and the involvement of another party.<br><br>III. The response of the Queensland Police Service to the death, including the basis for decisions about prosecution actions.<br><br>IV. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances. | No |

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| **Coolwell, Shaun Charles** | 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;<br>2. Whether the administration of midazolam by Queensland Ambulance Service officers was appropriate;<br>3. Whether the restraint of Mr Coolwell was appropriate; and<br>4. To consider if there are ways to prevent a similar death occurring in the future. | No |
| **Dreamworld River Rapids Fatalities**<br>**Araghi, Roozbeh;**<br>**Dorsett, Luke Jonathon;**<br>**Goodchild, Kate Louise; and**<br>**Low, Cindy.** | Pre inquest conference scheduled for 25 May 2018 at 10.00am in Court 16 at SOUTHPORT | James McDougall | • 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 what caused the death.<br><br>• The circumstances and cause of the fatal incident on the Thunder River Rapids Ride at the Dreamworld Theme Park, which occurred on 25th October 2016.<br><br>• Examination of the Thunder River Rapids Ride at the Dreamworld Theme Park, including but not limited to, the construction, maintenance, safety measures, staffing, history and modifications.<br><br>• Examination of the sufficiency of the training provided to staff in operating the Thunder River Rapids Ride.<br><br>• Consideration of the regulatory environment and applicable standards by which Amusement Park rides operate in Queensland and Australia, and whether changes need to be made to ensure a similar incident does not happen in the future.<br><br>• What further actions and safety measures could be introduced to prevent a similar future incident from occurring? | No |
| **Farrell, Bethany Emily** | Inquest scheduled for 22 May 2018 to 24 May 2018 at 10:00am in Court TBA at MACKAY | David O'Connell | 1. The information required by section 45(2) of the Coroners Act 2003, namely when, where, and how, did Miss Farrell die, and what caused her death?<br><br>2. Was the conduct of Miss Farrell's dive excursion conducted in accordance with the Recreational Diving, Recreational Technical Diving and Snorkelling Code of Practice 2011 and with best safety principles?<br><br>3. Were the weather, location, and ocean conditions on 17th February 2015 suitable for novice divers learning to dive?<br><br>4. What caused Miss Farrell to become separated from her dive group at Blue Pearl Bay on the 17th February 2015?<br><br>5. Should novice divers first satisfactorily demonstrate elementary dive skills in a controlled environment, such as a pool, before participating in an Open Water dive to reduce the risk of future diving fatalities? | No |
| **Giorgio, Pasquale** | Inquest scheduled for 02 Jul 2018 to 06 Jul 2018 at 10:00am in Court TBA at SOUTHPORT | John Lock | 1. The findings required by s.45 (2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how he died and what caused his death.<br>2. The circumstances surrounding the death of the deceased whilst in police custody in Victoria Park, Broadbeach on Tuesday 5 April 2016 (including police interaction with the deceased on the day of his death and the day prior, Monday 4 April 2016.<br>3. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003. | No |

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| **Hamilton, Blair Andrew** | Inquest scheduled for 11 Jun 2018 to 15 Jun 2018 at 10:00 in Court TBA at BOWEN | John Lock | I. The findings required by s.45 (2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how he died and what caused his death.<br>II. The circumstances surrounding the incident on 12 December 2015 where police attended the home of the deceased, at which time the deceased appears to have caused a gas bottle to explode, resulting in injuries to both himself and the attending Queensland Police Service officers.<br>III. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003 | No |
| **Hamilton, Stella** | Pre Inquest Conference scheduled for 18 May 2018 at 9.00 am in Court 2, level 1 at CAIRNS. | Nerida Wilson | 1. The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how she died and what caused her death; 2. Whether any persons contributed to her death; 3. The adequacy of security procedures including monitoring the movement of residents and visitors in and around Ozcare Malanda aged care facility; and 4. Whether recommendations can be made that relate to public health and safety and/or to prevent deaths from happening in similar circumstances in the future pursuant to s46 of the Coroners Act 2003. | No |
| **Harmer, Jay Maree** | 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 she died and what caused her death;<br><br>2. The appropriateness of the facilities available to inmates with chronic or terminal illness at the Brisbane Women's Correctional Centre. | No |
| **Hodgkinson, Bryan** | Inquest scheduled for 12 Jun 2018 at 10:00am in Court 2 at BUNDABERG | David O'Connell | Coroner was Magistrate GA Stubbins. Matter was adjourned as QPS investigations still ongoing as to suspects in the Murder of the deceased. Inquest remained part-heard until State Coroner transferred file around 23/01/2017. | No |
| **Holstein, Zachary James David** | Inquest scheduled for 17 May 2018 to 18 May 2018 at 10:00am in Court 4 at BRISBANE | John Lock | 1. The findings required by s.45 (2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how he died and what caused his death.<br>2. Whether there is information held by Offender Health Services, Metro North Hospital and Health Service and/or any of its staff who provided health services to Mr Holstein whilst he was a prisoner at the Woodford Correctional Centre that would further add to or amend the findings and recommendations made by the Office of the Chief Inspector arising from Mr Holstein's death.<br>3. The response of Queensland Corrective Services and Queensland Health to the recommendations made by the Office of the Chief Inspector.<br>4. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003. | 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 |
| **Houdini, Franky** | Inquest scheduled for 08 May 2018 to 09 May 2018 at 9:30am 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:<br>2. The adequacy of the sharing of information relating to prisoners' mental health treatment between Corrective Services and the West Moreton Hospital and Health Services, including information relevant to the Prisoner Mental Health Service and the High Risk Offender Management Unit; and<br>3. The adequacy of policies and procedures in place to deal with the mental health treatment of prisoners who are the subject of orders made pursuant to the Dangerous Prisoners (Sexual Offenders) Act. | No |

