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# CORONERS COURT OF QUEENSLAND

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## Annual Report

**2024-25**



QUEENSLAND  
COURTS

## Purpose

The Coroners Court of Queensland Annual Report provides information about the Court's structure and operations as well as financial and non-financial performance measures for the period 1 July 2024 to 30 June 2025. The report has been prepared in accordance with the requirements of the *Coroners Act 2003*.

This report is accessible online at: Publications Queensland Courts at [www.courts.qld.gov.au/about/publications](http://www.courts.qld.gov.au/about/publications) and the Coroners Court of Queensland website at: [www.coronerscourt.qld.gov.au](http://www.coronerscourt.qld.gov.au)

## Data

Data contained in this report has been obtained from the SAS Dashboard and the Coroners Case Management System (CCMS). CCMS is a 'live' operational database in which records are updated as the status of the coronial investigations change and/or input errors are detected and rectified. Content presented in this report was correct at the time of publication but data verification may result in variance of figures over time.

## Enquiries

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For further information about the Coroners Court of Queensland, please visit our website: <https://www.coronerscourt.qld.gov.au>

## Feedback

The Coroners Court of Queensland values your feedback on this report. Any comments can be provided through the Contact us part of our website: <https://www.coronerscourt.qld.gov.au/>



The Queensland Government is committed to providing accessible services to Queenslanders from all culturally and linguistically diverse backgrounds. If you have difficulty in understanding the annual report, you can contact us on telephone (07) 3738 7050 and we will arrange an interpreter to effectively communicate the report to you.



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## WARNING

Please be advised some content in this report may be distressing to readers.

Aboriginal and Torres Strait Islander people are advised this report contains the names of people who have passed away.

30 October 2025

The Honourable Deb Frecklington MP  
Attorney-General and Minister for Justice  
and Minister for Integrity  
GPO Box 149  
BRISBANE QLD 4001

Dear Attorney-General

In accordance with section 77 of the *Coroners Act 2003*, I am pleased to present the Coroners Court of Queensland Annual Report for the year ended 30 June 2025.

As required by section 77(2) of the Act, the report contains a summary of each death in custody investigation finalised during the reporting period. The report also contains a summary of other investigations of public interest and the names of persons given access to coronial investigation documents as genuine researchers.

No updates were made to the State Coroner's Guidelines nor directions given to coroners under section 14 of the Act during the reporting period.

The guidelines are publicly available at:

<https://www.coronerscourt.qld.gov.au/resources/legislation-and-resources>.

No practice directions were issued during the reporting period under section 69 of the Act.

Yours sincerely



Terry Ryan  
State Coroner

## Acknowledgement of Country

The Coroners Court of Queensland acknowledges the Traditional Owners and Custodians of the lands across Queensland. The Court pays respect to Elders past and present. We value the culture, traditions and contributions that Aboriginal and Torres Strait Islander people have made to our communities, and recognise our collective responsibility as government, communities and individuals to ensure equality, recognition and advancement of Aboriginal and Torres Strait Islander Queenslanders in every aspect of our society.

The coronial system is underpinned by a shared understanding that society values and protects the life of every person.

We extend our condolences to the families of those who are entrusted to our care.

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## FINDINGS

The digital version of this Report includes interactive links to findings and other relevant information. These links are provided as tabs above each instance.

This content can be accessed by visiting the CCQ website: <https://www.coronerscourt.qld.gov.au>

# Our year in review

## Body releases

2,829

2,032 or 71.82%  
released  
within 7 days

## Performance measures – cases

5,990  
lodged

6,623  
finalised

110.6%  
clearance  
rate

2,256  
pending  
(total)

484 or 21.5%  
backlog indicator

## Timeframes

3.5  
average months  
to finalise

4,729 or 78.9%  
finalised  
within 12 months

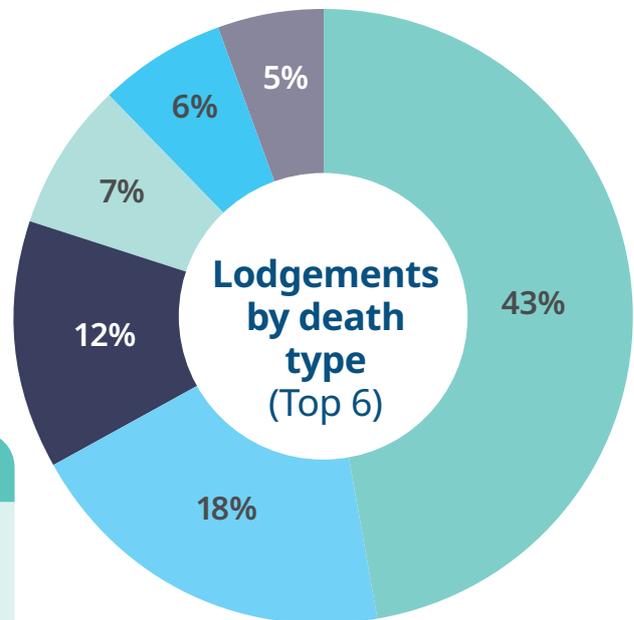
## Inquests

20  
finalised

3  
joint inquests

27  
deaths  
investigated  
at inquest

15  
recommendations  
made



- Natural causes
- Domestic accident
- Suspected suicide
- Suspected drug/Alcohol/Poison related
- Hospital/Medical procedures
- Transport related - road

# State Coroner

## State Coroner Terry Ryan

I am pleased to present the Coroners Court of Queensland Annual Report for the financial year 2024–25.

This year the court received 5,990 lodgements, a marginal 1.3% decrease from 6,071 lodgements in 2023–24. The court's clearance rate was a record 110.6%, exceeding our target of 100%. This was a significant increase compared to 99.74% in 2023–24.

Coroner numbers increased to 10 full-time coroners in early 2024. The first full financial year with additional coroners is reflected in improved clearance rates and reduced number of pending cases. I acknowledge the hard work of all coroners and coronial registrars in achieving this result.

The appointment of the Mining and Resources Coroner in May 2025 brought the total number of full time coroners to 11. The new coroner will investigate reportable deaths on mine, quarry, petroleum and gas sites in addition to undertaking general coronial work.

The number of preliminary examinations ordered by coroners greatly increased in 2024–25. Often, a preliminary examination can avoid the need for a more invasive postmortem examination. As a result of the increase in preliminary examinations, the number of internal autopsies reduced, lessening the potential emotional burden on families as well as increasing the efficiency of the coronial process.

The addition of dedicated data analyst positions in the CCQ registry during the year has delivered new and improved data tools, providing coroners and registry staff with enhanced case management capability.

Queensland's coronial system operates within a multidisciplinary framework under the *Coroners Act 2003*.

Representatives of the system's partner agencies make up the Coronial System Board: Coroners Court, the Department of Justice, Queensland Health (Forensic Pathology and Coronial Services; and Forensic Medicine Queensland) and Queensland Police Service. The Board oversees the work of its two sub-committees, the Performance and Operations Sub-Committee and the Coronial System Reform Sub-Committee which met regularly during 2024–25.

Partner agency collaborations produced a number of highlights over the year.

Coordinated work continued across the system, particularly between Forensic Medicine Queensland, the Queensland Police Service Coronial Support Unit, and Coronial Registrars to reduce the over-reporting of deaths due to natural causes.

In June 2025, the CCQ registry hosted an education and networking event with staff presentations from each of the partner agencies. Attendees demonstrated an eagerness to learn and understand more about the day to day responsibilities and challenges of their colleagues in other agencies. The Board will continue to support similar events.

Throughout the year, the Coroners Court together with system partners focused on improving the experiences of families at what is a distressing and overwhelming time for those bereaved. The *Coronial Investigations Guide for Families and Friends* was revised and translated into 18 languages and an Easy English version for people with low English language literacy.

I am grateful to my fellow coroners, the coronial registrars and the dedicated staff of the court for their efforts throughout another busy year for the court. I would like to also express my gratitude for the hard work and commitment across our partner agencies.

# Executive Director

## Therese Oxenham

After expansion in early 2024, the Coroners Court of Queensland (CCQ) registry consolidated over 2024-25, exploring how we can improve the way we work to better support coroners and deliver registry services for families and the community.

This was my first full financial year in the dedicated CCQ Executive Director position supported by the Directors of Operations, Legal Services and Coronial Services Practice Prevention and Reform, as well as the Manager, Business Services.

During the year we welcomed new positions in key areas.

A new coronial team commenced, to support the Mining and Resources Coroner. A Principal Program Officer – Family Liaison position was also created, to work closely with other agencies and ensure support for families during the coronial investigation and inquest process. The position establishes a new dedicated function within the registry, highlighting the importance of ensuring families are informed about the coronial investigation as it progresses and are connected with appropriate supports.

A critical priority is employee wellbeing and support to manage the inherent psychosocial risks of coronial work. A full-time and permanent Principal Wellbeing and Organisational Support Officer joined the registry in 2024-25 to support senior leaders and managers.

Increasing court user accessibility has been a focus. The registry has worked with coroners to develop improved resources for families and have arranged translated guides to investigation and inquest processes. These guides provide families with crucial information about coronial processes and support services.

The Manager, Cultural Capability has continued delivering training for registry staff as well as providing direct support to Aboriginal and Torres Strait Islander families, under the direction of coroners.

The appointment of two dedicated coronial data analysts has provided coroners, the registry and partner agencies with in-depth data capability and analysis, improving oversight and enabling more proactive case management.

Our Legal Services Team has continued to provide quality in-house Counsel Assisting services for coroners through provision of advice and appearing at inquests in locations across Queensland, with a presence in Cairns, Mackay, Southport and Brisbane.

The Business Services Team has provided efficient and timely administration of the Funeral Assistance Scheme on behalf of the Department of Justice, as well as management of Government contracted undertakers, which has included site visits to undertakers across the State.

I thank the State Coroner for his guidance and leadership over the year. I also acknowledge and thank the Deputy State Coroner and coroners for their hard work and support.

