# Inquest Proceedings

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

**Coroners Court of Queensland - COVID-19 arrangements**

**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 |
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| **Abdi, Raghe Mohamed; Antill, Maurice; Antill Zoe** | Adjourned DTBF for hearing | Stephanie Gallagher | • 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.<br>• Examine the circumstances surrounding the deaths of Maurice and Zoe Antill at their residence on or around 16 December 2020.<br>• Examine the circumstances leading up to the shooting of Raghe Abdi by police on 17 December 2020.<br>• Consider whether the actions of the attending police officers, who were involved in the shooting, were appropriate in the circumstances.<br>• Consider the adequacy of the police investigation into the deaths.<br>• Consider what further actions, if any, could be undertaken to prevent a similar incident from occurring again in Queensland? | No |
| **Bahram, Mohamad Ikraam** | Inquest scheduled for 17 -19 Jan 2023 at 10:00am in Court 4 BRISBANE | 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.<br>• 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.<br>• 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.<br>• Whether the training provided to officers in responding to a similar incident is sufficient. | No |

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| **Ball, Leslie Ralph** | Pre inquest conference scheduled for 14 Jun 2022 at 10:00am in Court 4 at BRISBANE | Stephanie Gallagher | 1. Whether or not a person has died;<br>2. The identity of the deceased person;<br>3. When, where and how the death occurred;<br>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** | Adjourned DTBF for hearing | Nerida Wilson | 1) The information required by s.45(2) of the Coroners Act 2003, namely –<br>a) When the deceased person died;<br>b) Where the deceased person died;<br>c) How (ie by what means, and in what circumstances) the deceased person died;<br>d) What was the cause of death?<br>2) What caused Toyota sedan Reg No 517-NBX to leave the carriageway and collide with a tree, on Queen's Road, Bowen, on 9 June 2021?<br>3) Should security at youth residential care facilities be reviewed with respect to –<br>a) Reducing the potential for access by unauthorized persons to motor vehicles, or keys to motor vehicles, then located at residential care facilities?<br>b) Are the existing security measures in respect of motor vehicles at youth residential care facilities sufficient?<br>c) Is it desirable that specific security measures, eg key-safes, should be installed at such facilities to reduce potential access to car keys and vehicles?<br>4) With respect to supervision of young persons residing in youth residential care facilities –<br>a) Were there, as at 9 June 2021, Guidelines or Instructions given by the Department to providers of residential care facilities, as to (i) the number of supervisors to be in attendance at a facility at particular times; (ii) the duties of such supervisors; and (iii) the qualifications of such supervisors?;<br>b) Have there been any changes made to such Guidelines or Instructions since 9 June 2001; and if so, what were the changes?<br>c) What were the arrangements, as at 9 June 2021, for the supervision of young persons at such facilities during the hours of night, with respect to (i) the number of supervisors on the premises during the night-time; and (ii) any requirements that a supervisor should be awake at all times during the night-time, to monitor the residents?<br>d) Have there been any changes made to such arrangements or requirements since 9 June 2021?<br>5) Whether it may be desirable, and reasonable, to review the policy underlying placement of young persons in residential care facilities, with a view to more effectively protecting young and vulnerable persons who are to be placed in a facility which also houses youths with greater experience within the Youth Justice System. | Yes |

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| **Brooks, Jeffrey Lawrence** | Inquest scheduled for 26 Jul 2022 to 04 Aug 2022 at 10:00 in Court 4 at BRISBANE | Donald MacKenzie | • 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.<br>• 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.<br>II. The circumstances surrounding the death, including the mechanism by which the injuries were inflicted, and the involvement of another party.<br>III. The response of the Queensland Police Service to the death, including the basis for decisions about prosecution actions.<br>IV. Whether any recommendations can be made to prevent deaths from occurring in similar circumstances. | No |
| **Clarke/Baxter inquest** | Findings scheduled for 29 Jun 2022 in Court 9 at 1:15pm SOUTHPORT and court 4 in BRISBANE (streamed) | Jane Bentley | The inquest will investigate:<br>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;<br>2. The nature and extent of any contact by Hannah Ashlie Clarke with domestic violence services or counselling prior to 19 February 2020;<br>3. The nature and extent of any contact by Rowan Charles Baxter with domestic violence services or counselling prior to 19 February 2020; and<br>4. The appropriateness of responses to any contact by Hannah Ashlie Clarke and/or Rowan Charles Baxter with domestic violence services and the Queensland Police Service prior to 19 February 2020.<br>5. The appropriateness of responses by relevant agencies to the safety and welfare of Aaliyah Baxter, Laianah Baxter, Trey Baxter. | No |

