

Inquest Proceedings

Please refer to the CCQ - COVID-19 arrangements notice from the State Coroner

[Coroners Court of Queensland - COVID-19 arrangement - July 2022 \(courts.qld.gov.au\)](https://courts.qld.gov.au)

All persons entering Queensland Courts are strongly encouraged to wear face masks when inside court buildings.

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	NPO
Abdi, Raghe Mohamed; Antill, Maurice Frederick; Antill, Zoe Dorothea	Adjourned DTBF for hearing	Stephanie Gallagher	<ul style="list-style-type: none"> • The findings required by s.45(2) of the Coroners Act 2003; namely the identity of the deceased persons, when, where and how he/she died and the cause of his/her death. • 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. • What further actions, if any, could be undertaken to prevent a similar incident from occurring again in Queensland? 	Yes
Bahram, Mohamad Ikraam	Inquest scheduled for 17 Jan 2023 to 20 Jan 2023 at 10:00am in Court 4 at BRISBANE	Terry Ryan	<ol style="list-style-type: none"> 1. The findings required by s.45(2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how he died and the cause of his death. 2. Consideration of the circumstances leading up to the shooting of the deceased man by Police on the 23 February 2020, including his mental health treatment. 3. Whether the police officers involved acted in accordance with the Queensland Police Service (QPS) policies and procedures then in force and whether said actions were appropriate. 4. Whether the training provided to officers in responding to a similar incident is sufficient. 	No
Ball, Leslie Ralph	Adjourned DTBF for findings	Stephanie Gallagher	<ol style="list-style-type: none"> 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	Inquest scheduled for 9 May 2023 to 10 May 2023 at 10:00am in Court 2 at CAIRNS	Nerida Wilson	1. Findings required by s 45(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; 2. If deceased, the circumstances surrounding her death; and 3. If deceased, whether the actions of any other person contributed to her death. 4. The adequacy of the police investigation.	Yes
Brooks, Jeffrey Lawrence	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 person, when, where and how he died and the cause of his death, including how the gunshot wound came to be identified. 2. The adequacy of the police investigation and the processes relating to the management of exhibits.	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
Dodunski, Gareth Leo	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 this death. 2. The circumstances surrounding the death and, in particular, the chain of events leading to the deceased's death by gross cerebral trauma caused by a crushing injury from a drill rig ST-80 Iron Roughneck tool. 3. The adequacy of safety management systems both at the time of this death and now to prevent or minimise risk of death or injury relating to the operation of the drill rig ST-80 Iron Roughneck tool. 4. The adequacy and timeliness of investigations conducted by police, work health and safety and petroleum and gas inspectorates in relation to this death. 5. What actions have been taken since this death to prevent deaths from happening in similar circumstances in the future. 6. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003.	No
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	Adjourned 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. 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

