QUEENSLAND COURTS

# CORONERS COURT OF QUEENSLAND

## FINDINGS OF INVESTIGATION

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| CITATION: | **Non-inquest findings into the death of Ashley William Schultz and Jessica May Homewood** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | MACKAY |
| DATE: | 10 September 2026 |
| FILE NO(s): | 2026/353 and 2026/359 |
| FINDINGS OF: | Wayne Pennell<br>Mining and Resources Coroner and Northern Coroner |
| CATCHWORDS: | CORONERS: Fatal motor vehicle collision – Peak Downs Highway – vehicle driven by Jessica May Homewood crossed double centre lines and entered the incorrect side of the roadway, colliding with an oncoming Mitsubishi motor vehicle driven by Ashley William Schultz – evidence established that stimulant drug intoxication and excessive speed significantly impaired Ms Homewood's driving performance – consideration of the relationship between illicit drug use and road safety – drug impairment identified as the principal causal factor in the collision – whether the deaths constituted mining-related deaths requiring a mandatory inquest – Ms Homewood was driving a CoreFleet vehicle leased by a Moranbah-based company but was not employed in, nor engaged in, mining activities at the relevant time – although Mr Schultz was employed within the mining industry, the collision did not arise out of, or in the course of, mining operations and did not involve a mining related injury – not mining related deaths for the purposes of the *Coroners Act 2003 (Qld)* and therefore did not attract the statutory requirement for a mandatory inquest – public interest considerations arose from the demonstrated nexus between illicit stimulant drug use, impaired driving, excessive speed, and fatal road trauma |

## INTRODUCTION

1. These findings concern the deaths of Ashley William Schultz (Mr Schultz), aged 49 years, and Jessica May Homewood (Ms Homewood), aged 39 years, who both died following a catastrophic head-on collision on the Peak Downs Highway near Nebo on the evening of 20 January 2026. The deaths were reportable deaths within the meaning of the *Coroners Act 2003 (Qld)* because they resulted from a motor vehicle incident. The available evidence comprises the detailed investigation undertaken by the Mackay Forensic Crash Unit, the toxicological and forensic medical opinion provided by Dr Mitchell Shaw (Dr Shaw) of Forensic Medicine Queensland, autopsy findings, vehicle data downloads, and associated investigative enquiries.

2. The evidence establishes that this incident was a tragic but fundamentally explainable fatal traffic collision. The circumstances of the collision, the cause of the deaths, and the factors contributing to the collision were thoroughly investigated and are capable of determination on the available evidence.

## CIRCUMSTANCES OF THE COLLISION

3. Between approximately 10:05pm and 10:10pm on 20 January 2026, a fatal two-vehicle collision occurred on the Peak Downs Highway at Epsom, approximately 20 kilometres north-east of Nebo. The collision involved a westbound Toyota Hilux utility driven solely by Ms Homewood and an eastbound Mitsubishi Triton utility driven solely by Mr Schultz.

4. The impact occurred within an eastbound overtaking lane after the Toyota crossed the double centre lines and traversed the one metre painted median separating opposing traffic flows. The collision was a partial-overlap head-on impact involving the right-front portions of both vehicles.

5. The Peak Downs Highway at that location consisted of a three-lane rural highway with one westbound lane and two eastbound overtaking lanes. The road surface was sealed, in good condition, and subject to a 100 km/h speed limit. Queensland Police forensic crash investigators observed no defects, potholes, obstructions, or environmental hazards that might have contributed to the collision. Weather conditions were fine and dry, although the collision occurred during darkness on an unlit section of highway.

6. The physical evidence left at the scene was highly significant. Gouge marks, fluid trails, debris distribution, and the position of detached vehicle components demonstrated that the point of impact was entirely within the eastbound lane being travelled by Mr Schultz. Investigators found no tyre marks indicating emergency braking or evasive manoeuvres by Ms Homewood. Conversely, data recovered from the Mitsubishi demonstrated braking and steering inputs by Mr Schultz immediately before impact.

## INVESTIGATION OF THE SCENE AND VEHICLES

7. The Forensic Crash Unit undertook an extensive examination of the collision scene and both vehicles. Investigators documented significant damage to each vehicle, consistent with a high-energy head-on collision.

8. The Toyota sustained severe right-front impact damage resulting in substantial intrusion into the driver's compartment. Following the impact, the vehicle rolled onto its roof and came to rest inverted on the roadway. Examination established that Ms Homewood had been wearing her seatbelt and that all major airbag systems had deployed. Investigators also located what appeared to be illicit drugs and drug paraphernalia within the vehicle.

9. The Mitsubishi similarly sustained catastrophic front-end damage with extensive intrusion into the driver's compartment. Evidence demonstrated that Mr Schultz was also correctly restrained by a seatbelt and that his vehicle's airbag systems had deployed as designed.

10. Independent mechanical inspections of both vehicles revealed no defect or malfunction capable of contributing to the collision. Vehicle condition was therefore excluded as a causal factor.

