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Coronial Inquests - April 2016

as at 31 March 2016

Inquest Status Key			
Inquest open:	Inquest scheduled to open		
Inquest part heard:	Inquest adjourned for further hearing		
Findings reserved:	Inquest adjourned for findings		
DTBF - Date To Be Fixed: date not yet allocated			

Inquest Status	Name of Deceased	Inquest Dates	Case Location	Coroner	ReportableType	Issues to be Considered	Date of Death	Place of Death	Non-publication order
Findings reserved	**Antonio, Rachel**	Inquest adjourned DTBF for findings	MACKAY	David O'Connell	Suspected death (missing person)	1. Whether or not Rachel Joy Antonio is deceased? If it is found that she is deceased, then:- 2. When did Rachel die? 3. Where did Rachel die? 4. What caused Rachel's death? 5. How did Rachel die?	Last seen: 25 Apr 1998	Esplanade, BOWEN	NO
Inquest part heard	**Blutcher, Micheal Wayne**	Inquest scheduled for 19 Apr 2016 to 21 Apr 2016 at 9:30 am in Court 3 at ROCKHAMPTON	BRISBANE	Terry Ryan	Death in custody	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 security and surveillance surrounding the Capricornia Correctional Centre so as to prevent prohibited items being accessed by prisoners; and 3. The adequacy of the surveillance within the Capricornia Correctional Centre so as to detect prohibited items in the possession of prisoners.	17-Sep-13	Capricornia Correctional Centre, NORTH ROCKHAMPTON	NO
Inquest open	**Calder, Michael James**	Pre inquest conference scheduled for 15 Apr 2016 at 10:00am in Court 4 at BRISBANE	BRISBANE	John Lock	Health care related death	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 leading up to the death. 3. The appropriateness of the health care provided to the deceased at the Holy Spirit Northside Private Hospital from his admission on 8 July 2014 and up until his death	11-Jul-14	Holy Spirit Northside Hospital , CHERMSIDE	NO
Inquest open	**CAPPS, Ruth**	Pre inquest conference scheduled for 08 Apr 2016 at 10:00am in Court TBA at SOUTHPORT	SOUTHPORT	James McDougall	Violent or unnatural	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 circumstances surrounding the collision between Ms Capps' vehicle and another on Mudgeeraba Road, Mudgeeraba on 18th July 2013. 3. Whether Ms Capps was fit to hold a Queensland driver's license. 4. The role of medical practitioners in assessing a person's fitness to drive and issuing the necessary medical certificates for a license application/renewal, particularly following a license cancellation as a result of a show cause notice. 5. The role and responsibilities of the Department of Transport and Main Roads in relation to assessing driver license applications/renewals for which a medical certificate is required. 6. Whether any modification is required to the current regime in relation to driver license application/renewals and associated medical certificates, following a show cause notice. 7. Whether there are any further measures that could be introduced, which may assist in preventing similar incidents from occurring in the future.	18-Jul-13	Gold Coast Hospital, SOUTHPORT	NO
Inquest part heard	**Chan, Shui Ki**	Inquest scheduled for 4 Apr to 8 Apr 2016 and 14 Apr 2016 to 15 Apr 2016 at 09:30 in Court 5 at BRISBANE	BRISBANE	John Hutton	Violent or unnatural	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.	22 Aug 2012 - 23 Aug 2012	Warrego Highway, LAWES	YES
Inquest part heard	**Cheney, Danny George**	Inquest scheduled for 06 Jun 2016 to 09 Jun 2016 at 13.00 hrs in Court 4 at BRISBANE	CAIRNS	Kevin Priestly	Violent or unnatural	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?	5-Dec-09	Ross River Dam, TOWNSVILLE	NO

Findings reserved	**Clarke, David Michael**	Inquest adjourned DTBF for findings	SOUTHPORT	James McDougall	Violent or unnatural	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 specific circumstances surrounding Mr Clarke's death, including the mechanism of and relevance of any assaults committed upon him from 26 January 2010, until his death; 3. The adequacy and appropriateness of the interactions with Mr Clarke by responding police, emergency communications staff and hospital staff leading up to his admission to hospital, and subsequent death; 4. Whether the police investigation into the assaults upon Mr Clarke ought to have been commenced earlier; and 5. Whether any change to the existing arrangements for reporting assaults by hospital staff committed upon patients prior to their arrival at the hospital, with or without the consent of the patient, are necessary and appropriate.	30-Jan-10	Gold Coast Hospital, SOUTHPORT	NO
Inquest part heard	**Coleman, Kyle Jack**	Inquest scheduled for 04 Apr 2016 to 08 Apr 2016 at 10:00 am in Court Court 1, Level 1 at MOUNT ISA	CAIRNS	Jane Bentley	Suspected death (missing person)	The circumstances surrounding the disappearance of Kyle Coleman	Last seen: 21 Jan 2014	Undilla Cattle Station, MOUNT ISA	NO