Finally, I would like to recognise the dedication and resilience of the CCQ registry staff. They continue to demonstrate a high standard of professionalism and empathy in their work, making CCQ a supportive, values-driven workplace, delivering important front-line services for families and the broader community throughout the State.

## **Our vision**

Coronial services that partner to deliver independent, family-centred, and timely investigations.

# Our Court

The Coroners Court of Queensland (CCQ) provides Queenslanders with a consistent and coordinated system to investigate deaths that are violent, unnatural, sudden, unexpected or occur in custody, police operations, or in care.

## Our jurisdiction

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Queensland's coronial jurisdiction operates in accordance with the functions outlined in the *Coroners Act 2003* (Qld) (the Act). The Act establishes the position of the State Coroner, requires the reporting of certain deaths, authorises the State Coroner to issue guidelines for investigations and inquests, provides for the prevention of future deaths by authorising coroners to make comments and recommendations, and establishes the Domestic and Family Violence Death Review and Advisory Board.

## Our commitment

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A coronial investigation is an independent, impartial, open, and transparent inquisitorial process. The investigation provides answers to families and informs the community about death prevention. We aim to deliver timely, family-focused, and culturally safe services. We are continuously working towards improving how we engage and support bereaved families, our stakeholders, and our coroners.

## Our purpose

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Coroners and coronial registrars are responsible for investigating 'reportable deaths'<sup>1</sup> as set out in section 8 of the Act. Coroners are required to establish, if possible, who the deceased person was, when, where, and how they died, and the cause of the death.

Most investigations are finalised by chamber findings and do not require an inquest to be held. Whether an inquest is held is determined by requirements outlined in sections 27 and 28 of the Act, which include requirements for inquests into deaths occurring in custody or care. Coroners have a broad discretion to hold an inquest if satisfied it is in the public interest.

Where an inquest is held, coroners can make comments and recommendations about systemic issues or policy and procedural changes that could contribute to improvements in public health and safety, the administration of justice, or prevent or reduce similar deaths in future. It is not the role of a coroner to find people guilty of criminal offences or civilly liable.

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<sup>1</sup> Refer to [Appendix One – Reportable death types within Queensland](#).

# Our Coroners

Queensland has 11 coroners located in Brisbane, Southport, Mackay, and Cairns.

During the reporting period the court also had the assistance of Magistrate Christine Roney, and Acting Magistrates Don Buchanan, Christine Clements, Judith Simpson, and Jessica Lambert.

## State Coroner

*Terry Ryan*

State Coroner Terry Ryan was appointed as a Magistrate and as State Coroner on 5 July 2013. State Coroner Ryan holds a Bachelor of Social Work, Bachelor of Laws (Honours), Graduate Diploma in Legal Practice and Master of Laws. State Coroner Ryan started as a social worker in 1984, before being admitted as a solicitor in 1991. He returned to work for the Queensland Government in 1993 and to the Department of Justice in 1995 until 2013 when he commenced with CCQ. The State Coroner oversees and coordinates the Queensland Coronial system to ensure it is administered efficiently and appropriately. The State Coroner may issue directions or may issue guidelines in respect of the conduct of an investigation.

## Deputy State Coroner

*Stephanie Gallagher*

Deputy State Coroner Stephanie Gallagher was appointed as a Magistrate and Brisbane Coroner on 2 August 2021. On 23 May 2022, she was appointed Deputy State Coroner. Deputy State Coroner Gallagher holds a Bachelor of Arts (Psychology and Economics), Bachelor of Laws and Master of Health Administration. Deputy State Coroner was admitted as a solicitor in 1989 and, before her appointment, practiced for more than 30 years as solicitor and a barrister, predominately in health law matters. She chaired the Medical Board in Queensland (QMING) for approximately one year and chaired the professional standards committee for the (then) Nursing Board for 7 years. For more than 15 years she sat as a member on various hospitals' National Health and Medical Research Council committees. She has sat on the Board of St Andrew's and QEII Hospitals. Her practice at the private Bar was a health law practice and she has extensive experience in health regulatory matters, special health matters, health litigation, mental health and health and other coronial matters. Deputy State Coroner Gallagher is an Adjunct Associate Professor in the School of Applied Psychology at Griffith University.

## Brisbane Coroner

*Ainslie Kirkegaard*

Coroner Ainslie Kirkegaard was appointed as a Magistrate and Brisbane Coroner in December 2023. Coroner Kirkegaard has been with CCQ for over 14 years, first joining the court as Counsel Assisting the Deputy State Coroner in 2008, being appointed as the inaugural Coronial Registrar in 2012 in a unique role designed to triage daily deaths reported to CCQ across Queensland, and assisting the court as an Acting Magistrate from 2015. Coroner Kirkegaard holds a Bachelor of Arts and Bachelor of Laws. She was admitted as a solicitor in Queensland and to the High Court in 1996. Coroner Kirkegaard brings with her over 15 years of experience in policy and legislation development in the health, education, and justice portfolios, with specialist expertise in coronial and health regulatory law and policy prior to joining CCQ.

## Brisbane Coroner

*Don MacKenzie*

Coroner MacKenzie has worked within the Criminal Justice System for over 35 years. He holds a Master of Laws, a Bachelor of Arts and a Graduate Diploma of Military Justice and was the James Douglas Memorial Prize winner in September 1993. Working for the Legal Aid Office and Director of Public Prosecutions (Qld), he became a Consultant Crown Prosecutor before joining the Bar in 2008, appearing in 800 jury trials, hundreds of Court of Appeal matters and as sole counsel in the High Court. He is a Royal Australian Navy Officer with Inspector General Australian Defence Force and is Senior Editor of the Thomson's Summary Offences Queensland. He was appointed a Coroner in 2019, completing over 2000 coronial investigations since.

## Brisbane Coroner

### *Melinda Zerner*

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Coroner Melinda Zerner was appointed as a Brisbane Coroner and Magistrate in December 2023. She holds tertiary qualifications in law, education, and nursing. She was admitted as a solicitor in 2004 and joined the private Bar as a barrister in 2011. She had a successful practice in medical negligence and public liability insurance. She was regularly briefed in medical and non-medical inquests as either Counsel Assisting or for an interested party in coronial matters. Her legal expertise extends to mediations, coronial inquests, civil litigation, and commissions of inquiry. Prior to her career in law, Coroner Zerner worked as a registered nurse, nurse educator, and clinical nurse manager.

## Brisbane Coroner

### *Megan Fairweather*

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Coroner Megan Fairweather was appointed as a Magistrate and as a Brisbane Coroner in May 2024. After being admitted as a solicitor in 2003, Coroner Fairweather specialised in health and human rights law, coronial, and health regulatory and corrupt conduct matters. Immediately before her appointment, Coroner Fairweather was Chief Legal Counsel for Queensland Health where she led a team of lawyers to manage matters of legal work including coronial, commission of inquiry, judicial review, commercial, employment and administrative law matters. Coroner Fairweather holds a Bachelor of Laws (Hons) and a Bachelor of Arts (Philosophy).

## Brisbane Coroner

### *Carol Lee*

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Coroner Carol Lee was appointed as a Magistrate and Southern Coroner in May 2022 until she was transferred to the role of Brisbane Coroner in 2023. She holds a Bachelor of Laws in addition to the qualification of registered nurse. Coroner Lee was admitted as a barrister in 1992. From her time in leading law firms, she gained a specialisation in the field of health law. She has had extensive clinical experience in the Queensland public hospital system, gained a deep understanding of the multifaceted environment in which the health sector operates, and has served on a variety of committees, boards and tribunals. Coroner Lee has also undertaken nationally accredited mediation training.

## Central Coroner

### *David O'Connell*

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Coroner David O'Connell was appointed as the Central Coroner in August 2012. He was admitted as a solicitor in 1991, and holds a Bachelor of Laws, Graduate Diploma in Taxation, and Master of Business Administration. He is Queensland's longest currently serving coroner. He is based in Mackay and is one of the three coroners serving Regional Queensland which area extends from Goondiwindi in the south, Bundaberg in the east, Cape York in the north, and west to the SA and NT borders.

## Southern Coroner

### *Amanda Bain*

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Coroner Amanda Bain was appointed as a Magistrate and as the Southern Coroner on 7 May 2024. Coroner Bain has handled prosecutions across various jurisdictions as has previously represented clients at coronial inquests, appeals and applications. Coroner Bain is based in Southport Magistrates Courts. The Southern Coroner investigates deaths in the Gold Coast and Beenleigh area, Scenic Rim and the Southern Downs. Coroner Bain holds a Bachelor of Laws from Queensland University of Technology.

## Northern Coroner

### *Stephanie Williams*

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Coroner Stephanie Williams was appointed as Magistrate and Northern Coroner on 11 December 2023. She holds a Bachelor of Laws from James Cook University. Coroner Williams was a specialist criminal and coronial lawyer in Queensland and the Northern Territory. Coroner Williams is based in the Cairns Magistrates Court. The Northern Coroner investigates deaths in the North Queensland region, which extends from Cairns south to Ayr, west to Mount Isa, and north to the Papua New Guinea border.

## Mining and Resources Coroner

### *Wayne Pennell*

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Coroner Wayne Pennell was appointed as the Mining and Resources Coroner in May 2025 and will conduct all coronial investigations into deaths on the State's mine, quarry, petroleum, and gas sites. He has significant investigative skills which have been forged from his 20 years policing experience (1983-2003) as a Detective Sergeant with the Queensland Police Service. After being admitted as a Barrister to the Supreme Court of Queensland in 2003, he practised at the private bar in Townsville for 19 years in both the state and federal jurisdictions. From 2010 to 2022, he was a Member (Sessional) of QCAT, and from 2022 to 2025 he was a Senior Member of the AAT and a Member of the ART.

# Our Coronial Registrars

The Coronial Registrars based in Brisbane triage deaths from an apparent natural cause, review potentially reportable deaths and provide telephone advice to clinicians about whether to issue a cause of death certificate. The Coronial Registrars operate under a delegation from the State Coroner to manage these matters.