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| **Dodunski, Gareth Leo** | Inquest scheduled for 05 Sep 2022 to 16 Sep 2022 at 10:00 in Court 4 at BRISBANE | 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.<br>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.<br>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.<br>4. The adequacy and timeliness of investigations conducted by police, work health and safety and petroleum and gas inspectorates in relation to this death.<br>5. What actions have been taken since this death to prevent deaths from happening in similar circumstances in the future.<br>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;<br>(a) the fact that a person has died;<br>(b) the identity of the deceased person;<br>(c) when, where, and how the death occurred;<br>(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 |

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| **Forte, Brett Andrew** | 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;<br>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;<br>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;<br>4. Consider the appropriateness of actions by the attending police officers on 29 May 2017 in relation to Ricky Maddison;<br>5. Examine the Queensland Police Service response following the shooting of Senior Constable Brett Forte, including the provision of assistance and retrieval;<br>6. Consider the adequacy of the investigation into the death conducted by officers from the Queensland Police Service (QPS) Ethical Standards Command; and<br>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 |

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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.<br>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.<br>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?<br>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?<br>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 |
| **Ho, Duy Linh** | Inquest scheduled for 07 to 09 Jun 2022 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 person, when, where and how he died and the cause of his death;<br>2. Consideration of the circumstances leading up to the shooting of Mr Duy Linh Ho on 22 July 2019, including the timeliness of the response by police and engagement with Police and the Queensland Ambulance Service at the residence immediately preceding the death;<br>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, including but not limited to, the positioning of officers and decision to remain in the residence; and<br>4. Whether the training provided to officers in responding to a similar incident is sufficient. | No |
| **House Fire Browns Plains; Hely, Gary Matthew & Langha, Doreen Gail** | Findings scheduled for 27 Jun 2022 in Court 9 at 1:15pm SOUTHPORT and court 4 in BRISBANE (streamed) | 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;<br>2. The adequacy of the Queensland Police Service response to Ms Langham's complaints to the Queensland Police Service in relation to Mr Hely;<br>3. The adequacy of the Queensland Police Service response to Ms Langham's triple zero call on the night of her death;<br>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 |

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| **Ishak Ahmed, Faysal** | 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;<br>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;<br>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;<br>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;<br>5. Whether there was an avoidable delay in Mr. Ishak Ahmed being medically evacuated from the Manus Island Regional Processing Centre to Australia;<br>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 |
| **Kermode, Jesse Aaron** | Findings scheduled for 03 Jun 2022 at 10:00 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 person, when, where and how he died and the cause of his death;<br>2. Consideration of the circumstances leading up to the shooting of the deceased man by Police on the 16 September 2018, including his mental health treatment after his release from custody in March 2017, and his engagement with Queensland Corrective Services after his release from custody;<br>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;<br>4. Whether the training provided to officers in responding to a similar incident is sufficient. | No |

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| **Maddison, Ricky 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;<br>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;<br>3. Consider the appropriateness of actions by the attending police officers on 29 May 2017 in response to Ricky Maddison;<br>4. Examine the siege management strategies and negotiation processes employed, including the effectiveness of the negotiation processes;<br>5. Examine the events that led to the decision by police to shoot Ricky Maddison;<br>6. Consider the adequacy of the investigation into the death conducted by officers from the Queensland Police Service (QPS) Ethical Standards Command; and<br>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 | The findings required by s45 of the Coroners Act 2003:<br>(a) who the deceased person is;<br>(b) how the person died;<br>(c) when the person died;<br>(d) where the person died,<br>(e) what caused the person to die. | Yes |
| **Watcho, Constance May** | Pre inquest conference scheduled for 21 Jun 2022 at 10:30am 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<br>2. The identity of any other persons involved in the death of Constance May Watcho. | No |
| **Mitchell, Rowan Douglas** | Inquest scheduled for 5-7 Sept 2022 at 10:00am in Court TBA at GLADSTONE | Terry Ryan | 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.<br>2. The circumstances surrounding Mr Mitchell's death including the attending officers' manner of force in an attempt to restrain Mr Mitchell;<br>3. The appropriateness of police response in placing Mr Mitchell in the POD despite complaints of not being able to breathe during the arrest;<br>4. Whether the officers should have recognised if Mr Mitchell's condition was deteriorating and required first aid;<br>5. Whether the officers' actions complied with the requisite QPS policies and procedures, and;<br>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. | No |