Inquest part heard	**COOLWELL, Bradley Karl**	Inquest scheduled for 11 Apr 2016 to 14 Apr 2016 at 10.00am in Court Court 4 at BRISBANE	SOUTHPORT	James McDougall	Death in care	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 conduct of Police who caused Mr Coolwell to be admitted to hospital; 3. The standard of mental and physical health care provided by the Logan Community Hospital; 4. The appropriateness of security measures taken by the Logan Community Hospital staff in relation to Mr Coolwell; and 5. The level and nature of communication between the Logan Community Hospital and Mr Coolwell's family members.	12-Sep-11	Logan Hospital, MEADOWBROOK	NO
Inquest open	**Crowley, Bryon James**	Pre inquest conference scheduled for 14 Apr 2016 at 14.00 hrs in Court 5, Level B at TOWNSVILLE	CAIRNS	Kevin Priestly	Violent or unnatural	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.	30-Sep-15	Bruce Highway, BLUEWATER	NO
Inquest open	**Davis, Bernard Ashton**	Pre inquest conference scheduled for 14 Apr 2016 at 14:00 hrs in Court 5, level B at TOWNSVILLE	CAIRNS	Kevin Priestly	Violent or unnatural	Road and Land Manager's management of the risk to road users from stray horses in the Clement and Bluewater areas near Townsville	31-Jul-15	Leichardt Creek Bridge, BLUEWATER	NO
Inquest open	**Drane, John Edward**	Pre inquest conference scheduled for 15 Apr 2016 at 11:00am in Court 4 at BRISBANE	BRISBANE	John Lock	Violent or unnatural	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 death. 3. The appropriateness of the care provided to the deceased at the residential care facility; in particular, the identification, assessment and management of risks associated with the deceased's recent medical treatment and smoking behaviours. 4. Whether any additional risk management strategies should be implemented in facilities where elderly persons reside so as to ensure their safety in the event of a fire.	9-Jan-14	Royal Brisbane Hospital , HERSTON	NO
Findings reserved	**FINLAYSON, Eric Davis**	Inquest adjourned DTBF for findings	CAIRNS	Kevin Priestly	Violent or unnatural	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.	9-Oct-12	Michaelmas Cay, Coral Sea, Great Barrier Reef, CAIRNS	NO
Inquest open	**Floyd, Leah Elizabeth**	Inquest scheduled for 11 Jul 2016 to 15 Jul 2016 at 10:00am in Court 1 at MAROOCHYDORE	BRISBANE	John Lock	Health care related death	The findings required by s45(2) of the Coroners Act; namely the identity of the deceased, when, were and how she died and what caused her death. 2. The circumstances leading up to the death 3. The adequacy of care provided to the deceased at BE Lifestyle from 19 September 2013 to 6 October 2013, particularly in relation to pressure sore prevention and treatment.	10-Oct-13	Nambour Hospital, NAMBOUR	NO
Inquest open	**Gudge, Shawn Bradley Joseph**	Pre inquest conference scheduled for 14 Apr 2016 at 14:45hrs in Court 5, level B at TOWNSVILLE	CAIRNS	Kevin Priestly	Violent or unnatural	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.	10-May-15	Townsville Hospital, TOWNSVILLE	NO
Inquest open	**Hitchins, Steven John**	Pre inquest conference scheduled for 14 Apr 2016 at 14:30hrs in Court 5, level B at TOWNSVILLE	CAIRNS	Kevin Priestly	Violent or unnatural	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.	3-Aug-14	Townsville Hospital, TOWNSVILLE	NO
Inquest open	**Hou, Xiangxiong**	Pre inquest conference scheduled for 13 May 2016 at 14.00 hrs in Court 2, level 1 at CAIRNS	CAIRNS	Kevin Priestly	Violent or unnatural	Fair and Safe Work Queensland's engagement with accommodation providers about the safety of resort swimming pools following Mr Hou's death.	22-Nov-15	Sea Temple Resort, Pullman Hotel, PALM COVE	NO
Findings reserved	**James, Kesler Lee**	Inquest adjourned DTBF for findings	CAIRNS	Kevin Priestly	Health care related death	1. The clinical management of Master James and Mt Isa Base Hospital, including the opportunity for the treating team to access specialist advice and for arranging the transfer of Master James to a higher level of appropriate care at another facility; and 2. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances.	25-Feb-12	Mt Isa Base Hospital, MOUNT ISA	YES

Inquest open	**Jones, Anthony John**	Pre inquest conference scheduled for 14 Apr 2016 at 10:00am in Court 4 at BRISBANE	BRISBANE	Terry Ryan	Suspected death (missing person)	To be determined	Last seen: 03 Nov 1982	Unknown	NO
Inquest part heard	**Kennedy, Dale Daniel**	Inquest scheduled for 09 May 2016 to 12 May 2016 at 13:00 in Court 2, Level 1 at CAIRNS	CAIRNS	Kevin Priestly	Violent or unnatural	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.	12-Dec-12	Bentley Park College, EDMONTON	NO
