QUEENSLAND COURTS

Coroners Court of Queensland
Inquest List for November 2018

at 26 October 2018

Name of deceased	Inquest date and location	Coroner	Issues to be considered	NPO
Appleton, Garry Ronald (combined with MALONE)	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
Banjo, Neil Richard	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.	No
Barrett Centre Deaths; Fowell, William Johnathan Nebauer, Talieha Whiticker, Caitlin Wilkinson	Inquest scheduled for 19 Nov 2018 to 23 Nov 2018 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/she died and what caused his/her death; 2. The immediate circumstances surrounding death; 3. The impact on the person of the closure of the Barrett Adolescent Centre; 4. The adequacy of the management of the person's clinical needs and suicide risk before and after leaving the Barrett Adolescent Centre; 5. Opportunities to improve management of the risk of suicide.	Yes
Blair, Colin Wayne	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 mental health treatment provided to the deceased in the lead up to his death, and whether a referral to the Prison Mental Health Service should have been made earlier; 3. The adequacy of the decisions made at the Risk Assessment Team meeting on 12 November 2015; 4. The adequacy of the observations regime of the deceased in his cell on the day of his death; 5. The adequacy of the response by Arthur Gorrie Correctional Centre and the Brisbane Correctional Centre to the recommendations made as a result of the investigations conducted by the Office of the Chief Inspector; and 6. The adequacy of the cells within the dependency unit of Brisbane Correctional Centre with regard to hanging points and the availability of aids to suicide.	No
Brown, Holly Winta	Adjourned DTBF for findings	Nerida Wilson	• 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	Adjourned DTBF for findings	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
Caboolture Plane Crash 2014; **Aitken, Andrew** **Glesk, Juraj** **Norman, Glenn** **Hohua, Rahuia** **King, Joseph**	Adjourned DTBF for hearing	Terry Ryan	1. The formal findings required to be made pursuant to s 45(2) of the Act – this will incorporate the investigation as to how the crash occurred, and look at the various options including whether uncommanded pilot seat movement was the most likely cause; 2. Whether it was appropriate in the circumstances that, despite being categorised as mandatory for the pilot's seat by the aircraft manufacturer (Cessna), a secondary seat stop modification was not fitted to the aircraft; 3. Whether it is appropriate for air operations involving the transport of tandem parachutists to be classified by CASA as 'private' operations for regulatory purposes; 4. Whether the role of the APF in relation to the carriage of parachutists in aircraft used by its members for parachute operations, and the oversight of parachuting aircraft during the conduct of APF audits is appropriate and sufficient; 5. Whether Skydive Bribie Island provided adequate information to potential tandem parachutists as to the risks associated with its parachuting operations, and whether its pre-flight briefing was appropriate; 6. The adequacy of the responses provided by CASA and the APF to implement the recommendations arising out of the ATSB investigation; 7. The adequacy of the responses provided by CASA and the APF to implement the recommendations, where relevant, arising out of the coronial inquest into the aircraft crash near Willowbank; and 8. Whether any further changes to the regulation of skydiving would reduce the likelihood of deaths occurring in similar circumstances in the future or otherwise contribute to public safety.	No
Coolwell, Shaun Charles	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. Whether the administration of midazolam by Queensland Ambulance Service officers was appropriate; 3. Whether the restraint of Mr Coolwell was appropriate; and 4. To consider if there are ways to prevent a similar death occurring in the future.	No

Dreamworld River Rapids Fatalities Araghi, Roozbeh; Dorsett, Luke Jonathon; Goodchild, Kate Louise; and Low, Cindy.	Inquest scheduled for 12 Nov 2018 to 23 Nov 2018 at 10.00am in Court 17 at SOUTHPORT	James McDougall	• 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 what caused the death. • The circumstances and cause of the fatal incident on the Thunder River Rapids Ride at the Dreamworld Theme Park, which occurred on 25th October 2016. • Examination of the Thunder River Rapids Ride at the Dreamworld Theme Park, including but not limited to, the construction, maintenance, safety measures, staffing, history and modifications. • Examination of the sufficiency of the training provided to staff in operating the Thunder River Rapids Ride. • Consideration of the regulatory environment and applicable standards by which Amusement Park rides operate in Queensland and Australia, and whether changes need to be made to ensure a similar incident does not happen in the future. • What further actions and safety measures could be introduced to prevent a similar future incident from occurring?	Yes
Hamilton, Stella	Adjourned DTBF for findings	Nerida Wilson	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. Whether any persons contributed to her death; 3. The adequacy of security procedures including monitoring the movement of residents and visitors in and around Ozcare Malanda aged care facility; and 4. Whether recommendations can be made that relate to public health and safety and/or to prevent deaths from happening in similar circumstances in the future pursuant to s 46 of the Coroners Act 2003.	No
Hodgkinson, Bryan	Adjourned DTBF for findings	David O'Connell	Coroner was Magistrate GA Stubbins. Matter was adjourned as QPS investigations still ongoing as to suspects in the Murder of the deceased. Inquest remained part-heard until State Coroner transferred file around 23/01/2017.	No
Jones, Anthony John	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
Malone, Terrence Michael (combined with APPLETON)	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
Mason, Annette Jane	Re-opened Inquest scheduled for 19 Nov 2018 to 07 Dec 2018 at 10:00am in Court 34 at BRISBANE	Terry Ryan	Scope of inquest on death required by s24(1) of the Coroners Act 1958; (a) the fact that a person has died; (b) the identity of the deceased person; (c) when, where, and how the death occurred; (d) the persons (if any) to be charged with murder, manslaughter, the offence of dangerous driving of a motor vehicle causing death as set forth in the Criminal Code, section 328A, or any offence set forth in the Criminal Code, section 311.	Yes