## AIRBAG CONTROL MODULE DATA

11. One of the most compelling aspects of the investigation was the retrieval and analysis of Airbag Control Module data from both vehicles. This data provided an objective record of vehicle operation in the final seconds before impact.

12. The Toyota's recorded data commenced approximately 4.85 seconds before impact. During that period, the vehicle remained at speeds between 113 km/h and 115 km/h, above the posted speed limit. Steering data demonstrated a slight but sustained right steering angle. Importantly, there was no recorded reduction in speed and no evidence of any meaningful corrective manoeuvre to return the vehicle to its lane. Investigators concluded that the driver appeared not to have recognised or responded to the developing danger.

13. The Mitsubishi's data revealed a markedly different picture. Approximately one second before impact, steering input changed direction. Half a second before impact, a substantial left steering input was recorded, accompanied by braking and a reduction in speed from approximately 111 km/h to 100 km/h. Investigators interpreted these actions as a conscious and immediate evasive response by Mr Schultz in an attempt to avoid the oncoming vehicle.

14. The objective electronic evidence therefore strongly supports the conclusion that Mr Schultz was alert and reacted appropriately to an imminent hazard, whereas Ms Homewood took no identifiable action to prevent the collision.

## MR SCHULTZ'S MOVEMENTS PRIOR TO THE COLLISION

15. The available material concerning the movements of Mr Schultz provides a relatively clear picture of his activities on 20 January 2026 prior to the fatal collision. The evidence establishes that he was undertaking a routine journey home from work at the completion of a seven-day roster cycle at Moranbah North Coal Mine. The information obtained from employment records, mine access records, the Journey Management Plan (JMP), and telecommunications data demonstrates that his travel arrangements were planned, foreseeable, and consistent with his ordinary employment practices.

### Employment circumstances

16. At the time of the collision, Mr Schultz was employed at Moranbah North Coal Mine, located on Goonyella Road, Moranbah. His place of residence was in Mackay, requiring regular travel between the mine and his home. The records establish that he was working a seven-days-on, seven-days-off roster arrangement and had just completed the final shift of his roster cycle immediately prior to commencing his journey home.

17. His roster records reveal a structured and predictable work pattern. The first shift of the roster cycle commenced on 14 January 2026 and was worked from 11:00am until 9:00pm. Thereafter, he completed six consecutive shifts from 9:00am until 9:00pm, with the final shift concluding on 20 January 2026, the date of the collision. The roster information confirms that he had been engaged in an extended work period spanning seven consecutive days before beginning the return journey to Mackay.

18. The roster evidence is significant because it demonstrates that the journey occurred immediately after the completion of a full work swing. Travel at the conclusion of rostered mining shifts is a common feature of employment arrangements in regional Queensland and forms part of the routine movement of workers between mining communities and coastal population centres such as Mackay. The evidence indicates that Mr Schultz was undertaking precisely such a journey when the collision occurred.

### Departure from Moranbah North Mine

19. Objective mine records provide a reliable indication of when Mr Schultz commenced his journey. Those records show that he swiped out of Moranbah North Coal Mine at approximately 8:46pm on 20 January 2026. This provides a fixed reference point from which the remainder of his movements can be assessed.

20. The swipe-card data demonstrates that he departed the mine shortly before 9:00pm and commenced the approximately 210 kilometre journey to his residence in Mackay. There is no indication within the material that his departure was delayed, unplanned, or unusual in any respect. Rather, the evidence suggests he finished work and proceeded home in accordance with established travel arrangements.

21. From a chronological perspective, the departure time also aligns closely with the completion of his final rostered shift, reinforcing the conclusion that the journey was directly connected with the conclusion of his work commitments.

**Journey Management Plan**

22. Of particular significance is the existence of a JMP. The evidence demonstrates that Mr Schultz was travelling in accordance with a documented JMP on the evening of the collision. The purpose of such plans is generally to encourage safe travel practices, provide structure to the journey, and reduce risks associated with fatigue and long-distance driving.

23. The JMP recorded that he intended to travel approximately 210 kilometres between the mine and his home in Mackay over a period of 2.5 hours. The plan further identified Nebo as a designated rest location, where he intended to stop for approximately ten minutes during the journey.

24. The existence of the planned rest break is notable because it demonstrates that consideration had been given to travel management and fatigue mitigation before the journey commenced. The evidence therefore suggests that the journey was not undertaken spontaneously but had been structured in accordance with workplace travel expectations.

**Progress of the journey**

25. Evidence concerning the progress of the journey is provided through telecommunications records and information supplied by Mr Schultz's wife. On the evening of 20 January 2026, she spoke with him via mobile telephone at approximately 10:00pm. During that conversation he advised that he was at Nebo.

26. Importantly, this account could be verified by examining the call records from his mobile telephone. Those records confirmed that a call occurred at 10:00pm and lasted for forty-one seconds. The presence of objective telecommunications data corroborates the account provided by his wife and strengthens the reliability of the information regarding his whereabouts at that time.

