QUEENSLAND COURTS

Coroners Court of Queensland
Inquest List for September 2017
at 01 September 2017

Name of deceased	Inquest date and location	Coroner	Issues to be considered	NPO
Ackerman, James William	Inquest adjourned DTBF for findings	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	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 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, Samuel Timothy	Inquest scheduled for 16 Oct 2017 to 20 Oct 2017 at 10.00am in Court TBA 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. II. The circumstances surrounding the death, including the mechanism by which the injuries were inflicted, and the involvement of another party. III. The response of the Queensland Police Service to the death, including the basis for decisions about prosecution actions. IV. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances.	No
Brown, Stephen Ross	Inquest scheduled for 18 Oct 2017 to 19 Oct 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 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
Cardiac Surgery ; Statis, Joshua	Pre inquest conference held on 03 May 2017 to 03 May 2017, Inquest scheduled for 21 Nov 2017 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
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
36 year old male	Inquest adjourned DTBF for findings	Christine Clements	The inquest will investigate: • 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 his death; • The circumstances surrounding Mr Dardass' death including: o His movements/plans in the days leading to his death and reasons for his travel from Rockhampton to Brisbane; o Ms Maranda's dealings with Mr Dardass; o Whether there was any 3rd party involvement in the death; • The adequacy of the police investigation; • Any recommendations pursuant to s 46 of the Act; and • Any referrals under section 48 of the Act.	YES
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**	Inquest adjourned DTBF for findings	John Hutton	1. The identity of the deceased persons, when, where and how they died and what caused their 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. Recommendations to be considered include, but are not limited to: a. Whether the Franna AT-20 crane should be speed limited to 80km/h on public roads; b. Whether the manufacturer of Franna AT-20 cranes should consider implementing engineered counter measures to decrease lateral instability on public roads; c. Whether the training and licensing assessment for Franna AT-20 cranes should include a demonstrated ability to drive the crane safely on public roads; and d. Whether the Franna AT-20 crane Operators Manual and the Mobile Crane – Code of Practice 2006 should contain guidance about how to avoid and react to lateral instability on public roads.	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

Fuller, Jo-Anne Peta	Pre inquest conference scheduled for 08 Sep 2017 at 11:00am in Court 5 at MACKAY	David O'Connell	1. The information required by section 45(2) of the Coroners Act 2003, namely, when, where, and how Ms Fuller died, and what caused her death? 2. Whether either, or both, of the motor vehicles involved in the collision which led to Ms Fuller's death travelled out of the appropriate traffic lane immediately prior to the collision? 3. What caused either, or both, of the said motor vehicles (as the case may be) to travel out of the appropriate traffic lane immediately prior to the collision? 4. Whether any feature of the roadway, or any attendant signage or other traffic control feature, on Hervey Bay-Maryborough Road, Susan River, should be reviewed in the interest of preventing similar future collisions? 5. Given the deterrent effect of properly-instituted prosecutions to the prevention of similar future road incidents, whether any changes should be considered to the law governing the offences which may be committed by careless drivers, or by disqualified or suspended drivers, and which result in death or grievous bodily harm to any person?	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 findings	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	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 scheduled for 25 Oct 2017 to 27 Oct 2017 at 10:00 in Court 1 at TOOWOOMBA	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	Findings scheduled for 14 Sept 2017 at 10:00 in Court 4 at BRISBANE	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 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	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 Sept 2017 to 15 Sept 2017 at 10:00 in Court TBA 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 she died and the cause of her death. II. The specific circumstances surrounding Ms Mann's death. 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. IV. The appropriateness of utilising assessment pods for patients in the Hospital. V. The sufficiency of the changes made to relevant Hospital policies and procedures following Ms Mann's death. VI. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances.	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
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 1 Dec 2017 at 10:00 in Court TBA 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. 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
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
Sargent, Sean	Inquest scheduled for 20 Sep 2017 to 22 Sep 2017 at 10:00 in Court 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

Thwaites, Andrew John	Inquest scheduled for 25 Sep 2017 to 29 Sep 2017 at 9:30am in Court 4 at BRISBANE	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	Inquest adjourned DTBF for findings	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.	YES
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