During the reporting period the court also had the assistance of Joseph Crawfoot, Karen Dodds, Carolyn McKeon, Dr Jessica Page, Julie Pietzner-Hagan, Patricia Feeney, and Dean Clifford-Jones.

## Coronial Registrar

*Jessica Lambert*

Jessica Lambert was appointed the Coronial Registrar on 16 September 2021. She has experience serving as an Acting Magistrate performing the role of Coroner. Admitted as a Legal Practitioner since 2006, Ms Lambert has previously held various positions at the Office of the Director of Public Prosecutions, Supreme and District Courts and within the QUT Law Faculty. Additionally, as a nationally accredited mediator, Ms Lambert is an inaugural member of the National Sports Tribunal.

## Deputy Registrar

*Lisa Hendy*

Admitted as a solicitor in 2000, Lisa was employed in private practice, primarily in criminal law, until she was appointed as a legal officer at the Criminal Justice Commission in 2001. She has since held positions in Strategic Policy at the Department of Justice and Attorney-General, as a Solicitor Advocate at Legal Aid Queensland, Principal Lawyer for the Queensland Floods Commission of Inquiry, General Counsel for the Queensland Ombudsman and Director of Legal Services, Parole Board Queensland. Lisa holds a Master of Laws from the University of Queensland. She joined CCQ in September 2024.

# Our partnerships

The coronial jurisdiction operates within a multidisciplinary framework, with the work of CCQ supported by two key partner agencies, Queensland Police Service and Queensland Health. These agencies each have expertise which is applied at different stages of the coronial process, facilitating a seamless and interdependent coronial service delivery system.

## Queensland Police Service (QPS)

QPS provides the statewide frontline and specialist investigative capability for coroners. QPS officers attend the scene of a death and obtain initial information from family, friends, and witnesses to commence the coronial investigation. QPS holds wide ranging specialist forensic and investigative capabilities and will deploy these resources as directed by the coroner. The QPS Coronial Support Unit (CSU) co-ordinates coronial processes on a statewide basis with officers liaising with coroners, CCQ registry, forensic physicians, forensic pathologists, coronial counsellors and mortuary staff. The CSU's Detective Inspector is the Deputy Commander of the Disaster Victim Identification Squad (DVIS). The DVIS is responsible for the removal and identification of deceased persons from mass fatalities, air and natural disasters.

Part of the QPS CSU role is engaging in more effective triaging of apparent natural cause deaths out of the coronial system to alleviate pressures. QPS CSU reported in 2024-25, general duties police officers attended 4,883 deaths and diverted 1,855 deaths from the coronial system through obtaining a Cause of Death Certificate (CODC). Of the 4,883 deaths police registered 3,028 deaths with CCQ.

## Queensland Health (QH)

QH, through Forensic Pathology and Coronial Services (FPaCS), provides clinical, advisory, scientific, and forensic pathology services, including autopsies, to support Queensland's coronial and criminal justice systems. FPaCS is a statewide service and coronial postmortem examinations are performed in Pathology Queensland mortuaries located in Brisbane (Coopers Plains), Gold Coast University Hospital, and Townsville

University Hospital. Working in partnership with CCQ and QPS, FPaCS is responsible for undertaking examinations and investigations where a person's death is reportable to the coroner. FPaCS comprises professionals from a range of medical, scientific, technical, nursing, counselling, radiography disciplines and support staff.

FPaCS' Coronial Family Services provide information and counselling support to families, work through objections to autopsies, organ and tissue retention and inform families of postmortem examination findings. Coronial counsellors are often the first point of contact for bereaved families following the death of their loved one. They provide timely information to families about bereavement supports, obtain views on postmortem examination, and work with the CCQ registry to communicate important cultural and religious considerations or family concerns to coroners.

Coronial nurses assist families by explaining medical information, collect medical records and liaise with other health practitioners to assist the forensic pathologist, and talk through potential inheritable illnesses and health risks with the families where needed. The coronial nurses also assist the coroner and coordinate cases where a preliminary postmortem examination is to occur.

Forensic Physicians within Forensic Medicine Queensland (FMQ) based in Brisbane provide independent clinical advisory services including toxicology interpretation, and advice about issues requiring further investigation. FMQ provides statewide assistance to CCQ coronial registrars, QPS, and clinicians regarding coronial matters. FMQ also assists coroners with expert opinions. The Gold Coast Forensic Medicine Team based in Southport also assists the Southern Coroner.

# Our achievements

## Cultural Capability

Throughout the reporting period, the Manager, Cultural Capability has developed information resources and delivered practical and tailored training to CCQ registry staff to increase cultural awareness and build confidence in engaging with First Nations families respectfully and sensitively. A referral pathway is in place to provide a clear way for coroners and staff to seek advice and assistance in supporting Aboriginal and Torres Strait Islander families and assisting them in understanding coronial processes. Registry staff are engaged through events such as Reconciliation Week to raise awareness about the importance of improving cultural capability in the coronial system.

Cultural advice and guidance is provided to coroners and registry staff on a range of matters, including cultural care considerations for inquests and guidance on sensitive case issues. Culturally sensitive support has been provided to Aboriginal and Torres Strait Islander families in preparation for receiving coronial findings and to access funeral assistance.

Building relationships with stakeholders is recognised as being critical to developing cultural capability across the coronial system. The Manager, Cultural Capability and senior registry leaders engaged with a range of community and government organisations to identify ways to better coordinate support for families. Meetings were held with community legal services providing assistance to Aboriginal and Torres Strait Islander families on coronial matters and Community Justice Groups in the Mackay, Townsville and Cairns regions.

In September 2024, coroners and registry staff attended the Asia Pacific Coroners Conference in Uluru themed *Sorry Business – Can the Coroners Court investigate, interrogate, and heal?* to explore the ways coroners courts around Australia are working to improve their engagement with Aboriginal and Torres Strait Islander families and communities.

## Wellbeing

CCQ recognises psychosocial hazards, including the risk of vicarious trauma inherent in its work. CCQ has continued to enlist the expertise of an external wellness provider consisting of organisational specialists and clinical psychologists and during the year appointed a Principal Wellbeing and Organisational Support Officer.

## Courts and Tribunals (CAT) Awards

In June 2025, the annual CAT divisional award ceremony took place. Continuing the trend of previous years, CCQ was well represented.

The following CCQ representatives received awards:

- Customer Focus – Jyoti Barry
- Workplace Culture – Yasmin Gunn
- Rising Star – Ellana Tidbold

CCQ's nominees were:

- Sophie Worthington – State Coroner's Team
- Ruby Donehue – Coroner Lee Team
- Deputy State Coroner Team
- Finance and Contracts Team
- Domestic and Family Violence Death Review Unit

## Appointment of the Mining and Resources Coroner

In May 2025, CCQ welcomed Coroner Wayne Pennell who was appointed as the Mining and Resources Coroner. Coroner Pennell will spend the first 12 months of his tenure in Brisbane before being based in Mackay.

The Coroners (Mining and Resources Coroner) Amendment Bill 2025 (the Bill) was introduced into Parliament in June 2025 and will mandate an inquest into mining and resources related reportable deaths.

When the mining and resources coroner is not performing mining-related work, he will undertake general coronial work.

## Appointment of a Family Liaison Officer

A Principal Program Officer – Family Liaison commenced in June 2025 to provide family engagement in the coronial investigation and inquest process. The role focuses on proactive family support and engagement and trauma informed coronial practice for those losing a loved one through mining-related deaths.

The Family Liaison Officer will formalise partnerships and referral pathways with key stakeholders to ensure seamless family support and improve family experiences of the coronial system.

## Accessibility

In 2024–25, CCQ revised and translated its *Coronial investigations guide for families and friends* and *What to expect at an inquest* guide into eighteen languages.<sup>2</sup>

A QR code on the English language guide is accessible using a mobile phone to link to the translations on our website.

CCQ also developed, with assistance of Scope Australia, an Easy English version of the *Coronial investigations guide for families and friends*.<sup>3</sup>

## Coronial System Reform

The Coronial Services System Delivery Framework 2021–2025 is the overarching strategic charter for partner agencies delivering coronial services. Our shared vision is for coronial services to deliver independent, family-centered and timely investigations.

The Coronial System Board assists the State Coroner to coordinate and administer the coronial system. The Board, chaired by the State Coroner, has remained active during the 2024–25 reporting period.

The Board's two sub-committees were also active throughout the reporting period.

The Performance and Operations Sub-Committee (POSC) oversees and monitors coronial system operational performance. A key focus was backlog reduction including producing a detailed audit and analysis of aged cases for the Board with recommendations for next steps.

The functions of the POSC include:

- identifying and developing solutions to operational issues
- managing cases through the coronial system
- driving system improvements.

In September 2024, the Queensland Audit Office (QAO) reported that the remaining recommendations of QAO's report *Delivering coronial services* (Report 6: 2018–19) were fully implemented according to entity progress on implementation self-assessment.

The Coronial System Reform Sub-Committee continues to work to bring system-wide reform to the delivery service model.

The *Colleagues across the coronial system* Education and Networking event was held as part of the Coronial System Board's reform work, in response to need across partner agencies for greater understanding about roles in the system. Presentations covered the specialist disciplines across police, medical and scientific and legal areas. Intersections between coronial partners were explored to increase knowledge and promote improved communication.