27. It is further accepted that the timing of the call was consistent with his recorded departure from Moranbah and with the anticipated travel time between the mine and Nebo. This observation indicates that his journey was progressing in accordance with the expectations contemplated by the Journey Management Plan. There is no evidence in the available material of any unexpected delays, diversions, or deviations from the planned route before the collision.

**Assessment of the evidence**

28. The evidence available concerning the movements of Mr Schultz is relatively straightforward and internally consistent. Employment records establish that he had completed the final shift of a seven-day work cycle.

29. Mine access records establish the time of his departure. The JMP documented his intended route, anticipated travel duration, and planned rest break. Finally, the mobile telephone records confirm that he had reached Nebo at approximately the time expected under that plan.

30. Collectively, this material supports the conclusion that Mr Schultz was engaged in a routine journey home after work and that his travel arrangements were proceeding substantially as planned. The evidence discloses no indication of unusual activities, personal errands, or significant interruptions during the period between his departure from the mine and the collision. Instead, the available information depicts a worker who had completed a full seven-day roster, departed his workplace, and commenced the familiar journey home to Mackay in accordance with established travel procedures.

## MS HOMEWOOD'S MOVEMENTS PRIOR TO THE COLLISION

31. The available material provides a partial but important reconstruction of Ms Homewood's activities during the afternoon and evening of 20 January 2026, prior to the fatal collision. Although some aspects of her movements remain unknown, the information obtained through employer inquiries, Automatic Number Plate Recognition (ANPR) data, police investigations, club records, CCTV footage, and information supplied by her partner enables a reasonably detailed chronology to be established. The evidence is also relevant to understanding her purpose for travelling to Mackay, her activities before commencing the return journey to Moranbah, and potential factors that may have influenced her condition and decision-making before the collision.

### Employment and reason for travelling to Mackay

32. The evidence indicates that Ms Homewood travelled from Moranbah to Mackay on 20 January 2026 in a CoreFleet Toyota Hilux utility, which was leased by her employer which was a contracting company based in Moranbah. According to inquiries conducted by police with her employer, Ms Homewood was employed with that company in a broad support role involving cleaning duties, yard work, and the collection of parts and supplies for the company.

33. On the day of the incident, she travelled to Mackay to undertake errands on behalf of the company. Importantly, the available information suggests that although she worked for a contractor operating in the Moranbah area, she was not directly employed on a mine site nor engaged in mining activities at the time of the trip.

34. This distinction is significant because it provides context for the journey and indicates that the trip to Mackay was largely administrative and logistical in nature. The evidence supports the conclusion that the Mackay visit was connected with routine employment duties rather than operational mining work.

**Arrival in Mackay and afternoon movements**

35. The earliest objective evidence of Ms Homewood's presence in Mackay comes from ANPR camera data. At approximately 12:29pm on 20 January 2026, her Toyota Hilux was detected at the intersection of Connors Road and Boundary Road, Paget.

36. This location is situated near the Mackay Ring Road and the Walkerston Bypass connection to the Peak Downs Highway, the principal route linking Mackay and Moranbah. Investigators considered this detection to be a likely indication of her arrival in Mackay.

37. The next confirmed sighting of the vehicle occurred more than five hours later when a second ANPR camera recorded the Hilux travelling on Shakespeare Street at 5:42pm. Between these two detections, police were unable to determine with certainty where Ms Homewood travelled or what activities she undertook. This represents a substantial gap in the evidentiary timeline.

38. However, investigators noted an important physical difference between the two ANPR images. The arrangement of toolboxes and a 400-litre plastic fuel tank positioned in the tray of the utility had changed between the sightings.

39. This observation gives rise to a reasonable possibility that Ms Homewood spent part of the afternoon collecting equipment, supplies, or materials and may have refuelled the large fuel tank while in Mackay. Although police were unable to verify these activities, the changed configuration of the load is consistent with the purpose of her employment-related errands.

**Attendance at Souths Leagues Club**

40. Further evidence concerning Ms Homewood's movements was obtained from materials recovered during the collision investigation. A visitor pass from the Souths Leagues Club dated 20 January 2026 and bearing her name was located inside the Toyota Hilux. Follow-up inquiries by police confirmed that she attended the club between 6:38pm and 7:31pm on the evening of the collision. CCTV footage established that she was accompanied by her partner during this period.

41. The club attendance is significant because it narrows the period during which her whereabouts were previously uncertain and provides independent evidence of her activities immediately before commencing the return journey to Moranbah. The CCTV footage further confirmed that Ms Homewood departed the premises in the Toyota Hilux at approximately 7:31pm accompanied by her partner. Investigators calculated that this occurred approximately two hours and thirty-nine minutes before the collision.

**Interactions with her partner**

42. The forensic crash investigator subsequently interviewed Ms Homewood's partner. He confirmed that they had known each other for approximately three years and had been in a relationship for around two years. He also confirmed that she had travelled from Moranbah to Mackay that afternoon and his evidence provides useful contextual information concerning her activities after leaving the Souths Leagues Club.