Inquest part heard	**KHAZAEI, Hamid**	Pre inquest conference scheduled for 10 Jun 2016 at 10:00 in Court 4 at BRISBANE	BRISBANE	Terry Ryan	Death in custody	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.	5-Sep-14	Mater Hospital Intensive Care Unit, SOUTH BRISBANE	NO
Inquest part heard	**Mickelo, Garnett Allan**	Inquest scheduled for 26 Apr 2016 to 29 Apr 2016 at 10:00 in Court 4 at BRISBANE	BRISBANE	John Lock	Death in custody	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 cardiac care provided to the deceased during his final admission to the Princess Alexandra Hospital (PAH); 3. The adequacy of the management of the deceased's medication upon his discharge from the PAH on 22 November 2012, and his subsequent re-admission to Woodford Correctional Centre; and 4. The adequcay of the health care provided to, and the observations of, the deceased in his cell over 22-24 November 2012.	24-Nov-12	Woodford Correctional Centre, WOODFORD	YES
Findings reserved	**Newport, Glenn Richard**	Inquest adjourned DTBF for findings	BRISBANE	John Hutton	Death certificate not issued and not likely to issue	1. The matters to be considered under section 45 of the Coroners Act 2003, with a particular focus on the issue of what caused Mr Newport's death; 2. Whether Mr Newport's employer had in place adequate policies and procedures relating to arduous physical work in extreme heat; 3. Whether the first aid given to Mr Newport on-site was appropriate; 4. Whether clinical decisions made by medical treating personnel were appropriate; 5. Whether a focus on hydration led to an under appreciation to other heat related medical dangers; and 6. Whether there were underlying physical or pharmacological factors which were exacerbated by strenuous physical activity in extreme heat.	13-Jan-13	Roma Hospital, ROMA	NO
Findings reserved	**Corben, William Chase**	Inquest adjourned DTBF for findings	BRISBANE	John Lock	Violent or unnatural	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. To discover what happened so as to inform the family and the public of how the death occurred, with a view to raising awareness and reducing the likelihood of similar deaths, including by way of preventive recommendations if appropriate.	4-Mar-15	Lady Cilento Children's Hospital, SOUTH BRISBANE	NO
Inquest open	**Plumb, Mark Anthony**	Pre inquest conference scheduled for 06 Apr 2016 at 10:00am in Court 4 at BRISBANE	BRISBANE	John Lock	Health care related death	1. the findings requested 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 appropriateness of the surgical procedure conducted by Dr Pitre Anderson on 19 September 2014; The appropriateness of the post-operative care provided to Mr Plumb at the Friendly Society Private Hospital in Bundaberg, including whether staff recognised and responded appropriately to Mr Plumb's clinical deterioration; 4. The timeliness of the decision to transfer Mr Plumb to the Wesley Hospital in Brisbane for urgent surgical treatment.	23-Oct-14	Wesley Hospital, AUCHENFLOWER	NO
Inquest part heard	**Police Shooting -** **FOSTER, Troy Martin**	Findings scheduled for 3 May 2016 at 10:30am in Court 4 at Brisbane	BRISBANE	Terry Ryan	Death in custody	1. The findings required by s. 45(2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how they died and what caused the death; 2. The appropriateness of actions by the attending police officers on the facts of the particular case; 3. The appropriateness of the current QPS use of force model and the options of force available to police officers; 4. The appropriateness of the current training provided by the QPS to its officers with respect to 'shoot to kill', rather than 'shoot to wound'; 5. The adequacy of the investigation into the death conducted by the Ethical Standards Command Internal Investigations Group, particularly the separation of the first response police officers post-incident and the timing of their interviews with ESC officers; 6. The adequacy of the response to the initial call for assistance by the dog squad officers; 7. The adequacy of the availability of information/records from Queensland Health, and other medical practitioners, regarding mental health history to the QPS; 8. The adequacy of the current process by which police escort a person detained under ss33 – 36 of the Mental Health Act 2000, in particular: • the circumstances where that person is wanted for a serious offence/s; • whether the police should remain with that person until the MHA process is finalised; and • what other security measures are there at a hospital for this category of person to prevent his/her absconding? 9. The current position regarding ownership of body worn cameras used by QPS officers and the storage of data; and 10. Lessons learned from these incidents as to the benefits of body worn cameras being used by the police officers in terms of: • preserving evidence; • providing a reliable record of what occurred; • avoiding unnecessary controversy about what happened; • vindicating police officers who have acted in accord with their training and policy.	24-Nov-14	SOUTHPORT	YES