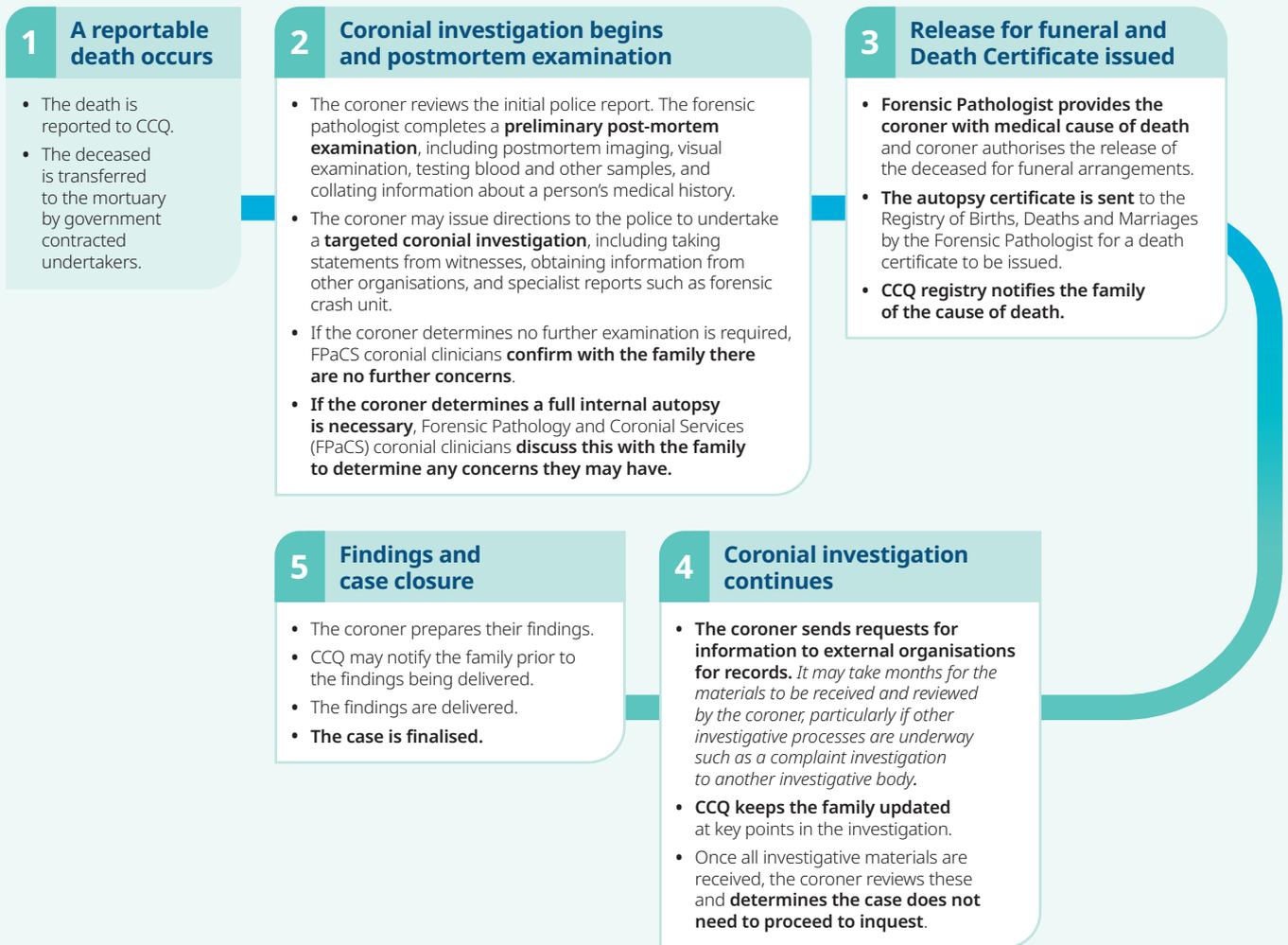
<sup>2</sup> <https://www.coronerscourt.qld.gov.au/for-families/coronial-investigation-guide-for-families-and-friends>

<sup>3</sup> [https://www.coronerscourt.qld.gov.au/\\_data/assets/pdf\\_file/0018/830034/about-coroners-court-easy-english.pdf](https://www.coronerscourt.qld.gov.au/_data/assets/pdf_file/0018/830034/about-coroners-court-easy-english.pdf)

# Pathway of a non-inquest case

AN EXAMPLE

The following case example is based on investigative elements of many coronial investigations. This example is intended to illustrate the general pathway of a coronial investigation and does not represent how a specific coronial investigation may be conducted in the future.



# Pathway of an inquest case

## AN EXAMPLE

The following case example is based on investigative elements of many coronial investigations. This example is intended to illustrate the general pathway of a coronial investigation and does not represent how a specific coronial investigation may be conducted in the future.



# Examples of non-inquest cases

*The following anonymised case presents an example based on investigative elements of many coronial investigations. This example is intended to illustrate the general pathway of a coronial investigation and does not represent how a specific coronial investigation may be conducted in the future.*

## Sepsis related death in a Nursing Home

Mrs Jones is an 82-year-old woman who resides in a Residential Aged Care Facility – RACF. Her only son, Mr Jones, lives interstate and is not able to visit. He is aware that because of her health conditions his mother is susceptible to skin injuries and wound infections. During her eight-month stay, Mrs Jones develops a number of infections which are treated by the GP and RACF carers. After two weeks of becoming increasingly unwell, Mrs Jones is taken to hospital with a significant deep infection that is covered by dressings that do not look recently changed. She dies at the hospital in the Emergency Department shortly after her arrival. As no investigations were able to be carried out by the hospital, it is not known whether she has died because of her other medical conditions or sepsis from the wound infection.

- The hospital contacts police to report the death to the coroner because the probable cause of Mrs Jones' death is not known and there are significant concerns that the health care she received while at the RACF caused or contributed to her death.
- Police or coronial counsellors ask the family their views on autopsy.
- The coroner reviews the police report and family views and orders the forensic pathologist to conduct a postmortem examination. After a preliminary examination and reviewing the CT scans and toxicology results, the forensic pathologist can determine the cause of death and the coroner determines a full autopsy is not needed.
- The forensic pathologist sends an autopsy certificate to the Registry of Births, Deaths and Marriages so a death certificate may be issued and the coronial investigation continues.
- Mr Jones has been assisted by coronial counsellors in navigating how to engage a funeral director. He advises the counsellor he has lodged a complaint to the Aged Care Quality and Safety Commission (ACQSC) about his mother's care. The counsellor notifies him of the cause of death.
- CCQ registry writes to Mr Jones advising how the coronial investigation process works and assistance available to him.
- Once the forms have been provided by the funeral director, the coroner orders Mrs Jones' body be released for her funeral.
- Based on the information received and concerns raised in this case, the coroner requests other organisations to provide their records about Mrs Jones. Records may take months to receive as they are from external agencies.
- The coroner requests the ACQSC to provide its investigation records and the outcome of any complaints made about the RACF or residents' care.
- Once the requested records are received, the coroner reviews the materials to decide if any further investigation, or an inquest, is needed.
- Upon finalising the investigation, the coroner will make findings into the cause of Mrs Jones' death.
- The coroner decides that while no inquest will occur, it may benefit others to know the investigation details and findings – known as being in the public interest. CCQ registry notifies Mr Jones the findings will be made soon, and the coroner wishes to publish them. Mr Jones does not object.
- CCQ registry notifies Mr Jones when the findings are published, and Mrs Jones' case is finalised.

*The following anonymised case presents an example based on investigative elements of many coronial investigations. This example is intended to illustrate the general pathway of a coronial investigation and does not represent how a specific coronial investigation may be conducted in the future.*

### A mechanical fall injury related death in a Nursing Home

Mr Lewis is an 82-year-old man who moves to a Residential Aged Care Facility (RACF) because he no longer wishes to live home alone. After living happily in the RACF for some years, he trips over a chair in the busy dining room and hits his head. He is taken to hospital and after investigations which include scans, he is diagnosed with brain bleed, a subdural hematoma. He stabilises and is returned to the RACF. Some weeks later he is found lying on the path, alone in the garden. After this unwitnessed fall he is taken to hospital once again. Further scans show that the bleeding has worsened and this is a terminal event. After discussion with family Mr Lewis is returned to the RACF for end-of-life care. He dies some days later in his room at the RACF with family present.

- Because he has had recent medical attention including scans, the cause of death is known and the treating team at the hospital or his treating GP can write a cause of death certificate because the probable cause of death is known.
- However because he died from an mechanical fall related injury, this death is reportable to the coroner/coronial registrar as violent or otherwise unnatural.
- Mr Lewis' body can be moved from his room at the RACF to the family funeral director.
- The hospital or the GP reports the death to the coronial registrar using a Form 1A and provides the coronial registrar with the death certificate. No autopsy is required.
- The reporting doctor informs the family that the death has been reported to the Coroners Court.
- The coronial registrar requests the recent hospital admissions and the records from the RACF, including details of the falls risks management strategies. The coronial registrar also considers any family concerns.
- The coronial registrar may seek input from independent forensic physicians from Forensic Medicine Queensland to answer questions about the health care provided.
- A Form 1A investigation usually takes between 3 and 5 working days once all the records have been received.
- When the coronial registrar is satisfied that while reportable, there are no outcome changing issues with Mr Lewis' care, including that appropriate steps were taken to prevent mechanical fall related injuries, the cause of death certificate is authorised and the investigation is finalised.
- CCQ registry informs the doctor who reported the death that the cause of death certificate has been authorised and the investigation finalised. The doctor informs the family. Burial or cremation can now proceed.

# Coronial performance

Coronial performance in Queensland is assessed against national benchmarking standards outlined in the Report on Government Services.

Performance is evaluated based on a **clearance rate** and a **backlog indicator**.

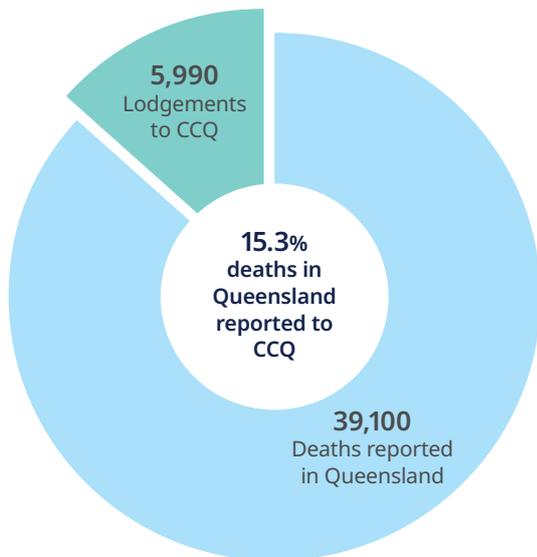
- The **clearance rate** provides insight into the court's efficiency in handling cases promptly. It is measured by comparing the number of cases lodged to those finalised.
- The **backlog** assesses the 'age' of a pending case on 30 June each year against specific benchmarks.