43. According to her partner, after leaving the club at about 7:30pm they spent some time "chilling down the beach". However, he was notably evasive when questioned about the precise location or what activities occurred during this period. When investigators specifically asked whether illicit drugs had been consumed, he declined to answer directly and instead suggested that police should await pathology results. This response was notable because it left unresolved questions regarding what occurred during the hours before Ms Homewood began her westbound journey.

44. The partner further advised that Ms Homewood dropped him home sometime between 9:00pm and 9:30pm. He stated that she intended to refuel the vehicle, secure the load carried in the tray, and then commence the return trip to Moranbah because she wished to get home to her children. This explanation is consistent with the earlier observations concerning the cargo and fuel tank carried on the utility.

**Return journey towards Moranbah**

45. Evidence obtained from communications between Ms Homewood and her partner provides insight into the commencement of her return journey. Her partner reported receiving a voice-to-text message at approximately 9:45pm indicating that she had reached the top of the Eton Range while travelling west along the Peak Downs Highway. This communication is important because it places her on the return route and demonstrates that she was actively progressing toward Moranbah shortly before the collision.

46. The partner also claimed that he sent Ms Homewood a text message approximately two minutes before the collision informing her that he was doing his washing and that she replied, "Have fun." However, he later acknowledged that he could not confirm the exact timing of that exchange.

**Ms Homewood's condition and state of mind**

47. Ms Homewood's partner's account also sheds light on her physical condition and mindset on the evening of the collision. He described her as being eager to return home to her children and prepare for work. He further stated that she did not consume alcohol and had been drinking soft drinks while at the Souths Leagues Club.

48. According to him, she was experienced in long-distance driving and generally preferred to drive rather than travel as a passenger because she was prone to motion sickness.

49. These observations suggest that Ms Homewood's focus was directed toward completing the journey home and resuming her domestic and employment responsibilities. The evidence also indicates that long-distance road travel was familiar to her and did not constitute an unusual undertaking.

50. Nevertheless, the available material leaves unanswered questions about her activities between their visit to the Souths Leagues Club and the commencement of her return journey, particularly given her partner's reluctance to provide details and his refusal to answer questions concerning possible illicit drug use.

## FORENSIC PATHOLOGY FINDINGS

51. The Preliminary Examination Reports prepared by forensic pathologist Dr Isaac Han (Dr Han) provide a detailed medical account of the injuries sustained by Mr Schultz and Ms Homewood during the fatal two-vehicle collision. The reports were prepared following a review of police material, Queensland Ambulance Service records, medical records, post-mortem CT imaging, external examinations and the collection of toxicological samples. Together, the reports establish the extent of the injuries sustained by each occupant and provide a clear medical explanation for their deaths.

### Death of Mr Schultz

52. According to information reviewed by Dr Han, attending paramedics found extensive damage to the vehicle and identified no signs of life upon their arrival. Mr Schultz was assessed within the vehicle and declared deceased at the scene.

53. The post-mortem CT examination revealed catastrophic injuries involving the chest, abdomen, spine and limbs. Among the most significant findings were extensive right-sided rib fractures accompanied by moderate to large haemothoraces, indicating substantial internal bleeding into the chest cavities. The imaging also identified rupture of the diaphragm with traumatic herniation of the liver into the right chest cavity, demonstrating the severe compressive forces sustained during the collision. Additional injuries included fractures of the thoracic spine at T9/T10, pelvic fractures predominantly affecting the right side, fractures of the left radius, fractures involving both the right radius and ulna, and fractures of the right tibia.

54. These injuries reflected a devastating transfer of force throughout the body and were characteristic of a high-speed head-on motor vehicle collision. The multiple fractures together with the extensive thoracic and abdominal trauma were unsurvivable and explain the absence of signs of life when emergency services arrived at the scene.

55. External examination demonstrated widespread blunt force injuries involving the head, torso and extremities. Similar to the findings in relation to Ms Homewood, there were characteristic banded abrasions across the torso consistent with use of a driver-side seatbelt. This finding indicated that Mr Schultz was restrained at the time of impact and further confirmed the dynamics of the collision.

56. Routine toxicological samples were collected for analysis. As with Ms Homewood, blood and urine specimens were obtained for comprehensive testing and formed part of the wider coronial investigation.

57. After considering the imaging findings, external examination and investigative material, Dr Han concluded that Mr Schultz's death resulted from multiple injuries due to motor vehicle collision (driver). The severity and distribution of the injuries left no doubt that the collision directly caused his death.

**Death of Ms Homewood**

58. According to the information reviewed to Dr Han, Ms Homewood, following the collision, she remained conscious but was trapped within the vehicle, necessitating extrication by emergency services. During that process her condition deteriorated, she suffered a cardiac arrest, and despite resuscitative efforts she was pronounced deceased at the scene.

