CORONERS COURT
OF QUEENSLAND

Inquest Proceedings

Please note the dates listed below can be subject to change - this list is updated monthly.

Please contact (07) 3738 7050 should you have any queries in relation to the listed hearing dates.

Name of Deceased	Inquest Status	Coroner	Issues to be considered	Non publication order
Abdi, Raghe Mohamed; Antill, Maurice Frederick; Antill, Zoe Dorothea	Pre inquest conference scheduled for 17 Feb 2022 at 10:00AM in Court 10 at SOUTHPORT	Jane Bentley	• The findings required by s.45(2) of the Coroners Act 2003; namely the identity of the deceased persons, when, where and how they died and the cause of their deaths. • Examine the circumstances surrounding the deaths of Maurice and Zoe Antill at their residence on or around 16 December 2020. • Examine the circumstances leading up to the shooting of Raghe Abdi by police on 17 December 2020. • Consider whether the actions of the attending police officers, who were involved in the shooting, were appropriate in the circumstances. • Consider the adequacy of the police investigation into the deaths. • Consider what further actions, if any, could be undertaken to prevent a similar incident from occurring again in Queensland?	No
Ball, Leslie Ralph	Adjourned DTBF for hearing	Stephanie Gallagher	1. Whether or not a person has died; 2. The identity of the deceased person; 3. When, where and how the death occurred; 4. 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
Bernard, Allison Neridine	Pre inquest conference scheduled for 09 Nov 2021 at 10.00am in Court 2, level 1 at CAIRNS	Nerida Wilson	The findings required by s45(2) of the Coroners Act 2003, namely; whether or not Allison Neridine Bernard is in fact deceased and if so how, when and where she died and what caused her death; and If deceased, the circumstances surrounding her death; If deceased, whether the actions of any other person contributed to her death.	No

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Brooks, Jeffrey Lawrence	Pre inquest conference scheduled for 25 Nov 2021 at 10:00am in Court 10 at SOUTHPORT	Jane Bentley	• 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 the cause of his death, including how the gun shot wound came to be identified. • The adequacy of the police investigation and the processes relating to the management of exhibits.	No
Brown, Casey Lenard	Adjourned DTBF for findings	David O'Connell	1. The information required by section 45(2) of the Coroners Act 2003, namely- (a) Who the deceased person is? (b) How (i.e. by what means, and in what circumstances) the person died? (c) When the person died? (d) Where the person died? (e) What was the medical cause of death? 2. What caused the Bustech XDi omnibus Reg No 251-TRQ to leave the sealed carriageway on Shute Harbour Road, Cannonvale, and to overturn? 3. Would the nature of the injuries suffered by Casey have been less serious if- (a) If the bus had been travelling at a slower speed; or (b) If Casey had been wearing a properly fitted and worn seat belt? 4. Should the issue of safety for passengers in “route” buses be re-con-sidered by the State Government, with particular regard to - (a) Requiring route buses to be fitted with compliant lap/sash seat belts for the driver and all passengers either- (i) immediately; or (ii) over the course of a fixed phasing-in period? (b) Limiting the speed of route buses during operations to a specific maximum speed, even if that is lower than that of the relevant applicable speed zone? (c) Requiring that any new bus, even if it is intended to be used only for “route” services, be fitted with compliant lap/sash seat belts?	No
Brown, Samuel Timothy	Adjourned for hearing	Stephanie Gallagher	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
Clubb, Monique Irene	Inquest scheduled for 14 Dec 2021 to 17 Dec 2021 at 10:00am in Court 15 at SOUTHPORT	Jane Bentley	1. The findings required by s.45(2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how she died and the cause of her death. 2. The adequacy of the Queensland Police Service investigation.	No

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Edwards, Brad Arthur	Adjourned DTBF for hearing	Stephanie Gallagher	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
Forte, Brett Andrew	Inquest scheduled for 12 Nov 2021 at 10:00am in Court 4 at BRISBANE	Terry Ryan	1. The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death; 2. Examine the interaction between the QPS and Ricky Maddison in the lead up to the death, including the Gatton Police investigation into Automatic Gunfire at Wellers Road, Ringwood; 3. Examine the circumstances, which led to Senior Constable Brett Forte coming in to contact with Ricky Maddison on 29 May 2017, including previous attempts to locate him, as well as the decision and management of the pursuit and attempted apprehension of Ricky Maddison on 29 May 2017; 4. Consider the appropriateness of actions by the attending police officers on 29 May 2017 in relation to Ricky Maddison; 5. Examine the Queensland Police Service response following the shooting of Senior Constable Brett Forte, including the provision of assistance and retrieval; 6. Consider the adequacy of the investigation into the death conducted by officers from the Queensland Police Service (QPS) Ethical Standards Command; and 7. Whether any preventative changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.	Yes
Grover, Gwen Lorraine	Findings scheduled for 09 Nov 2021 at 11.00am in Court 2 at CAIRNS	Nerida Wilson	1. The findings required by s.45 of the Coroners Act 2003, and 2. The adequacy of the original investigation by the Queensland Police Service.	No
Guise, Jason Barry	Inquest scheduled for 25 Oct 2021 to 28 Oct 2021 at 10:00 in Court 5 at BRISBANE	Donald MacKenzie	1. The findings required by s.45(2) of the Coroners Act 2003 (Qld)	No

