

## Coroners Court of Queensland Inquest List for February 2018

at 31 January 2018

Name of deceased	Inquest date and location	Coroner	Issues to be considered	NPO
<b>Appleton, Garry Ronald (combined with MALONE)</b>	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
<b>Beale, Tracy Ann</b>	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
<b>Brown, Holly Winta</b>	Inquest scheduled for 29 Jan 2018 to 01 Feb 2018 at 11.00 am in Court TBA at CAIRNS	Nerida Wilson	<ul style="list-style-type: none"> <li>The identity of the deceased, when where and how she died and what caused the death.</li> <li>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.</li> <li>The adequacy or otherwise of the medical care received by the deceased on the day of her death.</li> </ul>	No
<b>Brown, Samuel Timothy</b>	Inquest scheduled for 19 Mar 2018 to 23 Mar 2018 at 10.00am in Court TBA at SOUTHPORT	James McDougall	<p>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.</p> <p>II. The circumstances surrounding the death, including the mechanism by which the injuries were inflicted, and the involvement of another party.</p> <p>III. The response of the Queensland Police Service to the death, including the basis for decisions about prosecution actions.</p> <p>IV. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances.</p>	No

<b>Brown, Stephen Ross</b>	Inquest scheduled for 22 Feb 2018 to 23 Feb 2018 at 10.00 in Court TBA at KINGAROY	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
<b>Cheney, Danny George</b>	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
<b>Coolwell, Shaun Charles</b>	Inquest scheduled for 05 Mar 2018 to 07 Mar 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; 2. Whether the administration of midazolam by Queensland Ambulance Service officers was appropriate; 3. Whether the restraint of Mr Coolwell was appropriate; and 4. To consider if there are ways to prevent a similar death occurring in the future.	No
<b>Day, Robert Raymond</b>	Inquest scheduled for 06 Feb 2018 at 11:00am 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.	No
<b>Harmer, Jay Maree</b>	Pre inquest conference scheduled for 07 Feb 2018 at 12:00pm 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 she died and what caused her death; 2. The appropriateness of the facilities available to inmates with chronic or terminal illness at the Brisbane Women's Correctional Centre.	No
<b>Hou, Xiangxiong</b>	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

<b>House, William John Smith, Jodie Anne White, Vanessa Joan Milne, Daniel Keith</b>	Inquest adjourned DTBF for findings	James McDougall	<ol style="list-style-type: none"> <li>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.</li> <li>2. The prescribing of drugs of dependence by a number of different General Practitioners to each of the deceased, often at concurrent times.</li> <li>3. The provision of drugs of dependence by treating Hospitals to the deceased.</li> <li>4. The sufficiency of monitoring currently available in relation to the prescribing and dispensing of drugs of dependence in Queensland.</li> <li>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.</li> <li>6. What further actions could be undertaken to prevent doctor shopping and the inappropriate prescribing of drugs of dependence in Queensland?</li> <li>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?</li> </ol>	No
<b>Jones, Anthony John</b>	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
<b>Kennedy, Dale Daniel</b>	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.	No
<b>Khazaei, Hamid</b>	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
<b>Malone, Terrence Michael (combined with APPLETON)</b>	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
<b>Mann, Renae Jean</b>	Inquest adjourned DTBF for findings	James McDougall	<ol style="list-style-type: none"> <li>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.</li> <li>II. The specific circumstances surrounding Ms Mann’s death.</li> <li>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.</li> <li>IV. The appropriateness of utilising assessment pods for patients in the Hospital.</li> <li>V. The sufficiency of the changes made to relevant Hospital policies and procedures following Ms Mann’s death.</li> <li>VI. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances.</li> </ol>	No

<b>Mason, Annette Jane</b>	Pre inquest conference scheduled for 26 Feb 2018 at 10:00am in Court 5 at BRISBANE	Terry Ryan	Scope of inquest on death required by s24(1) of the Coroners Act 1958; (a) the fact that 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.	No
<b>Milward, Paul Joseph</b>	Inquest scheduled for 01 Feb 2018 to 02 Feb 2018 at 10.00am in Court 3 at IPSWICH	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
<b>Murray, Eric James</b>	Inquest scheduled for 06 Feb 2018 at 10:00am in Court 5 at BRISBANE	Terry Ryan	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
<b>Parkes, Michaelangelo George</b>	Pre-inquest conference scheduled for 12 Feb 2018 at 2:00pm in Court 4 at BRISBANE	Terry Ryan	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
<b>Robinson, Breeana Elaine Stewart</b>	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.  II. The specific circumstances surrounding Breeana's death, particularly how she came to fall to her death.  III. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances.	No
<b>Ross, Matthew Trent</b>	Inquest adjourned DTBF for findings	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.	Yes
<b>Smit, Bernardus Johan</b>	Inquest adjourned DTBF for hearing	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 adjourned DTBF for findings	Ainslie Kirkegaard	<ol style="list-style-type: none"> <li>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</li> <li>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</li> <li>3. what caused the CardioCel RVOT pericardial patch to rupture</li> <li>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</li> </ol>	No
Thwaites, Andrew John	Inquest adjourned DTBF for findings	Christine Clements	<ul style="list-style-type: none"> <li>• 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;</li> <li>• Whether the organisation/coordination of the dive trip was appropriate;</li> <li>• The role and responsibilities of Keswick Island Charters Pty Ltd and Get Wet Scuba Adventures in relation to the dive trip;</li> <li>• Whether the conduct of the dive trip was appropriate. Particularly in relation to: <ul style="list-style-type: none"> <li>? Experience and qualifications of boat crew and other key personnel;</li> <li>? Dive site and/or boat safety briefings;</li> <li>? Dive site risk assessment;</li> <li>? Site supervision;</li> <li>? Number and location of supervisory personnel;</li> <li>? First aid and emergency equipment;</li> <li>? Dive buddy protocols;</li> <li>? Emergency procedures and recovery efforts;</li> </ul> </li> <li>• When and how did the contamination enter the deceased's SCUBA cylinders?</li> <li>• The Ingersol Rand 15T4 compressor owned and operated by the Underwater Research Group of Queensland ('URGQ') for the production of breathing air: <ul style="list-style-type: none"> <li>? Adequacy of servicing and maintenance;</li> <li>? Adequacy of training provided to club members in the compressor's use;</li> <li>? Adequacy of records in relation to SCUBA cylinders that were filled using the compressor;</li> <li>? Adequacy of policies and procedures in place in relation to the compressor;</li> <li>? The applicability of the current regulatory regime to URGQ in relation to the compressor and the filling and handling of SCUBA cylinders;</li> </ul> </li> <li>• 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;</li> <li>• Recommendation pursuant to section 46; and</li> <li>• Referrals pursuant to section 48.</li> </ul>	No
Wright, Kenneth Douglas	Pre inquest conference scheduled for 07 Feb 2018 at 10:00am in Court 4 at BRISBANE	Terry Ryan	<ol style="list-style-type: none"> <li>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;</li> <li>2. The adequacy and appropriateness of the care provided to Mr Wright at the Acute Care Unit at SQCC, particularly on 20 March 2015;</li> <li>3. The management of the Code Blue and decisions surrounding resuscitation, in particular the decision not to commence CPR; and</li> <li>4. Whether any further recommendations can be made to prevent a death in similar circumstances from happening in the future.</li> </ol>	No

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