59. The pathology investigation noted the presence of methylamphetamine within Ms Homewood’s vehicle, a finding that is broadly consistent with her previous convictions for drug-related offending. The investigation also documented a significant medical history, namely a gunshot wound to her left thigh sustained in 2024. As a consequence of that injury, a projectile remained lodged within the thigh following specialist surgical assessment that determined it was appropriate for the projectile to remain in situ. The retained projectile was subsequently identified during post-mortem imaging; however, it bore no relevance to, and did not contribute to, the injuries that caused Ms Homewood’s death.

60. Post-mortem computed tomography demonstrated extensive traumatic injuries resulting from the collision. These included multiple left anterolateral rib fractures, bilateral pneumothoraces with collapse of both lungs, significant internal abdominal bleeding (haemoperitoneum) and a probable splenic injury. Imaging also identified fractures involving the pelvis, right ulna, right femur, right tibia and right fibula. These injuries reflected the enormous forces generated during the collision and indicated severe trauma affecting multiple body systems.

61. External examination revealed extensive blunt force injuries involving her head, torso and limbs. A particularly significant finding was the presence of a banded abrasion across her right shoulder consistent with a driver-side seatbelt mark. This finding indicated that Ms Homewood was restrained at the time of the collision and that the seatbelt functioned as designed during the impact sequence.

62. Blood and urine samples were collected for comprehensive toxicological assessment. Although the results of those analyses were not incorporated into Dr Han’s Preliminary Examination Report itself, they were separately examined as part of the broader coronial investigation as outlined in the report by Dr Shaw.

63. Having considered all available information, Dr Han concluded that the cause of Ms Homewood's death was multiple injuries due to motor vehicle collision (driver). The injuries identified on imaging and external examination were entirely consistent with the reported circumstances and were sufficient to explain her death.

**Comparative analysis of the forensic findings**

64. Dr Han's Preliminary Examination Reports reveal that both Mr Schultz and Ms Homewood sustained extensive polytrauma as a consequence of the same collision. In each case, the injuries involved multiple body regions and reflected the immense forces associated with a head-on impact between two vehicles. Both examinations identified extensive blunt force trauma and evidence of seatbelt restraint use, indicating that each occupant remained restrained during the collision sequence.

65. While both deaths were attributed to multiple injuries arising from a motor vehicle collision, the specific injury patterns differed. Ms Homewood survived briefly after the collision and displayed injuries involving the chest, abdomen, pelvis and lower limbs, together with evidence of respiratory compromise from bilateral pneumothoraces and splenic injury. Mr Schultz, by contrast, sustained catastrophic thoracic injuries including diaphragm rupture, traumatic displacement of the liver into the chest cavity, extensive haemothoraces and spinal fractures, injuries that were immediately fatal.

66. Ultimately, the forensic pathology evidence establishes a clear causal relationship between the collision and the deaths of both drivers. The injuries identified by Dr Han were wholly consistent with the known circumstances of the collision and provide a comprehensive medical explanation for the deaths of Ms Homewood and Mr Schultz.

## TOXICOLOGY AND FORENSIC MEDICAL OPINION

67. The toxicological and forensic medical evidence concerning the deaths of Mr Schultz and Ms Homewood provides important insight into the circumstances surrounding the fatal collision and the factors that may have contributed to its occurrence. The investigation involved toxicological testing conducted by Queensland Health Forensic and Scientific Services and a specialist forensic medical opinion prepared by Dr Shaw who was specifically asked to assess whether the substances detected in Ms Homewood's system were likely to have impaired her capacity to drive safely.

**Toxicology Findings: Mr Schultz**

68. Before addressing the toxicological and forensic interpretation of the samples obtained from Ms Homewood, it is necessary to first consider the toxicological findings relating to Mr Schultz. An examination of his blood and urine specimens provides important context for the investigation and assists in distinguishing the respective contributions, if any, made by intoxicating substances to the circumstances surrounding the fatal collision.

69. Analysis of Mr Schultz's femoral blood identified alcohol at a relatively small concentration of only 13 mg/100 mL together with low therapeutic concentrations of amlodipine (0.02 mg/L) and telmisartan (0.04 mg/L). Urine testing demonstrated alcohol at 11 mg/100 mL. No stimulants, benzodiazepines, cannabis, cocaine metabolites, opiates or other impairing substances were detected.

70. The medications detected, amlodipine and telmisartan, are commonly prescribed antihypertensive agents used in the treatment of elevated blood pressure and cardiovascular disease. The concentrations detected were low and consistent with therapeutic use. There was no indication from the toxicological findings that either medication contributed to impairment or played a role in the collision circumstances.

71. The exceptionally low alcohol concentration detected in both blood and urine was well below any level ordinarily associated with impairment. Importantly, the toxicological testing excluded the presence of illicit drugs, including amphetamines, MDMA, cannabis and cocaine metabolites. The results therefore provide no evidence that intoxication or substance impairment contributed to Mr Schultz's actions or behaviour at the time of the collision.