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| **Mitchell, Vanelee Curtis** | Inquest scheduled for 17 Jun 2022 at 10:00am in Court 4 at BRISBANE | 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? | No |
| **Molayee, Omid** | Inquest scheduled for 5 to 9 Dec2022 at 11:00 in Court 4 at BRISBANE | 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.<br>• Consideration of the circumstances leading up to the shooting of Mr Molayee by Police on the 6 April 2020.<br>• 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.<br>• 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.<br>• Consideration as to whether the training provided to officers in responding to a similar incident is sufficient.<br>• 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** | Inquest scheduled for 31 May 2022 to 02 Jun 2022 at 10:00am in Court 4 at BRISBANE | David O'Connell | 1. The information required by section 45(2) of the Coroners Act 2003, namely-<br>(a) Who the deceased person is?<br>(b) How (i.e. by what means, and in what circumstances) the person died?<br>(c) When the person died?<br>(d) Where the person died?<br>(e) What was the medical cause of death?<br>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? | 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;<br>2. The circumstances surrounding Sharron Phillips' disappearance; and<br>3. Consider whether the actions or omissions of any person caused the disappearance. | No |

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| **Pini, Bailey Ezekiel** | Inquest scheduled for 15 Jun 2022 to 17 Jun 2022 at 09.00am in Court at BOWEN | Nerida Wilson | 1) The information required by s.45(2) of the Coroners Act 2003, namely –<br>a) When the deceased person died;<br>b) Where the deceased person died;<br>c) How (ie by what means, and in what circumstances) the deceased person died;<br>d) What was the cause of death?<br>2) What caused Toyota sedan Reg No 517-NBX to leave the carriageway and collide with a tree, on Queen's Road, Bowen, on 9 June 2021?<br>3) Should security at youth residential care facilities be reviewed with respect to –<br>a) Reducing the potential for access by unauthorized persons to motor vehicles, or keys to motor vehicles, then located at residential care facilities?<br>b) Are the existing security measures in respect of motor vehicles at youth residential care facilities sufficient?<br>c) Is it desirable that specific security measures, eg key-safes, should be installed at such facilities to reduce potential access to car keys and vehicles?<br>4) With respect to supervision of young persons residing in youth residential care facilities –<br>a) Were there, as at 9 June 2021, Guidelines or Instructions given by the Department to providers of residential care facilities, as to (i) the number of supervisors to be in attendance at a facility at particular times; (ii) the duties of such supervisors; and (iii) the qualifications of such supervisors?;<br>b) Have there been any changes made to such Guidelines or Instructions since 9 June 2001; and if so, what were the changes?<br>c) What were the arrangements, as at 9 June 2021, for the supervision of young persons at such facilities during the hours of night, with respect to (i) the number of supervisors on the premises during the night-time; and (ii) any requirements that a supervisor should be awake at all times during the night-time, to monitor the residents?<br>d) Have there been any changes made to such arrangements or requirements since 9 June 2021?<br>5) Whether it may be desirable, and reasonable, to review the policy underlying placement of young persons in residential care facilities, with a view to more effectively protecting young and vulnerable persons who are to be placed in a facility which also houses youths with greater experience within the Youth Justice System. | Yes |

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| **RHD Cluster; Booth, Yvette Michelle Wilma; George, Shakaya; Diamond, Adele Estelle** | Inquest scheduled for 18 Jul 2022 at 11.15am in Court 1 at DOOMADGEE | Nerida Wilson | (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;<br>(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;<br>(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;<br>(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;<br>(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;<br>(f) The adequacy of screening for RHD and the public health education and follow up provided in the Doomadgee community regarding ARF and RHD. | No |
| **Schulte, John Fredrick** | Pre inquest conference scheduled for 15 Jun 2022 at 10:00 in Court 4 at BRISBANE | Terry Ryan | 1. The findings required by section 45 of the Coroners Act 2003 (Qld), namely the identity of the deceased person, when, where and how he died and the cause of his death;<br>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<br>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;<br>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;<br>5. The appropriateness of the review process of specialist officers such as the Domestic Violence Risk Manager;<br>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. | No |

