QUEENSLAND COURTS

Coroners Court of Queensland
Inquest List for May 2017

at 27 April 2017

Name of deceased	Inquest date and location	Coroner	Issues to be considered	NPO
Ackerman, James William	Pre inquest conference scheduled for 18 May 2017 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 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
Andriansyah, Febri (linked with VOLKE)	Inquest scheduled for 15 May 2017 to 17 May 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 she died and what caused her death.	NO
Appleton, Garry Ronald (linked with MALONE)	Inquest scheduled for 21 Aug 2017 to 25 Aug 2017 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; 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
Biffin, Albert Eric Bruce	Findings scheduled for 3 May 2017 at 10:00 in Court 5 at BRISBANE	Christine Clements	It is proposed that the inquest will investigate: • The identity of the deceased, when, where and how he died and what caused the death • Adequacy or otherwise of nursing and residential care – including monitoring, documentation and referral to medical care. • Adequacy or otherwise of medical treatment – including history, examination, handover and communication.	NO
Brown, Holly Winta	Inquest adjourned DTBF for hearing	Kevin Priestly	• The identity of the deceased, when where and how she died and what caused the death. • 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. • The adequacy or otherwise of the medical care received by the deceased on the day of her death.	NO

Brown, Stephen Ross	Inquest adjourned DTBF for hearing	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	Inquest adjourned DTBF for findings	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
Crowley, Byron James	Inquest adjourned DTBF for findings	Kevin Priestly	The required findings and the road & land managers' managementof the risk to road users from stray horse in the Clement and Bluewater areas near Townsville.	NO
Davis, Bernard Ashton	Inquest adjourned DTBF for findings	Kevin Priestly	Road and Land Manager's management of the risk to road users from stray horses in the Clement and Bluewater areas near Townsville	NO
Double Fatality Topcamp; Leonardi, Christine Nan Leonardi, Samuel John	Pre inquest conference scheduled for 23 May 2017 to 23 May 2017 at 10:00 in Court 5 at BRISBANE	John Hutton		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	The immediate circumstances surrounding death including first response management; Clinical management and risk mitigation used relevant to the risk of suicide; Management of environmental hazards relevant to the risk of inpatient suicide at Townsville Hospital Mental Health Unit, including implementation of previous coronial recommendations; and Opportunities to improve management of the risk of suicide and first response.	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	Kevin Priestly	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	Pre inquest conference scheduled for 05 May 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 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	Pre inquest conference scheduled for 05 May 2017 at in Court 4 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 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
John, Timothy	Inquest adjourned DTBF for findings	John Hutton	1. The identity of the deceased, when, where and how he died and what caused the death; 2. The adequacy of the product labelling and instructions provided with Champix in relation to potential adverse neuropsychological effects; 3. The adequacy of the care provided by the deceased's General Practitioner when prescribing Champix in the circumstances; and 4. Whether any recommendations can be made to reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.	NO
Jones, Anthony John	Inquest scheduled for 24 Jul 2017 to 04 Aug 2017 at 9:30 in Court Level D Court 2 at TOWNSVILLE	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