**Toxicology Findings: Ms Homewood**

72. Toxicological testing performed on samples obtained from Ms Homewood revealed a markedly different profile to those of Mr Schultz. Post-mortem toxicological analysis of femoral blood collected from her revealed the presence of multiple stimulant substances. Alcohol was not detected. However, testing identified amphetamine at 0.20 mg/L, methylamphetamine at 1.7 mg/L, methylenedioxymethylamphetamine (MDMA) at 0.15 mg/L, methylenedioxyamphetamine (MDA) at 0.01 mg/L and benzoylecgonine at 0.08 mg/L. Urine analysis was positive for amphetamines and cocaine metabolites, with no evidence of benzodiazepines, cannabinoids, opiates or barbiturates.

73. The toxicological findings disclose recent use by her of a combination of stimulant drugs. The presence of methylamphetamine, amphetamine, MDMA and MDA indicates ingestion of potent central nervous system stimulants, while benzoylecgonine represents the principal metabolite of cocaine and confirms prior cocaine use. Although cocaine itself was not detected, the benzoylecgonine concentration demonstrated that cocaine had been consumed at some time before death, potentially within the preceding hours or one to two days.

**Forensic interpretation by Dr Shaw**

74. In his comprehensive forensic opinion, Dr Shaw explained the pharmacological significance of the substances detected. He noted that amphetamine and methylamphetamine are potent sympathomimetic stimulants that affect both the central nervous system and autonomic nervous system. Their effects include heightened alertness, euphoria, inflated confidence, increased energy and reduced fatigue. However, they are also associated with anxiety, confusion, irritability, hyperactivity, impaired judgement and risk-taking behaviour. Long-term use can lead to dependence and significant behavioural disturbances.

75. Dr Shaw observed that stimulation from methylamphetamine can occur at concentrations as low as 0.02 mg/L. By contrast, Ms Homewood's measured femoral blood concentration of methylamphetamine was 1.7 mg/L, a level he described as extremely high, even allowing for the recognised phenomenon of post-mortem redistribution. He considered that this concentration was substantially above levels ordinarily associated with impairment.

76. Dr Shaw further noted that MDMA is a stimulant and hallucinogenic substance known to impair safe driving. Its effects include psychomotor agitation, confusion, impaired concentration and sleep disturbance. The concentration of MDMA detected in Ms Homewood's blood was considered sufficiently high to be physiologically active at the time of the collision.

77. The combination of methylamphetamine and MDMA was regarded as particularly significant. Dr Shaw explained that both substances are incompatible with safe driving and are associated with a markedly increased risk of traffic collisions. Scientific studies reviewed by him demonstrated substantially increased odds of collision culpability in drivers with methylamphetamine in their system. He noted there is no recognised safe level of methylamphetamine use for driving.

**Relationship between drug use and the collision**

78. In assessing the significance of the toxicology results, Dr Shaw concluded that the driving behaviour described by investigators, namely travelling above the speed limit and failing to successfully negotiate a bend in the roadway, could readily be explained by the effects of methylamphetamine and MDMA.

79. Dr Shaw further observed that stimulant intoxication may lead to impaired judgement, excessive confidence, poor impulse control and risk-taking behaviour. Importantly, Dr Shaw also considered alternative mechanisms associated with stimulant use. He noted that methylamphetamine and MDMA can produce prolonged periods of wakefulness followed by profound fatigue and hypersomnolence. Consequently, loss of control might also be explained by fatigue-related impairment following a period of stimulant use. Furthermore, he explained that both methylamphetamine and MDMA are capable of precipitating neurological or cardiovascular events that could cause a sudden loss of consciousness.

80. After weighing these possibilities, Dr Shaw ultimately concluded that the driving behaviour observed in this case was readily explicable by the effects of stimulant intoxication and that the drugs detected were likely to have significantly impaired Ms Homewood's ability to drive safely.

**Toxicological and forensic conclusion**

81. The toxicological and forensic medical evidence reveals a stark contrast between Mr Schultz and Ms Homewood. The forensic and toxicological investigation relating to Ms Homewood demonstrated significant recent use of methylamphetamine, MDMA and cocaine, with methylamphetamine concentrations reaching a level that Dr Shaw

considered extremely high and clearly capable of causing substantial driving impairment. He concluded that the excessive speed and failure to successfully negotiate a bend could readily be explained by the effects of those stimulant substances, either directly through intoxication or indirectly through fatigue, loss of consciousness, or a drug-induced medical event.

82. Conversely, the toxicological findings relating to Mr Schultz disclosed only low therapeutic concentrations of prescribed cardiovascular medications and negligible alcohol levels. There was no toxicological evidence of illicit drug use or impairment. Accordingly, the available toxicological evidence does not support any conclusion that intoxication or impairment contributed to Mr Schultz's involvement in the collision.

83. Taken together, the toxicological evidence strongly supports the conclusion that stimulant drug intoxication was a significant factor affecting Ms Homewood's driving performance, whereas no comparable toxicological factor was identified in relation to Mr Schultz

## CAUSE OF THE COLLISION

84. Having regard to all evidence, the cause of the collision is clear.

85. The physical evidence, vehicle damage patterns, electronic data, toxicology findings, and forensic medical opinion consistently indicate that Ms Homewood drove her Toyota from the westbound lane across the double centre lines and median into the path of oncoming traffic.