External factors can influence the clearance rate and backlog, such as fluctuation in lodgements rates, shifts in court operational procedures, case complexity and matters awaiting finalisation of other investigations or court proceedings.

**Table 1:** Performance Summary 2017-18 to 2024-25

Year	Cases lodged	Percent change	Cases finalised	Clearance rate	Backlog	Inquests finalised	Cases finalised at inquest
2024-25	5,990	-1.3%	6,623	110.6%	21.5%	20	27
2023-24	6,071	-7.0%	6,055	99.7%	17.5%	23	31
2022-23	6,530	8.0%	5,999	91.9%	17.7%	20	24
2021-22	6,044	5.8%	6,115	101.2%	14.8%	27	35
2020-21	5,714	1.5%	5,845	102.3%	14.2%	26	27
2019-20	5,631	-2.9%	5,744	102.0%	14.8%	28	48
2018-19	5,797	-0.3%	5,860	101.1%	17.6%	29	29
2017-18	5,812	4.0%	5,618	96.7%	18.4%	40	52

**Figure 1:** Deaths reported in Queensland and percentage reported to CCQ



### Reported deaths

Not every death in Queensland is required to be reported to the coroner.

Of the **39,100 deaths that occurred in Queensland** during the reporting period, **5,990** were reported to the Coroners Court for investigation, representing 15.3% of all deaths in Queensland.

### Clearance rate

Between 2019-20 and 2022-23, there was an upward trend in the number of cases reported to CCQ. The latest reporting period showed a 1.3% decrease compared to the previous year.

The appointment of two additional coroners in May 2024 assisted the court to finalise 6,623 matters, lifting the clearance rate from 99.7% in 2023-24 to 110.6%. This represents an 8.6% increase in finalisations from the previous year. Of the 5,990 lodgements finalised, 4,729 (78.9%) were finalised within 12 months.

These trends also reflect the ongoing efforts of the court to manage and resolve cases in a timely way.

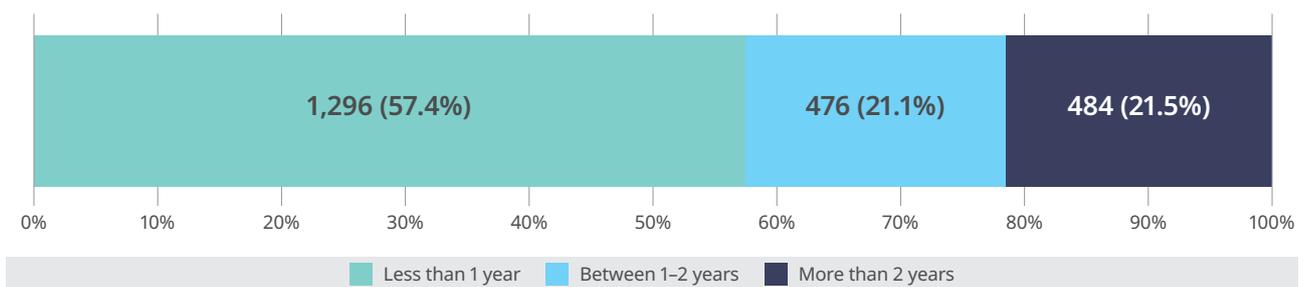
### Backlog indicator – pending cases

Finalising a coronial investigation can be dependent on several other investigative processes. These processes can include postmortem examination and associated reports including toxicology, police reports, other investigations and criminal proceedings. Coroners may also await outcomes of criminal proceedings and any other investigations that need to occur before finalising a coronial investigation.

CCQ has worked with partner agencies such as QPS and QH to drive implementation of new strategies, developing cross agency status reports and increasing resources for the CCQ registry to ensure timely investigations.

The CCQ backlog indicator percentage increased to 21.5% (or 484 cases) in this reporting period from 17.5% (or 503 cases) in 2023-24. The backlog indicator percentage is relative to the number of pending cases. As the court has made substantial progress in the timely management of existing caseloads and case finalisations in 2024-25, the number of cases pending has also decreased to 2,256 compared to 2,867 in 2023-24. Notably, over 25% of cases in the backlog are awaiting the resolution of related criminal proceedings.

**Figure 2:** Cases pending as at 30 June 2025



## Reportable type

Section 8(3) of the Act defines the types of deaths reportable to a coroner for investigation. The number of deaths reported to CCQ within each category are shown in the table below.

**Table 2:** Deaths reported statewide by primary reportable type 2024–25 compared to 2023–24

Category of death	2024–25	2023–24	Percent change
Suspected death (missing person)	7	12	71.4%
Death in custody	18	25	38.9%
Death as a result of police operation	10	8	-20.0%
Death in care	206	145	-29.6%
Health care related death	407	475	16.7%
Suspicious circumstances	26	12	-53.8%
Violent or unnatural	2,940	2,794	-5.0%
Death certificate not issued and not likely to issue	2,366	2,584	9.2%
Unknown persons	10	16	60.0%

## Deaths by coronial region

CCQ received reports of deaths across the state, which are categorised based on where the death occurred into one of the four registry (coronial boundary) locations. The figures below represent the performance per location from the previous year. It is important to note that the State Coroner, Deputy State Coroner and Coronial Registrars receive reports of deaths statewide.

**Table 3:** Regional performance 2023–24 to 2024–25

Deaths reported by coronial region	Brisbane		Northern		Central		Southern	
	2024–25	2023–24	2024–25	2023–24	2024–25	2023–24	2024–25	2023–24
Number of deaths reported for investigation	4,271	4,120	681	651	479	621	559	679
Number of coronial cases finalised	4,738	4,062	650	696	541	700	689	597
Number of coronial cases pending	1,235	1,697	511	479	228	275	282	416
Coronial cases pending – Greater than 24 months old	276	308	88	76	54	57	66	62

## Not reportable matters

Of the deaths reported to CCQ, many are found to be not reportable as the death does not meet the definition of a reportable death under section 8(3) of the Act.

In the 2024-25, reporting period, 2,272 lodgements were determined to be not reportable matters. These matters are included in the court's lodgement figures as significant work is involved in determining whether these matters are reportable or whether a death certificate can be authorised. This work can involve reviewing medical records, discussing the death with treating clinicians and family members and obtaining advice from FMQ.

## Review applications

The State Coroner has a review function under the Act with respect to coroners' decisions about whether a death is reportable, whether an inquest should be held and whether an inquest or non-inquest investigation should be reopened.

During the reporting period, the State Coroner received 28 applications for review of a coroner's decision and finalised 30 matters.

## How deaths are reported

Deaths are reported from police (via Form 1) and medical practitioners (via Form 1A). CCQ also received 'Other' reports of deaths for review and investigation. These can include phone calls from medical practitioners, funeral directors, or aged care facilities, family members, missing person reports/advice, child death advice and notifications from the National Disability Insurance Scheme (NDIS).

Of the  
**5,990**  
cases reported to the court,  
**98%**  
were reported by police, medical practitioners,  
and via phone calls to determine whether  
a death is reportable.

**Table 4:** Initiating report of death for 2023-24 and 2024-25

Initiating Form type / report	FY2024-25	FY2023-24
Form 1 – Police report of a death	3,028	3,187
Phone call	1,880	1,588
Form 1A – Medical practitioner report of a death	931	1,140
Cause of Death Certificate	40	33
Other	38	58
Concerns	32	21
NDIS notification	12	9
QP608	11	13
Child Death Advice-Report	9	21
OHO notification	9	-

## Death type – suspected suicides

Suspected suicides continue to be one of the leading preventable causes of death in Queensland.

During the reporting period, the court continued to provide coronial investigation data and documents to agencies to inform service responses and early intervention activities as well as support research into development of suicide prevention policy and planning and suicide monitoring surveillance systems and projects.

One of these agencies is the Queensland Mental Health Commission (QMHC). The QMHC maintains the Queensland Suicide Register (QSR) and the interim Queensland Suicide Register (iQSR).

The QSR is a longstanding surveillance system which includes records on all suspected suicides by Queensland residents from 1990. The iQSR is a real-time suicide monitoring system that records interim data on suspected suicides shortly after the death occurs.

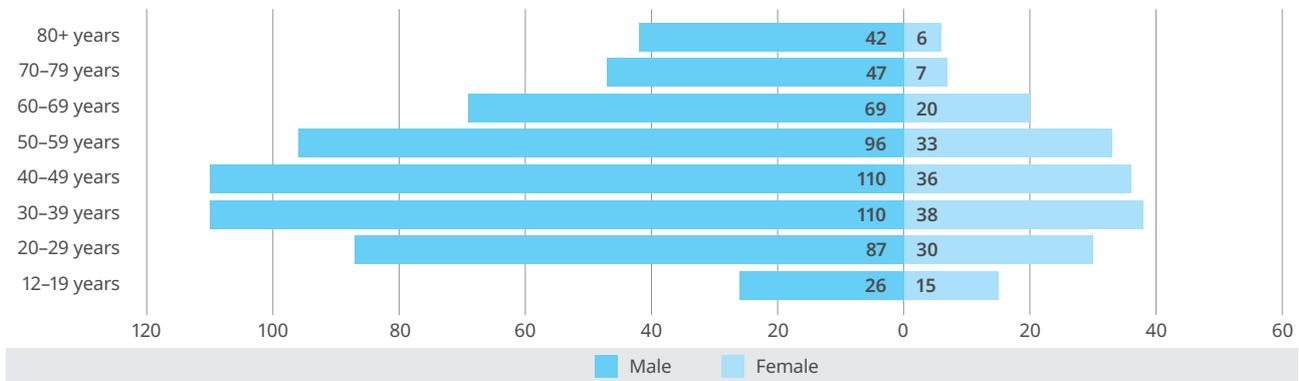
See iQSR information at <https://info.qmhc.qld.gov.au/suicide-data>. The figures on suspected suicides shown below may differ from iQSR data, as updates can occur over time.