GLT	Adjourned for findings	Terry Ryan	<ol style="list-style-type: none"> 1. The findings required by s.45(2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how he died and the cause of his death. 2. The circumstances surrounding GLT's death including the attending officers' manner of force in an attempt to restrain GLT; 3. The appropriateness of police response in placing GLT in the POD despite complaints of not being able to breathe during the arrest; 4. Whether the officers should have recognised if GLT's condition was deteriorating and required first aid; 5. Whether the officers' actions complied with the requisite QPS policies and procedures, and; 6. Whether any preventative recommendations might be made that could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice. 	Yes
Grimes, William George	Adjourned for findings	Terry Ryan	<ul style="list-style-type: none"> • 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. • Consideration of the circumstances leading up to the decision by police to taser Mr. Grimes on or about the 3 March 2020. • Consideration of Mr. Grimes mental health care and treatment prior to his death. • Whether the police officers involved acted in accordance with the Queensland Police Service (QPS) policies and procedures then in force and whether said actions were appropriate. • Whether the training and equipment provided to officers in responding to a similar incident is sufficient. 	No
Harvey, Thompson James	Adjourned DTBF for hearing	Terry Ryan	<ol style="list-style-type: none"> 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
Ishak Ahmed, Faysal	Pre inquest conference scheduled for 13 Feb 2023 at 10:00am in Court 4 at BRISBANE	Terry Ryan	<ol style="list-style-type: none"> 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 medical care and treatment provided to Mr. Ishak Ahmed whilst he was detained at the Manus Island Regional Processing Centre; 3. The adequacy and appropriateness of the treatment and care provided to Mr. Ishak Ahmed at the Manus Island Regional Processing Centre immediately following a fall on 22 December 2016, until the time of his medical evacuation; 4. The adequacy and appropriateness of the policies and procedures in place at, and with respect to, the Manus Island Regional Processing Centre in December 2016 relating to medical evacuations; 5. Whether there was an avoidable delay in Mr. Ishak Ahmed being medically evacuated from the Manus Island Regional Processing Centre to Australia; 6. The adequacy and appropriateness of any steps taken by the International Health and Medical Services or Department of Immigration and Border Protection, to prevent a similar death from occurring. 	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
Klumper, Joshua William	Adjourned for hearing	Stephanie Gallagher	<ol style="list-style-type: none"> 1. Whether the decision to close Joshua to the Child and Youth Mental Health Service in February 2017, was appropriate in the circumstances and made in accordance with relevant policies and procedures. 2. Whether the treatment and care provided to Joshua on 2 September 2017 was appropriate in the circumstances. 3. Whether Ms Wharton gave consent to Joshua being placed on the morphine and midazolam infusion on 14 September 2017. 	No

Kohl, Jennifer	Inquest scheduled for 09 May 2023 to 11 May 2023 at 10:00am in Court 15 at SOUTHPORT	Carol Lee	<ol style="list-style-type: none"> 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. What caused the mower to roll and land on Ms Kohl. 3. Whether Mr Jacobi and Ms Singleton had implemented appropriate workplace health and safety measures in relation to the use of the mower on the property. 4. Whether the Queensland Ambulance Service appropriately dispatched the paramedics and Queensland Fire and Emergency Services to the accident scene. 5. Whether there was a delay in the dispatch of emergency services, and if so, could this have been avoided, and would it have made any difference to the outcome. 6. What measures are in place to safeguard international backpackers, such as Ms Kohl and Mr Tunik, undertaking farm work, and are these measures adequate. 	No
Maddison, Ricky Charles	Adjourned DTBF for hearing	Terry Ryan	<ol style="list-style-type: none"> 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 findings	Terry Ryan	<p>The findings required by s45 of the Coroners Act 2003:</p> <ol style="list-style-type: none"> (a) who the deceased person is; (b) how the person died; (c) when the person died; (d) where the person died, (e) what caused the person to die. 	Yes
McLeod, Charmaine Louise	Pre inquest conference scheduled for 21 Feb 2023 at 10:00am in Court 4 at BRISBANE	Stephanie Gallagher	<ol style="list-style-type: none"> 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 appropriateness and adequacy of the police responses to the complaints of domestic and family violence and allegations of abuse made by Charmaine McLeod against her and her children. 3. The appropriateness and adequacy of the mental health responses by Queensland Health, associated entities and service providers responsible for Charmaine McLeod's care, treatment and monitoring as well as their responses to her domestic and family violence complaints and child abuse complaints. 4. The appropriateness and adequacy of responses by relevant agencies to the protection, safety and welfare of the children, including Department of Children, Youth Justice and Multicultural Affairs, the Queensland Police Service and Queensland Health. 	Yes
Molayee, Omid	Inquest scheduled for 05 Dec 2022 to 09 Dec 2022 at 10:00am in Court 4 at BRISBANE	Terry Ryan	<ul style="list-style-type: none"> • 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. • Consideration of the circumstances leading up to the shooting of Mr Molayee by Police on the 6 April 2020. • Consideration of the appropriateness and sufficiency of the actions by the attending police officers on 6 April 2020 in relation to Mr. Molayee, including but not limited to, the tactical strategy employed, effectiveness of the negotiations conducted and the decision by police to use lethal force. • Consideration as to whether the police officers involved acted in accordance with the Queensland Police Service (QPS) policies and procedures then in force and whether said actions were appropriate. • Consideration as to whether the training provided to officers in responding to a similar incident is sufficient. • Consideration of the adequacy of the investigation into the death conducted by officers from the Queensland Police Service (QPS) Ethical Standards Command. 	No