86. She was travelling above the speed limit and took no identifiable evasive action. At the time she was significantly affected by illicit stimulant drugs, particularly methylamphetamine and MDMA.

87. There is no evidence that road conditions, weather, mechanical defects, fatigue affecting Mr Schultz, mobile phone distraction, animal activity, another vehicle, or deliberate self-harm contributed to the collision. Each of those possibilities was specifically investigated and excluded.

88. The evidence supports the conclusion that drug impairment affecting Ms Homewood was the principal causal factor in the collision and that Mr Schultz was an innocent road user who attempted to avoid the impact when confronted by the hazard.

## FINDINGS REQUIRED BY SECTION 45(2) OF THE CORONERS ACT 2003 (QLD)

89. Having carefully reviewed and considered all of the evidence obtained during the coronial investigation, including the police, forensic, medical and expert materials, I am able to make the following findings pursuant to section 45(2) of the *Coroners Act 2003 (Qld).*

    (a) **Identity of the deceased:** Ashley William Schultz and Jessica May Homewood.

(b) **How they died:** They died as a consequence of a head-on motor vehicle collision that occurred on the Peak Downs Highway near Nebo, Queensland Ms Homewood was driving a vehicle that crossed onto the incorrect side of the roadway and collided with an oncoming vehicle being driven by Mr Schultz. The evidence establishes that Ms Homewood was significantly impaired by illicit stimulant drugs at the time of the collision. As a result of the impact, both drivers sustained multiple catastrophic injuries from which they died.

(c) **When they died.** On 20 January 2026.

(d) **Where they died.** Peak Downs Highway near Nebo, Queensland.

(e) **What caused their deaths.** Multiple injuries sustained in a motor vehicle collision while driving.

## WHY AN INQUEST IS NOT MANDATORY – WHY THE DEATHS OF MR SCHULTZ AND MS HOMEWOOD DO NOT SATISFY THE LEGISLATIVE CRITERIA FOR A MANDATORY INQUEST UNDER THE CORONERS ACT 2003 (QLD)

90. The deaths of Mr Schultz and Ms Homewood required consideration of the mining-related death provisions introduced by the amendments to the *Coroners Act 2003 (Qld)* establishing the office of the Mining and Resources Coroner. Although Mr Schultz was employed within the mining industry and was travelling home after completing a roster at Moranbah North Coal Mine, the evidence establishes that neither death satisfies the statutory definition of a mining-related reportable death. Consequently, neither death attracts the legislative requirement for a mandatory coronial inquest.

91. The legislative framework requires that a deceased person have suffered a mining-related injury that caused or materially contributed to their death, and that the injury was sustained in connection with qualifying mining, petroleum, gas, data acquisition, or water monitoring activities. The focus of the legislation is upon the nature and origin of the fatal injury rather than the occupation of the deceased. A sufficient causal connection must exist between the injury and the relevant mining operations.

92. Importantly, the statutory scheme does not extend to every death involving a mine worker. The explanatory materials expressly identify motor vehicle collisions occurring while travelling to or from a mine site as examples of deaths that fall outside the definition of a mining-related reportable death. While such deaths may still be investigated by a coroner, they do not automatically attract the mandatory inquest provisions.

93. The evidence establishes that Mr Schultz completed the final shift of a seven-day roster at Moranbah North Coal Mine on 20 January 2026 and departed the mine at approximately 8:46pm. Employment records, swipe-card data, telecommunications records, and the documented Journey Management Plan confirm that he had commenced his ordinary journey home to Mackay in accordance with established

arrangements. At the time of the collision, he was travelling on the Peak Downs Highway near Nebo, having already left the mine site and ceased any involvement in mining activities.

94. Although the journey occurred immediately after a rostered shift, that fact alone is insufficient to satisfy the statutory test. The fatal injuries sustained by Mr Schultz were suffered during a motor vehicle collision on a public roadway approximately 20 kilometres north-east of Nebo. The injuries were not sustained at a mine site, were not connected to mine plant or equipment, and did not arise out of mining operations. Rather, they resulted from a road traffic incident occurring independently of his employment.

95. Similarly, Ms Homewood was not engaged in mining operations at the time of the collision. While she was driving a CoreFleet vehicle leased by a Moranbah-based contractor, police investigations established that her role involved support duties, including cleaning, yard work, and the collection of parts and supplies. On the day of the incident, she had travelled to Mackay to undertake errands on behalf of her employer. Her travel was logistical and administrative in nature and was unrelated to operational mining activities.

96. The Mackay Forensic Crash Unit established that the collision occurred when Ms Homewood drove her Toyota Hilux across double centre lines into the path of the oncoming Mitsubishi Triton driven by Mr Schultz. Physical evidence, electronic collision data, vehicle examinations, and witness evidence confirmed that the impact occurred entirely within Mr Schultz's lane of travel. Investigators identified no mechanical defect, road condition, or environmental factor capable of contributing to the collision.