Inquest part heard	**Police Shooting -** **KUMEROA, Shaun Basil**	Inquest adjourned DTBF for hearing	BRISBANE	Terry Ryan	Death in custody	1. The findings required by s. 45(2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how they died and what caused the death; 2. The appropriateness of the current QPS use of force model and the options of force available to police officers; 3. The appropriateness of the current training provided by the QPS to its officers with respect to 'shoot to kill', rather than 'shoot to wound'; 4. The adequacy of the investigation into the death conducted by the Ethical Standards Command Internal Investigations Group, particularly, the separation of the first response police officers, post-incident, and the timing of their interviews with ESC officers; 5. The regulation of replica firearms in QLD; 6. The use of negotiators and the options available for use when trying to negotiate a surrender plan with an offender; 7. The effectiveness of the negotiation processes in the present case, including the reason for any technical difficulties encountered; 8. The positioning of the inner cordon police officers in the present case leading to the necessity to use lethal force soon after Shaun departed his car; 9. The appropriateness of actions by the attending police officers, generally, on the facts of the particular case; 10. The opiate treatment program in QLD and the restriction of individuals to one particular dispensing clinic; 11. The current position regarding ownership of body worn cameras used by QPS officers and the storage of data; and 12. Lessons learned from these incidents as to the benefits of body worn cameras being used by the police officers in terms of: • preserving evidence; • providing a reliable record of what occurred; • avoiding unnecessary controversy about what happened; and • vindicating police officers who have acted in accord with their training and policy.	29-Sep-14	INALA	YES
Inquest part heard	**Police Shooting -** **LOGAN, Edward Wayne**	Inquest adjourned DTBF for hearing	BRISBANE	Terry Ryan	Death in custody	1. The findings required by s. 45(2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how they died and what caused the death; 2. The appropriateness of actions by the attending police officers on the facts of the particular case; 3. The appropriateness of the current QPS use of force model and the options of force available to police officers; 4. The appropriateness of the current training provided by the QPS to its officers with respect to 'shoot to kill', rather than 'shoot to wound'; 5. The adequacy of the investigation into the death conducted by the Ethical Standards Command Internal Investigations Group, particularly, the separation of the first response police officers, post-incident, and the timing of their interviews with ESC officers; 6. The adequacy of the availability of information/records from Queensland Health and other medical practitioners, regarding mental health history 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: • preserving evidence; • providing a reliable record of what occurred; • avoiding unnecessary controversy about what happened; and • vindicating police officers who have acted in accord with their training and policy.	23-Nov-14	TEWANTIN	YES
Inquest part heard	**Police Shooting -** **YOUNG, Anthony William**	Inquest adjourned DTBF for hearing	BRISBANE	Terry Ryan	Death in custody	1. The findings required by s. 45(2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how they died and what caused the death; 2. The appropriateness of the current QPS use of force model and the options of force available to police officers; 3. The appropriateness of the current training provided by the QPS to its officers with respect to 'shoot to kill', rather than 'shoot to wound'; 4. The appropriateness of actions by the attending police officers on the facts of the particular case; 5. The adequacy of the investigation into the death conducted by the Ethical Standards Command Internal Investigations Group, particularly, the separation of the first response police officers, post-incident, and the timing of their interviews with ESC officers; 6. The adequacy of the availability of information/records from Queensland Health and other medical practitioners, regarding mental health history 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: • preserving evidence; • providing a reliable record of what occurred; • avoiding unnecessary controversy about what happened; and • vindicating police officers who have acted in accord with their training and policy.	22-Aug-13	Nambour General Hospital , NAMBOUR	YES