Moroney, Madeleine Kate	Adjourned DTBF for findings	David O'Connell	<p>1. The information required by section 45(2) of the Coroners Act 2003, namely-</p> <p>(a) Who the deceased person is?</p> <p>(b) How (i.e. by what means, and in what circumstances) the person died?</p> <p>(c) When the person died?</p> <p>(d) Where the person died?</p> <p>(e) What was the medical cause of death?</p> <p>2. Who was driving the Toyota Land Cruiser utility Reg No 359-WZM when it overturned on Ourdel Station, Windorah, in the early hours of 12 August 2017?</p>	No
Phillips, Sharron	Adjourned DTBF for findings	Terry Ryan	<p>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;</p> <p>2. The circumstances surrounding Sharron Phillips' disappearance; and</p> <p>3. Consider whether the actions or omissions of any person caused the disappearance.</p>	Yes
Rasmussen, Hayward	Adjourned for findings	Terry Ryan	<p>a. the findings required in accordance with s.45(2) of the Coroner's Act; and</p> <p>b. whether Mr Rasmussen had access to, and received appropriate medical care whilst he was in custody.</p>	No
RHD Cluster; Booth, Yvette Michelle Wilma; George, Shakaya; Sandy, Adele Estelle	Adjourned DTBF for findings	Nerida Wilson	<p>(a) The findings required by s45(2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how they died and what caused their deaths;</p> <p>(b) The adequacy of the primary health services provided by Gidgee Healing at Doomadgee in providing treatment, education and follow up to the deceased persons regarding their diagnosis of RHD;</p> <p>(c) The adequacy of the care provided by Doomadgee Hospital to the deceased persons, with particular emphasis on the six (6) months prior to their deaths;</p> <p>(d) Whether there was a delay transferring of Ms Shakaya (aka Kaya) George to the Queensland Children's Hospital for surgical intervention, and if so, why;</p> <p>(e) The adequacy of the care provided to Ms Shakaya (aka Kaya) George by the Queensland Children's Hospital in the period 28 July 2020 to 12 September 2020;</p> <p>(f) The adequacy of screening for RHD and the public health, education/prevention and follow up provided in the Doomadgee community regarding ARF and RHD.</p>	No
Schulte, John Fredrick	Adjourned for findings	Terry Ryan	<p>1. The findings required by s.45 of the Coroners Act 2003, namely the identity of the deceased person, when, where and how he died and the cause of his death;</p> <p>2. The appropriateness of the police response to reported concern over the deceased's mental health, domestic violence and possession of weapons made by Mrs Schulte on 30 November 2018;</p> <p>3. The appropriateness of the police response to reported concern over the deceased's mental health, domestic violence and possession of weapons made by Mrs Schulte on 17 December 2018;</p> <p>4. The appropriateness of the police response to reported concern over the deceased's mental health, domestic violence and possession of weapons made by Mrs Schulte on 24 December 2018;</p> <p>5. The appropriateness of the review process of specialist officers such as the Domestic Violence Risk Manager;</p> <p>6. Whether further specialist training in domestic violence for general duties police and specialist Domestic Violence Risk Managers may prevent future deaths in such circumstances.</p> <p>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.</p>	Yes