97. The toxicological evidence further clarified the circumstances of the incident. Mr Schultz had only negligible alcohol levels and therapeutic concentrations of prescribed medications, with no evidence of illicit drug use or impairment.

98. In contrast, Ms Homewood's toxicology revealed significant concentrations of methylamphetamine, amphetamine, MDMA, and cocaine metabolites. Toxicological opinion concluded that those substances were capable of causing substantial impairment and provided a clear explanation for the driving behaviour observed immediately before the collision.

99. Accordingly, the evidence demonstrates that both deaths resulted from injuries sustained in a motor vehicle collision caused by Ms Homewood's loss of control of her vehicle, her impaired driving, and excessive speed. The deaths were not caused or materially contributed to by any mining-related injury within the meaning of the legislation.

100. Although Mr Schultz was employed as a mine worker and was travelling home following a rostered shift, the collision occurred after he had left the mine and while travelling on a public highway. The injuries causing his death did not arise from mining activities or operations.

101. Likewise, Ms Homewood's death occurred in circumstances wholly unrelated to mining operations. Neither deceased therefore suffered a qualifying mining-related injury for the purposes of the *Coroners Act 2003 (Qld)*.

102. Having regard to the legislative framework and the available evidence, I am satisfied, and so find, that neither death constitutes a mining-related reportable death and that the mandatory inquest provisions administered by the Mining and Resources Coroner are not enlivened.

**Conclusion**

103. Section 28 of the *Coroners Act 2003 (Qld)* confers a discretion upon a coroner to hold an inquest where it is in the public interest to do so. Although Mr Schultz was employed within the mining industry and Ms Homewood was driving a vehicle leased by a Moranbah-based contractor, neither death arose from, nor was connected with, mining operations. As such, the deaths do not attract the statutory requirement for a mandatory inquest.

104. The question is therefore whether any uncertainty remains concerning the identities of the deceased persons, the medical causes of death, the circumstances of the collision, or whether any broader issue of public importance requires examination through a public hearing. Having carefully considered all of the available material, I am satisfied that no such uncertainty exists.

105. The investigation was comprehensive, thorough, and independent. The collision scene was subjected to detailed forensic examination by the Forensic Crash Unit. Electronic collision data was recovered and analysed, mechanical inspections of the vehicles were conducted, toxicological testing was completed, and forensic pathology investigations established the causes of death. Investigators reconstructed the movements of both drivers through ANPR data, CCTV footage, witness enquiries, mobile telephone records, and other objective evidence. Specialist forensic medical and toxicological opinions were also obtained and considered.

106. The resulting body of evidence provides a coherent and persuasive explanation for both the collision and the deaths. There is no material conflict in the evidence requiring resolution through the testing of witnesses at a public hearing. The identities of both deceased persons are known, the medical causes of death have been conclusively established, the mechanism of injury is clear, and the circumstances giving rise to the collision have been thoroughly investigated and explained.

107. Further, the evidence does not disclose any systemic failure, organisational misconduct, road design issue, vehicle defect, deficiency in the emergency response, or regulatory concern requiring further public examination. There is no evidence that mining operations, roster arrangements, journey management procedures, workplace practices, or any aspect of Mr Schultz's employment contributed to the collision. Likewise, there is no evidence that Ms Homewood's employment duties were causally connected to the circumstances giving rise to the collision.

108. The investigation identified no matters capable of supporting recommendations aimed at preventing future deaths, and no further line of inquiry remains outstanding. In those circumstances, an inquest would be unlikely to reveal additional relevant evidence, resolve any genuine factual controversy, or advance the purposes of the coronial jurisdiction.

109. Accordingly, I am satisfied that the deaths of Mr Schultz and Ms Homewood were not mining-related deaths within the meaning of the *Coroners Act 2003 (Qld)* and that it is not in the public interest to hold an inquest into either of their deaths.

## CONCLUSION

110. The deaths of Mr Schultz and Ms Homewood arose from a tragic head-on collision on the Peak Downs Highway on 20 January 2026. The evidence establishes that the collision occurred when Ms Homewood, who was significantly impaired by illicit stimulant drugs and travelling above the speed limit, crossed onto the incorrect side of the roadway and struck the vehicle being driven by Mr Schultz. Despite taking evasive action, Mr Schultz was unable to avoid the collision. The injuries sustained by both drivers were unsurvivable and resulted in their deaths.

111. I extend my sincere condolences to the family and friends of both Mr Schultz and Ms Homewood. Their deaths have undoubtedly caused profound grief and loss for those who knew and loved them. I hope that the careful investigation undertaken, and these findings provide some measure of understanding regarding the circumstances of this tragic event.

112. I also record my appreciation for the professional investigation conducted by the forensic crash investigator from the Mackay Forensic Crash Unit whose detailed forensic analysis, persistence and thorough consideration of all potential contributing factors greatly assisted the coronial investigation.

113. I now close my investigation.


Wayne Pennell
Mining and Resources Coroner and Northern Coroner
10 September 2026