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| **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.<br>(II) Consideration of the Mental Health treatment provided to Mr. O'Donohue by the various Mental Health Services in Queensland.<br>(III) Consideration of the circumstances and decision to discharge Mr. O'Donohue from the Metro South Mental Health Service in 2016.<br>(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.<br>(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 20 Sep 2022 to 23 Sep 2022 at 10:00am in Court 15 at SOUTHPORT | Nerida Wilson | 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:<br>I. Circumstances of the flight of VH-PAE on 5 June 2019 with reference to the ATSB & Police Air Accident Investigation Reports;<br>II. Level and adequacy of Mr Van Hattem's pilot training for aerobatic flight activity endorsements and his aviation proficiency;<br>III. Adequacy of oversight and regulation of Warbird flying operations;<br>IV. Airworthiness and maintenance of VH-PAE as a YAK-52 aircraft flown in Australia;<br>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. | No |
| **Tabuai, James Daniel** | Findings scheduled for 30 Jun 2022 at 10:00am in Court 2 at CAIRNS | Nerida Wilson | a. The findings required by s 45(2) of the Coroners Act 2003, namely, when, where and how James Daniel Tabuai died, and what caused his death;<br>b. Whether any person contributed to his death; and<br>c. The adequacy of the police investigation into James Daniel Tabuai's death. | No |
| **Tafaifa, Selesa** | Preliminary directions hearing scheduled for 13 Jun 2022 at 10:00 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 person, when, where and how she died and the cause of her death. | No |

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| **Thelander, Steven John** | Pre inquest conference scheduled for 21 Jun 2022 at in Court TBA 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 he died and what caused his death; and:<br>2. Whether Steven Thelander, and those in charge of his care, were appropriately informed of the services MultiCap would provide him?<br>3. Whether MultiCap appropriately discharged their responsibilities to Steven Thelander?<br>4. Whether there are ways to prevent a death occurring in similar circumstances in the future? | No |
| **Tilberoo, Shiralee Deanne** | 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 person, when, where and how she died and the cause of her death.<br>2. Adequacy of checks conducted by watch house staff whilst Ms Tilberoo was in custody;<br>3. Adequacy of the provision of medical treatment in the watch house;<br>4. Appropriateness of current Queensland Police Service policies and procedures relating to the supervision of prisoners in watch houses;<br>5. Appropriateness of the communication and liaison with next of kin and family following a death in custody of Ms Tilberoo. | No |
| **Watts, Billy-Joh** | Inquest scheduled for 3-5 Oct 2022 at 10:00 in Court 4 at BRISBANE | 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:<br>2. Whether there was appropriate fatigue and mental health management by Neil Mansell Group;<br>3. Whether appropriate measures were in place for the unloading of the steel pipes; and<br>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 inquest** | 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;<br>b. Whether James Richard Finch and John Andrew Stuart were the only parties who caused or contributed to the deaths;<br>c. The identity of any other parties who caused or contributed to the deaths;<br>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;<br>e. Whether there are any matters about which recommendations might be made pursuant to section 46 of the Act. | Yes |

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| **Wylucki, Vlasta** | 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 person, when, where and how she died and the cause of her death;<br>2. Adequacy of checks conducted by watch house staff whilst Ms Wylucki was in custody;<br>3. Adequacy of the provision of medical treatment in the watch house; and<br>4. Appropriateness of current Queensland Police Service policies and procedures relating to the supervision of prisoners in watch houses. | No |

**Disclaimer - Non-publication (suppression) orders (NPO) or statutory provisions prohibiting publication may have been applied to some of the information contained within this list. The onus remains on any person using this information or material from court files to ensure that the intended use of that information or material does not breach any such orders or provision. Should you need to seek assistance about the existence of any orders or provisions contact the Coroners Court of Queensland on 07 3738 7050**