Inquest part heard	**Police Shooting -** **ZIMMER, Laval Donovan**	Findings scheduled for 3 May 2016 at 10:00am in Court 4 at Brisbane	BRISBANE	Terry Ryan	Death in custody	1. The findings required by s. 45(2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how they died and what caused the death; 2. The appropriateness of the current QPS use of force model and the options of force available to police officers; 3. The appropriateness of the current training provided by the QPS to its officers with respect to 'shoot to kill', rather than 'shoot to wound'; 4. The adequacy of the investigation into the death conducted by the Ethical Standards Command Internal Investigations Group, particularly, the separation of the first response police officers post-incident and the timing of their interviews with ESC officers; 5. The adequacy of the availability of information/records from Queensland Health, and other medical practitioners, regarding mental health history to the QPS; 6. The adequacy and appropriateness of the decision by the five attending police to enter the residence of the deceased, thus placing themselves in a restricted environment; 7. Related issues include 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 some kind of negotiation should have been tried using the 000 contact that was under way; whether the officers should have been updated more thoroughly from the results of the 000 contact; 8. The current position regarding ownership of body worn cameras used by QPS officers and the storage of data; and 9. Lessons learned from these incidents as to the benefits of body worn cameras being used by the police officers in terms of: • preserving evidence; • providing a reliable record of what occurred; • avoiding unnecessary controversy about what happened; and • vindicating police officers who have acted in accord with their training and policy.	18-Nov-14	KIPPA-RING	YES
Inquest part heard	**Poxon, Simon James**	Inquest scheduled for 29 Mar 2016 to 01 Apr 2016 at 9:30AM in Court 1 at TOOWOOMBA, Inquest scheduled for 5 Apr 2016 at 10:00AM in Court 4 at BRISBANE	BRISBANE	John Lock	Violent or unnatural	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 death, including identification and management of the risk of persons being struck by vehicles or machinery at the workplace; and 3. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances.	26-Feb-13	TORRINGTON	NO
Findings reserved	**Sweet, Lilli**	Inquest adjourned DTBF for findings	BRISBANE	John Lock	Health care related death	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. The circumstances leading up to Lilli's death. 3. The adequacy and appropriateness of health services provided to Lilli following a splenectomy in 2011, particularly in relation to managing the long-term risk of overwhelming post-splenectomy infection. 4. The adequacy and appropriateness of health services provided to Lilli at the Nambour Hospital following her presentation to the Emergency Department on 25 August 2013.	27-Aug-13	Royal Children's Hospital, HERSTON	YES
Inquest part heard	**Talbot, James Patrick**	Inquest scheduled for 20 Jun 2016 to 23 Jun 2016 at 10:00AM in Court 4 at BRISBANE	BRISBANE	John Lock	Health care related death	• 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.	31-Dec-13	Wesley Hospital, AUCHENFLOWER	NO
Inquest part heard	**WALTON, Christopher Jon**	Inquest scheduled for 04 May 2016 to 06 May 2016 at 10.00am in Court 15 at SOUTHPORT	SOUTHPORT	James McDougall	Violent or unnatural	1. The findings required by Sect 45(2) Coroner's Act 2003; namely the identity of the deceased person, when, where, and how the person died and the cause of death. 2. The circumstances and cause of the awning collapse at 37 James Street, Burleigh Heads on 23 December 2012. 3. Whether the construction method used to attach the awning to 37 James Street, Burleigh Heads, is of common use in Queensland? 4. What further actions and safety measures could be introduced to prevent the future collapse of similar attached awnings?	23-Dec-12	BURLEIGH HEADS	NO
Inquest part heard	**WILSON, Glenn Anthony**	Inquest adjourned DTBF for hearing	CAIRNS	Kevin Priestly	Violent or unnatural	1. How and why did the dory capsize and Mr Wilson drown? 2. If Mr Wilson was attempting to recover an anchor stuck in the reef, how was the risk of capsize and drowning managed and how could it be better managed? 3. Did the design, construction, modification and maintenance of his dory have any impact on the risk of capsize? 4. Adequacy of regulatory standards and framework in reducing the risk of capsize and drowning.	26-Jul-13	Bowden Reef, TOWNSVILLE	NO
Findings reserved	**WLODARCZYK, Julian Werner**	Inquest adjourned DTBF for findings	CAIRNS	Kevin Priestly	Violent or unnatural	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?	29 Apr 2013 - 30 Apr 2013	Daintree River, DAINTREE	YES