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Harvey, Thompson James	Adjourned DTBF for hearing	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. Determine whether the authorities charged with providing for Mr. Harvey's mental health and physical care at the Capricornia Correctional Centre prior to his death adequately discharged those responsibilities. 3. Whether the mental health assessments conducted of the deceased upon his induction and prior to his death at the Capricornia Correctional Centre were appropriate? 4. Whether the placement of the deceased and the frequency of the observations conducted whilst he was an inmate at the Capricornia Correctional Centre were sufficient? 5. Consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.	No
House Fire Browns Plains; Hely, Gary Matthew, Langham, Doreen Gail	Pre inquest conference scheduled for 14 Jan 2022 at 10:00am in Court 10 at SOUTHPORT	Jane Bentley	1. The findings required by s.45(2) of the Coroners Act 2003; namely the identity of the deceased persons, when, where and how they died and the cause of their deaths; 2. The adequacy of the Queensland Police Service response to Ms Langham's complaints to the Queensland Police Service in relation to Mr Hely; 3. The adequacy of the Queensland Police Service response to Ms Langham's triple zero call on the night of her death; 4. Whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.	No
Jessen, Tyson	Adjourned DTBF for findings	Terry Ryan	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 facilities and resources available to securely accommodate and supervise Mr Jessen while he was in police custody as an acute inpatient at the Ipswich Hospital; and what, if any additional steps were undertaken by the hospital and the QPS to manage the risk of accommodating Mr Jessen at the hospital; 3. Whether the actions of the police officers who were tasked to guard Mr Jessen at the Ipswich Hospital before he attacked Senior Constable Richardson were appropriate in the circumstances; and 4. Whether information which was known about Mr Jessen was appropriately relayed to the police officers guarding Mr Jessen after Mr Jessen was transferred to the Ipswich Hospital.	No
Jones, Anthony John	Adjourned DTBF for findings	Terry Ryan	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

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King, Trevor	Adjourned DTBF for findings	Terry Ryan	i. 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. ii. Whether the actions of the attending police officers were appropriate in the circumstances. iii. Whether the actions of the attending QAS officers were appropriate in the circumstances.	No
Lewis, Daniel Patrick	Adjourned DTBF for findings	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; and: 1. The appropriateness of the actions of the attending police officers, including the decision by the police to enter the backyard of the residence; 2. The sufficiency of the training provided to officers in responding to a similar incident, particularly involving an armed offender; and 3. Whether any preventative changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice. 4. The sufficiency and appropriateness of the investigation conducted by Ethical Standards Command	No
Maddison, Ricky Charles	Inquest scheduled for 12 Nov 2021 at 10:00am in Court 4 at BRISBANE	Terry Ryan	1. The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death; 2. Examine the interaction between the QPS and Ricky Maddison in the lead up to the death, including the Gatton Police investigation into Automatic Gunfire at Wellers Road, Ringwood; 3. Consider the appropriateness of actions by the attending police officers on 29 May 2017 in response to Ricky Maddison; 4. Examine the siege management strategies and negotiation processes employed, including the effectiveness of the negotiation processes; 5. Examine the events that led to the decision by police to shoot Ricky Maddison; 6. Consider the adequacy of the investigation into the death conducted by officers from the Queensland Police Service (QPS) Ethical Standards Command; and 7. Whether any preventative changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.	Yes
Mason, Annette Jane	Adjourned DTBF for hearing	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.	Yes

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MASOUMALI, Omid	Findings scheduled for 1 Nov 2021 at 10:00am in Court 4 at BRISBANE	Terry Ryan	1. The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death. 2. The circumstances surrounding the incident on 27 April 2016 at the Nibok Settlement in the Republic of Nauru, whereby the deceased was seen to set fire to his own clothing, and the factors precipitating his decision to take that action. 3. The health and medical evacuation services provided to the deceased from the time of the incident until the time of his death on 29 April 2016. 4. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003.	Yes
Mathieson, Troy James and Morton, Hughie Kirk Douglas	Adjourned DTBF for findings	Terry Ryan	1. The findings required by s.45(2) of the Coroners Act 2003 (Qld); namely the identity of the deceased, when, where and how he died and what caused their death; 2. Whether having a grate installed on the culvert would have been outcome changing; 3. Whether the decision to categorise Mr Mathieson and Mr Morton as wanted persons, instead of missing persons, was outcome changing	No
Ofner, Johann	Adjourned DTBF for findings	Donald MacKenzie	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 and cause of the fatal shooting of Johann Ofner at the 'Brooklyn Standard Bar' at Lower ground level, 371 Queen Street, Brisbane, which occurred on 23 January 2017. 3. The adequacy of training and safety briefings provided to cast and crew on production sets. 4. Consideration of the regulation and applicable standards of the use of firearms by which the entertainment, film and production industry operates in Queensland and Australia. 5. Whether there are ways to prevent a similar death occurring in the future.	No
Phillips, Sharron	Adjourned DTBF for hearing	Terry Ryan	1. The findings required by section 45(1) & (2) of the Coroners Act 2003, namely; whether or not Sharron Phillips is in fact deceased and, if so, how, when and where she died and what caused her death; 2. The circumstances surrounding Sharron Phillips' disappearance; and 3. Consider whether the actions or omissions of any person caused the disappearance.	No