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| **House, William John**<br>**Smith, Jodie Anne**<br>**White, Vanessa Joan**<br>**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.<br>2. The prescribing of drugs of dependence by a number of different General Practitioners to each of the deceased, often at concurrent times.<br>3. The provision of drugs of dependence by treating Hospitals to the deceased.<br>4. The sufficiency of monitoring currently available in relation to the prescribing and dispensing of drugs of dependence in Queensland.<br>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.<br>6. What further actions could be undertaken to prevent doctor shopping and the inappropriate prescribing of drugs of dependence in Queensland?<br>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 |
| **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 |
| **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 adjourned DTBF for findings | James McDougall | I. 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.<br><br>II. The specific circumstances surrounding Ms Mann's death.<br><br>III. 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.<br><br>IV. The appropriateness of utilising assessment pods for patients in the Hospital.<br><br>V. The sufficiency of the changes made to relevant Hospital policies and procedures following Ms Mann's death.<br><br>VI. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances. | No |

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| **Mason, Annette Jane** | Re-opened Inquest scheduled for 30 Jul 2018 to 10 Aug 2018 at 10:00am in Court 4 at BRISBANE | Terry Ryan | Scope of inquest on death required by s24(1) of the Coroners Act 1958;<br>(a) the fact that a person has died;<br>(b) the identity of the deceased person;<br>(c) when, where, and how the death occurred;<br>(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 |
| **Maynard, Marcia Anne Kathleen** | Pre inquest conference scheduled for 14 May 2018 at 10:00am in Court 4 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 she died and what caused her death.<br><br>2. The circumstances surrounding the death and what factors or stressors combined or contributed to cause her death.<br><br>3. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003. | No |
| **Milward, Paul Joseph** | Inquest adjourned DTBF for findings | John Lock | 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 |
| **Parkes, Michaelangelo George** | Inquest scheduled for 14 Jun 2018 to 15 Jun 2018 at 10:00am in Court 5 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;<br>2. The adequacy and appropriateness of the conduct of persons involved in the traffic incident that occurred at 1:37pm on 31 July 2016 at Old Gympie Road, Mount Mellum, including compliance with QPS policies in place at the time. | No |
| **Robinson, Breeana Elaine Stewart** | Inquest adjourned DTBF for hearing | James McDougall | I. 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.<br><br>II. The specific circumstances surrounding Breeana's death, particularly how she came to fall to her death.<br><br>III. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances. | No |
| **Simon, Darrell Gene** | Inquest scheduled for 17 Sep 2018 to 21 Sep 2018 at 10:00AM in Court TBA at TOOWOOMBA | John Lock | 1. The findings required by s.45 (2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how he died and what caused his death.<br>2. The circumstances by which the deceased's remains came to be found at his rural property in May 2016, which was eighteen months after his reported disappearance in November 2014, and why the remains were not located sooner.<br>3. 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 01 Jun 2018 at 10:00am in Court TBA | 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;<br>2. The circumstances of the traffic incident on 8 September 2015 that resulted in the deceased's death;<br>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;<br>4. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003. | Yes |

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| **Statis, Joshua** | 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<br>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<br>3. what caused the CardioCel RVOT pericardial patch to rupture<br>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;<br>• Whether the organisation/coordination of the dive trip was appropriate;<br>• The role and responsibilities of Keswick Island Charters Pty Ltd and Get Wet Scuba Adventures in relation to the dive trip;<br>• Whether the conduct of the dive trip was appropriate. Particularly in relation to:<br>? Experience and qualifications of boat crew and other key personnel;<br>? Dive site and/or boat safety briefings;<br>? Dive site risk assessment;<br>? Site supervision;<br>? Number and location of supervisory personnel;<br>? First aid and emergency equipment;<br>? Dive buddy protocols;<br>? Emergency procedures and recovery efforts;<br>• When and how did the contamination enter the deceased's SCUBA cylinders?<br>• The Ingersol Rand 15T4 compressor owned and operated by the Underwater Research Group of Queensland ('URGQ') for the production of breathing air:<br>? Adequacy of servicing and maintenance;<br>? Adequacy of training provided to club members in the compressor's use;<br>? Adequacy of records in relation to SCUBA cylinders that were filled using the compressor;<br>? Adequacy of policies and procedures in place in relation to the compressor;<br>? The applicability of the current regulatory regime to URGQ in relation to the compressor and the filling and handling of SCUBA cylinders;<br>• 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;<br>• Recommendation pursuant to section 46; and<br>• Referrals pursuant to section 48. | No |
| **Wright, Kenneth Douglas** | 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;<br>2. The adequacy and appropriateness of the care provided to Mr Wright at the Acute Care Unit at SQCC, particularly on 20 March 2015;<br>3. The management of the Code Blue and decisions surrounding resuscitation, in particular the decision not to commence CPR; and<br>4. Whether any further recommendations can be made to prevent a death in similar circumstances from happening in the future. | No |