Masoumali, Omid	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. 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
Morcombe, Daniel James	Adjourned DTBF for findings	Terry Ryan	The inquest will investigate: Whether Daniel is deceased; If so, how he died when and where he died and what caused his death; The adequacy of the immediate QPS response to the report that Daniel was missing; and The adequacy of the investigation into Daniel's disappearance.	No
Murphy, Maxwell	Inquest scheduled for 03 Dec 2018 to 05 Dec 2018 at 10:00 am in Court TBA at SOUTHPORT	James McDougall	• The findings required by section 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. • With respect to section 45(2)(e) and section 45(2)(c) issues for investigation include (but are not limited to): o the substance Mr Murphy most likely ingested on 21 November 2014. o how the bottle of BACBAN (found by carer Janelle Preston in Mr Murphy's bathroom) came to be there and whether environmental officer Janet Manson in fact left BACBAN in Mr Murphy's room or whether it was left there by another person. o whether the information given to the Poisons Information Line NSW by Pamela Fox, Clinical Nurse Manager, as to the substance and quantity ingested by Mr Murphy was accurate and adequate. o whether the response of staff from Lions Haven for the Aged to Mr Murphy's medical situation was adequate, given the advice provided to them by Poisons Information NSW; o whether the outcome for Mr Murphy may have been different had the medical care he received from Lions Haven been different. o Whether the outcome for Mr Murphy may have been different had QAS been called earlier than they were. o Whether the changes made to policies, procedures and training by Lions Haven for the Aged following the incident involving Mr Murphy are adequate. o Whether the Dominant Pty Ltd Material Safety Data sheets for to BACBAN are accurate and whether any changes to these data sheets are required. o Whether the information regarding the impacts of BACBAN (at 3% and 4.9% concentrate quaternary ammonium compound) held by Poisons Information Line NSW and Poisons Information Line Qld is accurate. o Whether the information given to Lions Haven for the Aged by Poisons Information NSW was adequate and accurate. o Whether the information given to the Emergency Department Gold Coast University Hospital by Poisons Information Qld was accurate and adequate. o Whether any changes to the information held and the information distributed to callers by Poisons Information NSW and Qld regarding BACBAN are required. • Any potential section 46 Coroner Act 2003 recommendations that might be made by the Coroner in this matter, in order to avoid future deaths.	No
Parkes, Michaelangelo George	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 conduct of persons involved in the traffic incident that occurred at 1:37pm on 31 July 2016 at Old Gympie Road, Mount Mellum, including compliance with QPS policies in place at the time.	No
Robinson, Breeana Elaine Stewart	Adjourned DTBF for hearing	James McDougall	I. The findings required by s.45 (2) of the Coroners Act 2003; namely the identity of the deceased person, when, where and how they died and the cause of their death. II. The specific circumstances surrounding Breeana's death, particularly how she came to fall to her death. III. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances.	No