Langley, Archer	Inquest adjourned DTBF for findings	John Lock	1. The findings required by section 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 key staff involved in the clinical management of Archer's mother's labour from 25 July 2014, and experts who have examined the materials related to this clinical management, can offer any further insight in relation to the deficiencies identified within the Root Cause Analysis Report commissioned by the Royal Brisbane and Women's Hospital, and factors that contributed to those deficiencies. 3. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003, having regard to the changes that have already been implemented at the Royal Brisbane and Women's Hospital since Archer's death.	NO
Malone, Terrence Michael (linked with APPLETON)	Inquest scheduled for 21 Aug 2017 to 25 Aug 2017 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; 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
Mead, Gwendoline	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 she died and what caused her death; 2. Mrs Mead's clinical management at the Toowoomba Base Hospital including; a) the adequacy of the multidisciplinary team approach to her care, b) the appropriateness of the surgical decision making, c) the adequacy of communication between multiple treating teams about her post-operative condition and its management, d) the adequacy of the pre-operative assessment and planning of her care, e) the appropriateness of her discharge from the ICU on 25 February 2015. f) whether aspects of Mrs Mead's clinical management reflect broader system failures and if so, what system changes could be made to minimise the risk of adverse health outcomes in the future	NO
Parsons, Ann Louise	Inquest adjourned DTBF for findings	Christine Clements	The inquest will investigate: • The findings required by s45 of the Coroners Act 2003; • The delay in listing the deceased for surgery and the impact of that delay on the deceased; • The adequacy of the neurosurgical care(medical) provided to the deceased; • The appropriateness of discharging the deceased from ICU on 13 October 2012;• The adequacy of the communication between the receiving ward and ICU; • The adequacy of the nursing assessment and care provided to the deceased on the neurosurgical ward on 13/14 October 2012; • The cause of the deceased's global oedema and cerebellar herniation that progressed to brain death; and • The adequacy of the policies and procedures of the Royal Brisbane & Women's Hospital (RBWH) relevant to the care of the deceased.	NO

Police Shooting - "Recommendation Phase" Zimmer, Laval Donovan - Young, Anthony William - Logan, Edward Wayne - Foster, Troy Martin - Kumeroa, Shaun Basil	Inquest adjourned DTBF for findings	Terry Ryan	ISSUES COMMON TO ALL MATTERS(1)The appropriateness of the current QPS use of force model and the options of force available to police officers;(2)The adequacy and appropriateness of Queensland Police Service:(i)policies in relation to the use of firearms;and(ii)training provided to operational police officers in the use of firearms.(3)The approach taken inconducting the investigation into the deaths conducted by the Ethical Standards Command Internal Investigations Group,particularly,whether an improved methodology may be adopted which places appropriate weight on and protects the welfare of first response police officers,post-incident,and also preserves the integrity of the evidence of those officers and other evidence at the scene including whether the timing of and means of conducting interviews of first response officers by ESC officers should be varied or subject to greater flexibility.(4)The adequacy and appropriateness of the current training of police officers with respect to the imposition of handcuffs after the use of lethal force;(5)The adequacy of the current processesfor dissemination o f information,and updates of information,for attending crews to an incident including possible implementation of the Q-lite program;(6)The adequacy and appropriateness of QPS policies,procedures and training in relation to police dealing with mental health incidents,including the adequacy of the availability of information/records from Queensland Health,and other medical practitioners,regarding mental health history of persons to the QPS(7)The current position regarding ownership of body worn cameras used by QPS officers and the storage of data; and (8) Lessons learned from these incidents as to the benefits of body worn cameras being used by the police officers in terms of:(i)preserving evidence; (ii) providing a reliable record of what occurred; (iii)avoiding unnecessary controversy about what happened;(iv)vindicating police officers who have acted in accord with their training and policy.	YES
Police Shooting - "Recommendation Phase" Zimmer, Laval Donovan - Young, Anthony William - Logan, Edward Wayne - Foster, Troy Martin - Kumeroa, Shaun Basil	Inquest adjourned DTBF for findings	Terry Ryan	FURTHER ISSUES (NOT COMMON TO ALL MATTERS)(9) The regulation of replica firearms in QLD (Kumeroa)(10)The effectiveness of the negotiation processes in the present case,including the options available for use when trying to negotiate a surrender plan (Kumeroa)(11)The positioning of the innercordon police officers leading to the necessity to use lethal force (Kumeroa);(12)The adequacy and appropriateness of QPS policies, procedures and training for Police Communications personnel (Zimmer);(13)Whether the officers should have gathered more intelligence about who was in the house before making contact with Mr.Zimmer; whether the house should have been cleared of civilians before any such contact; whether containment was a better option;whether somekind of negotiation should have been tried using the 000 contact that was underway; whether the officers should have been updated more thoroughly from the results of the 000 contact (Zimmer); (14)The appropriateness of the mental health assessment conducted at the Gold Coast University Hospital on 24 November 2014 (Foster); and(15)The adequacy of the current process by which police escort a person detained under ss33 – 36 of the Mental Health Act 2000 (Foster)	YES
Richards, Karen Louise	Inquest adjourned DTBF for findings	John Hutton	1. The identity of the deceased, when, where and how she died and what caused her death; and 2. Whether any recommendations can be made to reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.	YES
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