In 2024–25, there were **733 suspected suicides** reported to the court for investigation. Of these:

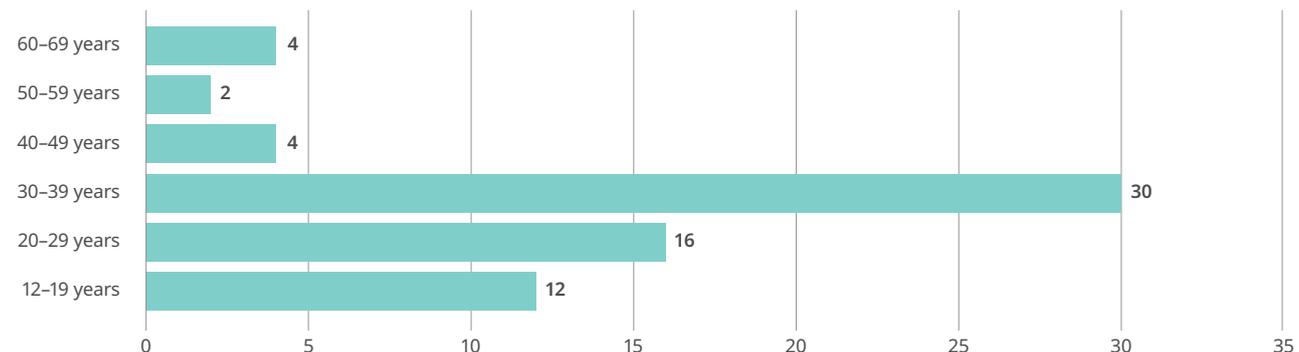
- **587 cases were men**, accounting for approximately 76% of the total.
- **185 cases were women**, making up about 24% of the total.
- **68 cases were persons** who identified as Aboriginal or Torres Strait Islander.

When reporting on Queensland suicide data, please consider the Mindframe guidelines, available at <https://mindframe.org.au/suicide/communicating-about-suicide/mindframe-guidelines>

**Figure 3:** Suspected suicides reported by age groups – male and female



**Figure 4:** Suspected suicides for Aboriginal and Torres Strait Islander people, by age group (male and female combined)



# Inquests

An inquest serves as the public face of the coronial process. This is an open court proceeding examining the events preceding a death. Inquests offer families insight into the circumstances surrounding the passing and offer transparency to the public regarding the death. Importantly, an inquest empowers coroners with legal authority to make comments and recommendations aimed at preventing or reducing deaths in similar circumstances in future and to comment on matters of public health and safety or the administration of justice. Each year only a small number of matters, less than one per cent of deaths reported to the court, progress to inquest.

## Inquests

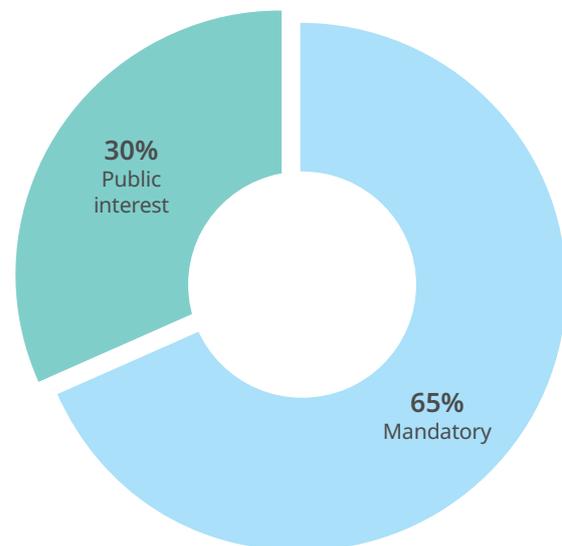
The Act requires certain deaths to be investigated at inquest, including those that occurred in custody, in care or in course of police operations, where there are issues regarding the care or police involvement. Inquests may be held at the direction of the Attorney-General or District Court. The State Coroner can also order an inquest to be held. A coroner may convene an inquest if satisfied it is in the public interest, including whether drawing attention to the matter may prevent similar deaths in the future.

During the reporting period, CCQ finalised inquests into the deaths of **27 persons with 20 inquest findings**. This represents a 13% decrease compared to the 23 inquests concluded in the 2023-24 reporting period.<sup>4</sup>

## Inquest categories

Of the 20 inquests finalised in the reporting period, there were **13 mandatory inquests**, including a State Coroner directed inquest, and **seven public interest inquests**.

Figure 5: Inquest categories for 2024-25



<sup>4</sup> To see the *Inquests Finalised During 2024-25 Reporting Period* refer to [Appendix Two](#).

## Counsel Assisting

CCQ has a team of legal officers to support coroners. These officers provide legal advice during an investigation and appear as counsel assisting the coroner during inquest proceedings. Advice can assist a coroner’s decision about whether to hold an inquest, the issues to be investigated at inquest, and possible findings.

This specialist in-house team means external barristers are briefed only as required, in line with equitable briefing practices. For example, to assist the coroner in uniquely technical investigations about air crashes or maritime safety, or in exceptionally complex matters.

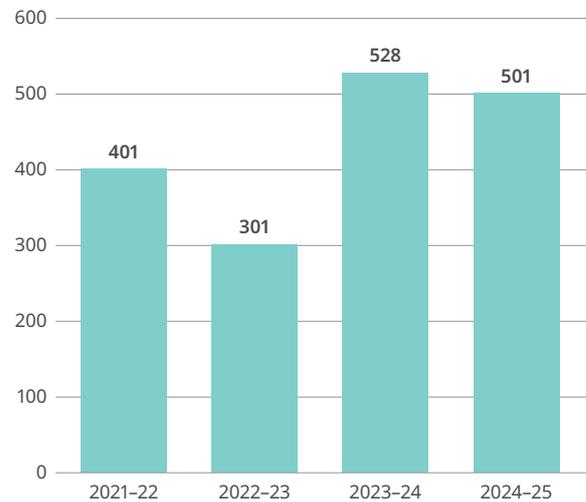
Of the 20 inquests finalised this financial year, external counsel assisting appeared in seven. In-house legal officers appeared as counsel assisting in the remaining 13 inquests.

## Media and community interest

Coronial inquests and coroners’ findings at inquests can attract significant attention from the media and community.

CCQ, in consultation with the Department of Justice’s Media Relations Unit, addressed **501 media queries in 2024–25**, a decrease from 528 in the previous year. These queries related to updates on investigations, requests for non-publication orders, exhibit requests, witness lists and other general investigative updates.

**Figure 6:** Media queries received from 2021–22 to 2024–25



# Reducing preventable deaths

## Responses to coronial recommendations

Responses to recommendations directed at the Queensland Government are published on the Coroners Court of Queensland website near the relevant inquest finding. These responses outline whether a recommendation is being considered, how it will be implemented or the rationale behind not supporting it. The Queensland Government endeavours to address coronial recommendations involving agencies by providing implementation updates until the recommendation is delivered or not supported.

### ABC (a pseudonym)

[READ RESPONSE](#)

#### *Coroner O'Connell*

**ABC was located unresponsive in their residence sitting in a lounge chair. It was determined they had passed away.**

An opened voluntary assisted dying (VAD) self-administration oral substance medication kit was located nearby, its contents were empty, and it appeared to have recently been consumed. ABC was not a VAD patient, their spouse was, but when their spouse was unable to use their supplied VAD self-administration oral substance they later received a practitioner administered VAD IV substance and they passed away in hospital on 8 May 2023. The unused and unrequired VAD self-administration oral substance that ABC had used to end their life had not been returned, as required, for appropriate disposal.

On 10 June 2025, the Minister for Health and Ambulance Services responded that Queensland Health took immediate action to mitigate risk including regulatory amendment, earlier notification and follow up for disposal of substance, and proactive monitoring of Births, Deaths and Marriages data. Supervised self-administration had always been an option, and steps had been taken to ensure people are aware of this choice.

### Maximilian Patrick McDowall (Max)

[READ RESPONSE](#)

#### *Coroner MacKenzie*

**Maximilian Patrick McDowall (Max) died aged 20 years when he sustained multiple injuries whilst riding his bicycle after being struck by a Brisbane City Council bus.**

On 23 April 2025, the Minister for Transport and Main Roads (TMR) responded that consultation with key stakeholders had commenced to develop an action plan to address the recommendation that Brisbane City Council and Translink Services install in its full fleet, technology of the type described as 'mobile eye' and 'camera mirrors' to assist bus drivers identifying hazard awareness training for pedestrians and cyclists.

## Inquest into the death of a 13-year-old child

[READ RESPONSE](#)

### *Coroner Lee*

**A 13-year-old child died while swimming in a rock pool at Cedar Creek Falls. He had been taken to the Falls for a swim by a youth worker, along with another boy from his residential placement.**

On 30 September 2024, the Minister for Environment and the Great Barrier Reef and the Minister for Science and Innovation responses included that Queensland Parks and Wildlife Service and Partnerships (QPWS&P) has drafted an 'Action Implementation Plan' from the 'accepted' recommendations of the Royal Life Saving Society – Australia (RLSSA) report, with accountable persons allocated individual recommendations.

Additionally, a Standard Operating Procedure (SOP) has been developed. In addition to the SOP, QPWS&P has installed a heavy duty steel 'closure' gate, wing fencing and associated signage along the main walking track to the falls area.

On 26 March 2025, the Minister for the Environment and Tourism and Minister for Science and Innovation responded that a Master planning project has been funded and is currently underway for the Cedar Creek section.