Sharma, Manmeet	Adjourned DTBF for findings	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
South Stradbroke Plane crash; Applebee, Trista Lea & Van Hattem, Martinus	Inquest scheduled for 13 Dec 2022 to 16 Dec 2022 at 10:00am in Court 15 at SOUTHPORT	Carol Lee	1. To enable statutory findings to be made in accordance with section 45(2) Coroners Act 2003 as to the identity of the deceased persons, when, where and how each person died and what caused the person's death, matters including: I. Circumstances of the flight of VH-PAE on 5 June 2019 with reference to the ATSB & Police Air Accident Investigation Reports; II. Level and adequacy of Mr Van Hattem's pilot training for aerobatic flight activity endorsements and his aviation proficiency; III. Adequacy of oversight and regulation of Warbird flying operations; IV. Airworthiness and maintenance of VH-PAE as a YAK-52 aircraft flown in Australia; V. Matters relevant to the prevention of similar accidents in the future and whether any recommendations may be made to reduce the likelihood of deaths occurring in similar circumstances.	Yes
Tafaifa, Selesa	Inquest scheduled for 06 Feb 2023 to 10 Feb 2023 at 10:00am in Court 5, Level B at TOWNSVILLE and 13 Feb 2023 to 17 Feb 2023 at 10:00am in Court 4 at BRISBANE	Stephanie Gallagher	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	No
Thelander, Steven John	Adjourned DTBF for hearing	Stephanie Gallagher	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 Steven Thelander, and those in charge of his care, were appropriately informed of the services MultiCap would provide him? 3. Whether MultiCap appropriately discharged their responsibilities to Steven Thelander? 4. Whether there are ways to prevent a death occurring in similar circumstances in the future?	No
Tilberoo, Shiralee Deanne	Inquest scheduled for 06 Mar 2023 to TBA 2023 at 10:00am in Court 4 at BRISBANE	Stephanie Gallagher	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
Te Paa, Aaliyah Kiri Kowhi; Coolwell, Rayvenna Tyrone Elizabeth; Barefoot; Robertson, Cayenne Muriel	Inquest scheduled for 29 Nov 2022 to 30 Nov 2022 at 10:00am in Court Court 2, Level D at TOWNSVILLE	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 each of them died and what caused each of their deaths and: 2. The adequacy and appropriateness of the actions of the Queensland Police Service on 7 June 2020; 3. The adequacy of the Queensland Police Service Investigation into the circumstances surrounding the deaths; 4. Further actions, if any, which could be undertaken to prevent a similar incident from occurring again.	No
Vignes, Khrys Alan Mark-Kelly	Inquest scheduled for 20 Feb 2023 to 24 Feb 2023 at 10:00am in Court TBA at CAIRNS	Terry Ryan	• 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. • Examine the circumstances and events, which led to the decision by Police to shoot Mr. Vignes on 29 March 2020, including but not limited to, the actions of Mr. Vignes that day, the police response, and the engagement and search management strategies employed to locate him by Police. • Whether the police officers involved acted in accordance with the Queensland Police Service policies and procedures then in force and whether said actions were appropriate. • Whether the training and equipment provided to officers in responding to a similar incident is sufficient.	No

Watcho, Constance May	Inquest scheduled for 15 Dec 2022 to 16 Dec 2022 at 10:00am in Court 4 at BRISBANE	Stephanie Gallagher	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; and 2. The identity of any other persons involved in the death of Constance May Watcho.	Yes
Watts, Billy-Joh	Adjourned DTBF for findings	Donald MacKenzie	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 there was appropriate fatigue and mental health management by Neil Mansell Group; 3. Whether appropriate measures were in place for the unloading of the steel pipes; and 4. Whether there are any further recommendations which can be made which could prevent deaths from happening in similar circumstances in the future.	No
Whiskey Au Go-Go ; Carroll, Decima Selma	Adjourned DTBF for findings	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.	Yes
Williams, Russell James	Adjourned DTBF for hearing	Terry Ryan	a) Whether Mr Williams' intake assessment was reasonable and appropriate in all the circumstances; b) Whether the making and cancellation of Mr Williams' Temporary Safety Order and full Safety Order were reasonable and appropriate in the circumstances; c) Whether the supervision of Mr Williams, upon his return to Secure Unit, was reasonable and appropriate in the circumstances.	No
Wylucki, Vlasta	Inquest scheduled for 06 Mar 2023 to TBA 2023 at 10:00am in Court 4 at BRISBANE	Stephanie Gallagher	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