Ross, Matthew Trent	Inquest scheduled for 22 May 2017 to 09 Jun 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
Sargent, Sean	Inquest scheduled for 08 May 2017 to 12 May 2017 at 10:00 in Court 4 at BRISBANE	John Hutton	1. The findings required by s 43 (4) of the Coroners Act 1958, namely: (i) The cause and circumstances of the disappearance of Sean Sargent; (ii) Whether he is alive or dead; (iii) If he is alive or likely to be alive – his whereabouts at the time of the inquiry; (iv) If he is dead or likely to be dead – the identity of the deceased person, how, when and where he died, what caused his death and whether any recommendations can be made to reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice; and 2. The adequacy of the civilian police and military police investigation into the disappearance of Sean Sargent.	NO
14 year old youth	Inquest adjourned DTBF for findings	John Hutton	1. The findings required by section 45 (2) of the Coroners Act 2003; namely the identity of the deceased persons, how, when and where he died, and what caused his death; 2. The adequacy of the procedures applied by the Russell Island police in relation to drug and alcohol testing of the driver; 3. The adequacy of the action taken by Redland Bay City Council to improve pedestrian safety; and 4. Whether any recommendations can be made to reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.	NO
Statis, Joshua	Pre inquest conference scheduled for 03 May 2017 at 9:00am in Court 4 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
Tonkin, Nixon Martin	Inquest adjourned DTBF for findings	John Lock	1. The findings required by section 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 key staff involved in the clinical management of Nixon's mother's pregnancy, induction, labour and caesarean section delivery, and experts who have examined the materials related to this clinical management, can offer any further insight in relation to the deficiencies identified within the Root Cause Analysis Report commissioned by the Royal Brisbane and Women's Hospital, and factors that contributed to those deficiencies.3. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003, having regard to the changes that have already been implemented at the Royal Brisbane and Women's Hospital since Nixon's death	NO

Turpin, Robert Noel	Inquest scheduled for 02 May 2017 to 05 May 2017 at 10:00am in Court 5, level 3 at CAIRNS	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 police response to the information conveyed during the 000 call relating to Mr Turpin expressing an intention to commit suicide; 3. The adequacy and appropriateness of the current methods by which first response crews are provided information, and updates of information, pertaining to jobs they attend; and 4. The adequacy and appropriateness of 'no contact' conditions pertaining to Domestic and Family Violence Protection Orders in terms of the practical issues they raise for both the aggrieved and the respondent, and the method by which potential breaches of those conditions are investigated and determined by police.	NO
Vance, Jason John	Pre inquest conference scheduled for 18 May 2017 at 11:00am in Court 4 at BRISBANE	John Lock	• 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; • The circumstances surrounding the death; and • 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.	NO
Volke, Marcus Peter (linked with ANDRIANSYAH)	Inquest scheduled for 15 May 2017 to 17 May 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; and 2. Whether the police officers involved in attempting to locate and detain the deceased shortly prior to his death adhered to QPS policy and procedure.	NO
WLODARCZYK, Julian Werner	Inquest adjourned DTBF for findings	Kevin Priestly	The inquest will investigate: • The identity of the deceased, when, where and how he died and what caused the death; • What lessons were learnt from past incidents about controlling vehicle movements on the ferry?; • How were those lessons taken into consideration in the design, commissioning and operation of the ferry?; • Were those lessons taken into consideration during inspections of marine surveyors and Marine Officers? If yes, how? If no, why?; • How did the operator and DSC retain and apply the lessons learnt vis-à-vis the Daintree operation? • How did MSQ retain and apply lessons learnt from earlier incidents vis-à-vis the Daintree operation and other like vehicle ferry operations in the State?	YES