# Non-inquest findings

The Act authorises coroners to publish non-inquest findings, known as chamber findings, when it is deemed in the public interest and to the extent practicable, the coroner has consulted with and had regard to the views of a family member of the deceased person.

This proactive publication may serve various purposes such as supporting initiatives to prevent deaths, increasing public awareness about preventable fatalities, correcting public misinformation, or informing regulators in specific professions and industries. In appropriate cases, findings can be anonymised. Additionally, the *State Coroner's Guidelines 2013* provide that any individuals named in findings should be notified and provided an opportunity to respond before the findings are published.

During 2024–25, coroners published 25 non-inquest findings. The findings are accessible at the Coroners Court website: <https://www.coronerscourt.qld.gov.au/findings-upcoming-inquests/search-findings>.

Deceased name/title	Date delivered	Catchwords	Coroner
<u>An eight month old twin whose family was known to Child Safety</u>	25 June 2025	Infant death, high risk infant, neglect, parental substance use, methylamphetamine, Child Safety involvement, delay commencing and lapse during Investigation & Assessment, Intervention with Parental Agreement lack of medical input to Child Safety assessment and decision making, emerging pattern of parental avoidance or disengagement, access to interstate child protection history	<i>Ainslie Kirkegaard, Coroner</i>
<u>Mr B.</u>	2 June 2025	Health care related death, iatrogenic death, premature death, overdose of phenol, interventional radiology, celiac plexus block, Queensland Health Medicines Advisory Committee, Royal Brisbane and Women's Hospital	<i>Melinda Zerner, Coroner</i>
<u>Francis Robert Falappi</u>	19 May 2025	Mountain bike riding, Smithfield Mountain Bike Park, Macalister Range, Far North Queensland, Worlds Downhill, singletrack, double black diamond, drop, invert, hardpacked, Trail Difficulty Rating System, Australian Mountain Bike Trail Guidelines	<i>Stephanie Williams, Coroner</i>
<u>Mr T.</u>	2 May 2025	Vulnerable Persons, Abandoned Vehicles, Department of Transport and Main Roads, Local Government Association of Queensland	<i>Melinda Zerner, Coroner</i>
<u>Indian citizen</u>	1 May 2025	Drowning, Indian citizen, Unpatrolled and hazardous beach-Warnings	<i>Carol Lee, Coroner</i>

Deceased name/title	Date delivered	Catchwords	Coroner
<u>Mr H.</u>	17 April 2025	Poor bowel care in an RACF, Faecal impaction, Faecal overflow, Inadequate resident assessment and monitoring in an RACF	<i>Melinda Zerner, Coroner</i>
<u>5-year-old boy</u>	14 March 2025	Non-Inquest findings, Fire, Rural property, Child-Modified motorcycle, Non-compliance with refuelling protocol	<i>Carol Lee, Coroner</i>
<u>Mr O.</u>	10 December 2024	Aged Care, and Falls Risk Management Falls in a Residential Aged Care Facility (RACF)	<i>Melinda Zerner, Coroner</i>
<u>Mr W</u>	20 November 2024	Pressure risk assessment and management, Hospital acquired pressure injury, Pressure risk mitigation strategies, Wound care management	<i>Melinda Zerner, Coroner</i>
<u>SD</u>	8 November 2024	Health care related death, large regional public hospital, malignant haematology, Hodgkin lymphoma, peripheral T-cell lymphoma (PTCL), onsite second pathology opinion diagnosis processes, lack of onsite subspecialised immunohistochemistry testing (PAX5), notification of critical diagnosis processes, Multidisciplinary Team (MDT) processes, misdiagnosis and incorrect treatment decision, Ryan's Rule procedure	<i>Ainslie Kirkegaard, Coroner</i>
<u>HK, a five year old boy</u>	28 October 2024	Child death, multiple clinical presentations, metropolitan public hospital emergency department, Influenza A, bacterial coinfection, paediatric sepsis, Queensland Paediatric Sepsis Pathway, Children's Early Warning Tool (CEWT)	<i>Ainslie Kirkegaard, Coroner</i>
<u>A commercial aerial spraying pilot</u>	28 October 2024	Work related death, aviation crash, commercial aerial spraying, low level spraying, bird strike, Air Tractor AT-502B aircraft	<i>Ainslie Kirkegaard, Coroner</i>
<u>MH, an aged care resident</u>	22 October 2024	Health care related death, residential aged care, skin integrity, pressure area risk assessment, pressure injury prevention, staging and management, wound care documentation, management of wound related pain, failure to recognise and respond to clinical deterioration, unmet care needs in people living with dementia	<i>Ainslie Kirkegaard, Coroner</i>
<u>Malcolm Daniel Moriarty</u>	10 October 2024	Storage and access to medications in Residential Aged Care Facility, Complacency in medication administration	<i>Melinda Zerner, Coroner</i>
<u>Diane Margaret Crowther</u>	10 October 2024	Wound infection, Wound care in Residential Aged Care Facility, Cellulitis	<i>Melinda Zerner, Coroner</i>

Deceased name/title	Date delivered	Catchwords	Coroner
<u>Jean Alice Dowson</u>	10 October 2024	Palliative Care in Residential Aged Care Facilities, End of Life Practices in Aged Care, Use of End of Life Medications and Doses	<i>Melinda Zerner, Coroner</i>
<u>Donald Richard Gunthorpe</u>	10 October 2024	Palliative Care in Residential Aged Care Facilities, End of Life Practices in Aged Care, Use of End of Life Medications and Doses	<i>Melinda Zerner, Coroner</i>
<u>Charlotte Paluszak</u>	10 October 2024	Palliative Care in Residential Aged Care Facilities, End of Life Practices in Aged Care, Use of End of Life Medications and Doses	<i>Melinda Zerner, Coroner</i>
<u>A residential aged care facility resident (a resident)</u>	19 September 2024	Residential Aged Care Facility, Management of Semi-Mobile Residents with Dementia, Environmental Hazards, Compliance with Observation Requirements, Heat Stroke	<i>Carol Lee, Coroner</i>
<u>Child Q</u>	6 September 2024	Bamaga Hospital, multiple presentations, appropriateness of care, bacterial chest infection	<i>Deputy State Coroner Gallagher</i>
<u>Pilot 1 and Pilot 2</u>	22 August 2024	Aviation, Recreational Flying, Plane crash, Touch-and-go manoeuvre, Insufficient thrust to maintain a climb	<i>Amanda Bain, Coroner</i>
<u>Mahsan Muhammad</u>	20 August 2024	Domestic commercial fishing vessel, Use of personal flotation devices in coastal waters, Noncompliance with procedures for onboard operational safety requirements	<i>Carol Lee, Coroner</i>
<u>RJH</u>	13 August 2024	Health care related death, complex cardiac history, intravenous flecainide, small regional hospital, cognitive bias, lack of cardiology consult, hospital dispensary phone consultation service, guideline for intravenous flecainide prescribing & administration	<i>Ainslie Kirkegaard, Coroner</i>
<u>Etevis Debroh Taai Patelesio</u>	30 July 2024	Management of Acute Behavioural Disturbance in the Emergency Department, Physical and Chemical Restraint, Droperidol, Monitoring Post Sedation, Compliance with Guidelines	<i>Carol Lee, Coroner</i>
<u>Mr K</u>	19 July 2024	Health care related death, chronic obstructive pulmonary disease (COPD), oxygen administration, oxygen saturations, carbon dioxide retainer, interhospital transfer	<i>Melinda Zerner, Coroner</i>

## **Case summaries**

Public interest and  
Attorney-General  
directed inquests

Section 28 of the Act authorises an inquest into a reportable death if a coroner investigating the death is satisfied it is in the public interest to do so. The 'public interest' is a discretionary consideration by a coroner.

Some factors considered when assessing whether an inquest should be held include, but are not limited to, whether there is reasonable doubt about the cause or circumstances of the death, if there is a public interest in drawing attention to the death to prevent similar deaths in future, whether previous inquests have dealt with similar deaths and made recommendations that have not been adopted or is there the potential

for publicity from an inquest to generate new evidence. The Attorney-General can also direct that an inquest be held.

The following section provides a summary of inquests finalised by coroners during the reporting period that were convened in the public interest or directed by the Attorney-General.

**WARNING: Aboriginal and Torres Strait Islander people are advised the following section contains the names of people who have passed.**

## Inquest into the death of Ivona Jovanovic

[READ FINDINGS](#)

### *Coroner MacKenzie – 26 June 2025*

**Ivona Jovanovic died on 8 September 2019 from a chest wound caused by inadvertent discharge of a firearm by Christos Panagakos.**

Mr Panagakos was arrested and charged with the manslaughter of Ms Jovanovic along with drug offences and offences against the *Weapons Act 1990* (Qld). He was committed for trial, however the Office of the Director of Public Prosecutions did not proceed with the manslaughter trial.

Coroner MacKenzie concluded that Mr Panagakos caused the death of Ms Jovanovic and that, on the evidence available, it was essentially an accident. Coroner MacKenzie found that many of the witnesses at the inquest were not telling the truth or were obfuscating its discovery. Coroner MacKenzie noted that, should further relevant evidence become available, there will always be an opportunity to re-open the inquest.

## Inquest into the death of Christopher Glen Essery

[READ FINDINGS](#)

### *Deputy State Coroner Gallagher – 20 June 2025*

**Christopher Essery died aged 74 on 20 February 2019 at the Princess Alexandra Hospital.**

Mr Essery died from sepsis secondary to fistulating Crohn's disease and post surgery complications following surgical treatment on 24 January 2019. The Deputy State Coroner determined the death was reportable.

The Deputy State Coroner found the failure to perform an early post-admission Colorectal Surgical Consultant review as a part of the formulation of a treatment and management plan was not appropriate.

The Deputy State Coroner found it was not possible to conclude a better outcome would have occurred if surgery was performed earlier. Evidence suggested the same or similar post surgery complications would have arisen. Systemic failings led to there not being a single Colorectal Surgical Consultant responsible for Mr Essery's care during a Consultant's extended leave.