Scaturchio, Joseph Mark	Inquest scheduled for 26 Nov 2018 to 27 Nov 2018 at 10:00 in Court 4 at BRISBANE	Graham Lee	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; 2. The adequacy of the police investigation and maritime services investigation; and 3. 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
Simon, Darrell Gene	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 person, when, where and how he died and what caused his death. 2. The circumstances by which the deceased's remains came to be found at his rural property in May 2016, which was eighteen months after his reported disappearance in November 2014, and why the remains were not located sooner. 3. Whether there are any matters about which preventative recommendations might be made pursuant to section 46 of the Coroners Act 2003.	Yes
Simons, Kathleen	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, how she died, when she died, where she died and what caused her death. 2. Any comments/recommendations that may be required pursuant to section 46 of the Coroners Act 2003. 3. In relation to the circumstances of Ms Simon's death (section 45(2)(b)): a. The adequacy or otherwise of the care received by Ms Simons from Regis Aged Care, its employees and consultants (including wound care consultants visiting the care facility), b. the adequacy of the care provided to Ms Simons by General Practitioners visiting Regis Canning Lodge prior to her death c. Whether communication by Regis Aged Care with Ms Simon's next of kin with respect to the state of Ms Simon's health in the months leading up to her admission to hospital were adequate	No
Skydiving Incident - Mission Beach **PIKE, Kerri** **TURNER, Tobias** **DAWSON, Peter**	Inquest scheduled for 26 Nov 2018 to 30 Nov 2018 at 10:00 in Court 2 at CAIRNS	Nerida Wilson	1. The information required by s45(2) of the Coroners Act 2003 ('the Act'), namely when, where and how Kerri Anne Pike; Peter Michael Dawson and Tobias John Turner died, and what caused their deaths. 2. The circumstances surrounding the deaths of Kerri Pike; Peter Dawson and Tobias Turner including whether there was a mid-air collision between tandem skydivers Peter Dawson and Kerri Pike, and the solo skydiver Tobias Turner and if so, to determine the cause of the collision; 3. To determine if the main, reserve and drogue parachutes (the parachutes') used by Kerri Pike and Peter Dawson, and Tobias Turner on 13 October 2017 deployed appropriately. 4. To determine what, if any, Australian standards, guidelines or practices ('relevant standards') existed on 13 October 2017: (i) to regulate commercial tandem skydivers (in harness with a customer) and a private solo skydiver jumping in the same group; (ii) to regulate the jump pattern or configuration of skydivers during freefall; (iii) to regulate the specifications of parachutes, rigging and packing of the parachutes used by Kerri Pike and Peter Dawson, and Tobias Turner; and (iv) if the relevant standards applied: a. did the parachutes, rigging and the packing of the parachutes comply; b. did Peter Dawson and Tobias Turner comply with the standards applying to freefall during the jump on 13 October 2017; c. did Skydive Cairns comply with respect to the jump of 13 October 2017;	No

			d. were those standards enforceable, if not, should they have been; e. were the standards adequate. 5. To determine the role and responsibility of Skydive Cairns: (i) for the maintenance and packing of all parachutes used by all skydivers during flights operated by Skydive Cairns; (ii) for regulating the jump patterns and configurations of skydivers during freefall during flights operated by Skydive Cairns. 6. To determine if Skydive Cairns had policies and procedures and/or a Safety Management System in place with respect to the tandem skydive of Kerri Pike and Peter Dawson, and the solo skydive of Tobias Turner, and if so, were they complied with, and were they adequate. 7. The role of Workplace Health and Safety Queensland ('WHSQ') and the Civil Aviation Safety Authority ('CASA') in monitoring and enforcing safe practices in the commercial / tourism parachuting industry, including the review of serious and fatal incidents. 8. In accordance with s46 of the Act, are there any comments the Coroner could make which may prevent deaths from happening in similar circumstances in the future?	
Tran, Lucas	Pre inquest conference scheduled for 09 Nov 2018 at 10:00am in Court 4 at BRISBANE	John Lock	1. The findings required by s45 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 of five-month-old Lucas Tran on 18 November 2015 at the home of a Family Day Care Educator. 3. Whether there are any matters about which preventative recommendations might be made pursuant to s 46 of the Coroners Act 2003.	No
Willersdorf, Maria Aurelia	Inquest scheduled for 10 Dec 2018 to 12 Dec 2018 at 9:00 AM in Court 16 at SOUTHPORT	James McDougall	"• The findings required by section 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. • Whether or not staff at Iris Imaging responded adequately to the medical emergency involving Mrs Willersdorf on 14 April 2015. • Whether or not Iris Imaging was appropriately equipped and had adequate procedures, policies and training in place to respond to medical emergencies involving patients. • Whether there are any comments or recommendations that ought to be made pursuant to Section 46 of the Coroners Act 2003."	No
Wills, Michael Vincent	Inquest scheduled for 20 Nov 2018 to 22 Nov 2018 at 10:00am in Court 1 at LONGREACH	David O'Connell	1. The findings required by section 45(2) of the Coroners Act 2003, namely: (a) Who was the deceased person? (b) How did the person die? (c) When did the person die? (d) Where did the person die? (e) What caused the person's death? 2. (a) Pilot error (b) Mechanical failure (c) Maintenance, modifications and/or repairs (d) Design/manufacture issues 3. Whether any further technical investigations should be undertaken addressing the possible cause, or causes, of any mechanical failure suspected to have contributed to this death?	No

Winks, Russell	Pre inquest conference scheduled for 30 Oct 2018 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. Whether the police use of lethal force against Mr Winks was in accordance with the Queensland Police Service 'use of force' policy in the Operational Procedures Manual at the time; 3. Whether there were any 'less than lethal' use of force options open to the officers which they did not take; 4. Whether the investigation by Ethical Standards Command was appropriate and sufficient; and 5. Whether there are any further recommendations which can be made which could prevent deaths from happening in similar circumstances in the future.	No