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Powell, Christopher Ian	Adjourned DTBF for findings	Donald MacKenzie	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 Industry best practices guides, in particular the Safe Support Mobile Plant Guide (2018), the EWPA Good Practice Guide and Australian Standards for the use of Elevated Work Platforms (EWPs) be amended in its guidance for EWP operators' assessments of ground types/conditions. 3. How the operator of an EWP can find information about a site in order to assess the ground conditions. 4. How to facilitate: (i) an operator of an EWP to make inquiries of a person possibly possessing relevant information about the site, or (ii) information being provided to an EWP operator before the EWP is brought to the site.	No
Row Row, Frederick Arthur James	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. Determine whether the authorities charged with providing for Mr Row Row's mental health and physical care at Capricornia Correctional Centre prior to his death, adequately discharged those responsibilities; 3. Consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances, including: a. the sufficiency of staffing the Detention Unit; b. whether changes need to be made in how risk assessment and RAT's are conducted; c. whether 'at-risk' prisoners should be housed in a more appropriate Unit within the facility that allows for continuous observation and monitoring.	No
Sharma, Manmeet	Adjourned DTBF for hearing	Terry Ryan	(I) The findings required by s.45(2) of the Coroners Act 2003; namely identity of the deceased, when, where and how he died and what caused his death. (II) Consideration of the Mental Health treatment provided to Mr. O'Donohue by the various Mental Health Services in Queensland. (III) Consideration of the circumstances and decision to discharge Mr. O'Donohue from the Metro South Mental Health Service in 2016. (IV) Consideration as to the actions taken, and those proposed, since October 2016, by the Queensland Government to Mental Health Services for high-risk consumers. (V) What further actions, if any, could be undertaken to prevent a similar tragedy from occurring again in Queensland, including any further changes necessary to address bus and bus operator safety?	No
Sheppard, Mark Andrew	Adjourned DTBF for findings	Terry Ryan	1. The findings required by s 45(2) of the Coroners Act 2003 (Qld); namely the identity of the deceased, when, where and how he died and what caused their death; 2. Whether the actions of the police officers who attended at the Endeavour Caravan Park were appropriate in the circumstances; & 3. Whether there are ways to prevent a death occurring in similar circumstances in the future.	No

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Tilberoo, Shiralee Deanne	Adjourned DTBF for hearing	Jane Bentley	1. The findings required by s.45(2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how she died and the cause of her death. 2. Adequacy of checks conducted by watch house staff whilst Ms Tilberoo was in custody; 3. Adequacy of the provision of medical treatment in the watch house; 4. Appropriateness of current Queensland Police Service policies and procedures relating to the supervision of prisoners in watch houses; 5. Appropriateness of the communication and liaison with next of kin and family following a death in custody of Ms Tilberoo.	No
Whiskey Au Go-Go	Adjourned DTBF for hearing	Terry Ryan	a. The findings required by section 45(2) of the Act in respect of each of the deceased persons, in particular, the circumstances that led to the WAGG fire; b. Whether James Richard Finch and John Andrew Stuart were the only parties who caused or contributed to the deaths; c. The identity of any other parties who caused or contributed to the deaths; d. The adequacy of the investigations carried out into the causes of and parties responsible for the fire and the deaths, immediately thereafter, and over subsequent years; e. Whether there are any matters about which recommendations might be made pursuant to section 46 of the Act.	No
Williams, Craig Leeton	Adjourned DTBF for findings	Christine Clements	The inquest will investigate: 1. whether the care and treatment provided to Mr Williams at Jacana was appropriate and sufficient in his particular circumstances; 2. whether there was/were any failure(s) in the care and treatment provided to Mr Williams which is likely to have caused or hastened his death; and 3. whether there are any further recommendations which can be made which could prevent deaths from happening in similar circumstances in the future.	No
Wylucki, Vlasta	Adjourned DTBF for hearing	Jane Bentley	1. The findings required by s.45(2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how she died and the cause of her death; 2. Adequacy of checks conducted by watch house staff whilst Ms Wylucki was in custody; 3. Adequacy of the provision of medical treatment in the watch house; and 4. Appropriateness of current Queensland Police Service policies and procedures relating to the supervision of prisoners in watch houses.	No

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