The Deputy State Coroner recommended review and consideration of changing protocols directed to providing Consultant coverage on a rotating roster basis in the Colorectal Ward or the Inflammatory Bowel Disease Clinic at the Princess Alexandra Hospital which gives rise to a risk of not providing effective continuity of care for patients during extended leave of the patient's admitting or treating Consultant.

## Inquest into the death of Audrey Yvette Carrick

[READ FINDINGS](#)

### *Coroner Lee – 06 December 2024*

**Audrey Carrick unexpectedly passed away on 22 January 2019 after a Transcatheter Aortic Valve Implantation (TAVI) surgery at The Prince Charles Hospital.**

Mrs Carrick had been discharged the previous day. The cause of death was pulmonary thromboembolism due to, or as a consequence of, aortic stenosis. The inquest investigated whether anticoagulation medication should have been administered, whether Mrs Carrick's pre and post-procedure heart failure was recognised and treated appropriately, whether a failure to implant a pacemaker contributed to her death and whether the decision to discharge Mrs Carrick was appropriate. The decision not to commence the anticoagulation therapy at an earlier time was found to be based on sound reasons.

The coroner was not satisfied that a failure to diagnose and treat symptoms of heart failure before the surgery made any difference to the outcome. The evidence suggested that a pacemaker, of itself, would not have prevented Mrs Carrick's death. There was justification for agreeing to Mrs Carrick's request to be discharged.

The coroner considered that some aspects of Mrs Carrick's treatment, centering around communication, could have been improved. The coroner concluded there were no matters to be meaningfully addressed through recommendations, but encouraged staff to reflect on their clinical practices.

## Inquest into the death of Maximilian Patrick McDowall (Max)

[READ FINDINGS](#)

*Coroner MacKenzie – 24 October 2024*

**Max McDowall died on 27 May 2021 from multiple injuries, due to, or as a consequence of motor vehicle collision whilst riding his bicycle.**

Max was struck by a Brisbane City Council (BCC) bus which did not give way to his crossing a pedestrian strip. The inquest examined the bus operator's ability to sight Max, steps taken to check for pedestrians, traffic light sequence appropriateness, design of the intersection and any further recommendations needed to improve safety following upgrades to the intersection.

The coroner recommended that BCC review and improve guidance for incident reporting and blind spot mapping. Installation of camera mirrors in the full BCC bus fleet was recommended.

The coroner recommended review of every intersection in Brisbane metropolitan area to prioritise installation of a red arrow prohibiting vehicles crossing pedestrian lanes which have a 'green man' light, assessing the risk posed by blind spots on buses at each intersection.

## Inquest into the death of Jeremiah (Jayo) Harold Rivers

[READ FINDINGS](#)

*Coroner MacKenzie – 17 October 2024*

**Jeremiah (Jayo) Rivers is believed to have passed by unknown cause on or about 18 October 2021.**

He was on a four-wheel drive pig-hunting expedition to the Northern Territory with six travelling companions. Members of the travelling group say that Jayo wandered off from a campsite at Wippo Creek. Despite an extensive search and rescue mission and police investigation, Jayo's body has not been found.

The coroner found the QPS search and rescue effort was extensive, sufficient and appropriate. Five recommendations were made in relation to training, risk assessment, access to information, and improving engagement with First Nations families during missing persons investigations.

The coroner noted the QPS investigation into Jayo's disappearance will remain open.

## Inquest into the deaths of Charmaine, Aaleyn, Matilda, Wyatt and Zaidock McLeod

[READ FINDINGS](#)

### Coroner O'Callaghan – 21 August 2024

**Charmaine McLeod died on 27 May 2019 when she drove her car into the path of an oncoming truck. Her four young children Aaleyn, Matilda, Wyatt and Zaidok who were in the car also died.**

Ms McLeod had made allegations of DFV and sexual assault and was engaged in Family Court proceedings. A note written by Ms McLeod, found at the crash site, revealed a sense of hopelessness in being let down by her lawyer and the legal system.

The coroner found the police investigation of Ms McLeod's complaints of DFV and sexual assault were appropriate. The coroner found agency responses towards the protection, safety and welfare of the children were adequate and appropriate. Ms McLeod was affected by comorbid borderline personality disorder and schizophrenia. It was found there was no evidence Ms McLeod was psychotic or that she required involuntary treatment. It was accepted an email exchange with her lawyer led her to believe she would lose custody of her children and triggered a response of intentionally driving her car into the truck.

The coroner recommended the Queensland Law Society consider providing a mental health specialist consultant service to solicitors, and with Legal Aid Queensland consider providing continuing professional development opportunities that address the coercive impact of family law proceedings on clients, with emphasis on those with mental health conditions, identifying and engaging when those clients are experiencing crisis.

## Inquest into the death of ABC (a pseudonym)

[READ FINDINGS](#)

### Coroner O'Connell – 11 September 2024

**ABC was found unresponsive at their home on 16 May 2023.**

An opened Voluntary Assisted Dying (VAD) self-administration oral substance medication kit was located nearby. Its contents were empty and it appeared to have been recently consumed. The VAD oral substance was not prescribed for use by ABC but by their spouse. The spouse was unable to use their supplied VAD oral substance and later received a practitioner administered VAD IV substance. The unused and unrequired VAD self-administration oral substance was used by ABC.

The inquest examined the circumstances of ABC's passing, the processes for returning unused VAD self-administration substances, and procedures for preventing unauthorised use of VAD substances provided for self-administration. The coroner found that non-observance of prescribed timelines for return of unused VAD substances provided an opportunity to ABC. The coroner accepted there was no breach in protocol or legislative process by Queensland VAD personnel.

The coroner recommended suitability checks should be conducted on the contact person for a VAD patient and the VAD substance should remain under the direct control of an authorised health professional until it is consumed.

## Inquest into the suspected passing of Markiah Eris Allenby Major

[READ FINDINGS](#)

### *Coroner Williams – 19 July 2024*

**Markiah went missing after he walked into dense rainforest surrounding Budabadoo Creek, Yarrabah on 19 August 2023.**

Markiah dropped off Person A before driving away and travelling around Cairns and Yarrabah, which was observed on several CCTV cameras. The car was found abandoned near a creek bordered by thick rainforest between 10pm and 11pm that night. A forensic examination found traces of Markiah's DNA on a shoe.

Cairns Property Crime Unit had commenced a search for Markiah on 16 August. The QPS Missing Persons Unit began conducting investigations with financial and health institutions on 3 September 2023 without success, after which Operation Victor Rhenium was commenced to investigate Markiah's disappearance. Three formal searches took place in Yarrabah and no evidence was found to suggest involvement of other people.

At inquest, the coroner found Markiah passed after he walked into the rainforest, likely in the area of Budabadoo Creek, on an unknown date between 19 August and 11 September 2023. The coroner considered the ongoing police investigation to be thorough and comprehensive.

No issues regarding public health or safety or the prevention of deaths in similar circumstances were identified and no recommendations were made.

## Case summaries

Deaths in custody  
of Aboriginal and  
Torres Strait Islander  
people

The need for public scrutiny and accountability requiring all deaths in custody to be investigated by the State Coroner or Deputy State Coroner arose out of the recommendations of the Royal Commission into Aboriginal Deaths in Custody. The following section provides a summary of the mandatory death in custody and directed inquests finalised during the period involving the passing of Aboriginal and Torres Strait Islander people.

**WARNING: Aboriginal and Torres Strait Islander people are advised the following section contains the names of people who have passed.**

## Inquest into the death of Trevor Charles Stone

[READ FINDINGS](#)

### *State Coroner Ryan – 26 May 2025*

Trevor Stone passed away on 29 June 2021 at the Princess Alexandra Hospital from metastatic lung adenocarcinoma with other significant conditions including diabetes mellitus, hypertension, dyslipidaemia and ischaemic heart disease.

Mr Stone was a prisoner in custody at the time of his passing. He was diagnosed with lung cancer in October 2019. Despite some positive responses to treatment, Mr Stone experienced a steady decline in health in the months preceding his passing as a consequence of end-stage lung cancer.

In June 2021, investigations revealed Mr Stone's cancer had metastasized to his brain. He agreed to commence palliation and died from natural causes. The inquest examined whether he had access to and received appropriate medical care while in custody. The State Coroner was satisfied Mr Stone did receive the treatment that was clinically indicated and accepted the expert opinion that the treatment was of a high professional standard.

The State Coroner found there were no comments or recommendations to be made to assist in preventing similar deaths.

## Inquest into the passing of Robert George Kenneth Malayta

[READ FINDINGS](#)

### *State Coroner Ryan – 12 December 2024*

**Robert Malayta's body was found on 25 February 2022 in the Ross River in Kirwan. The cause of his passing was determined to be drowning in the course of a police operation the previous day.**

Mr Malayta was a passenger in a suspected stolen car driven by his older brother. Police saw the car speeding and acted to stop the car using a tyre deflation device. The occupants ran away. Mr Malayta and his brother entered the Ross River to avoid being detained by police. Mr Malayta ran into difficulty because he was physically exhausted from running and needed to negotiate heavily weeded conditions near the edge of the River. He drowned at an unknown time, likely within minutes of entering the water.

The State Coroner was satisfied QPS' actions were adequate and appropriate. There was no attempt to intercept or pursue the car and QPS' coordinated movements after disabling the car were reasonable. The decision to establish a cordon was tactically sound and showed restraint. It was neither reasonable nor possible for police to enter the river or commence an immediate search of the river in the dark. The urgency to flee the scene was not precipitated by unjustified police action.

The State Coroner did not make any recommendations.

## Inquest into the death of Ashley Charles Washington

[READ FINDINGS](#)

### *State Coroner Ryan – 18 November 2024*

**Ashley Washington passed away on 13 December 2020 at Toowoomba Hospital.**

Ashley died after being restrained for around 20 minutes by police officers who used force to arrest him after he was Tasered. Police had responded to reports that Ashley had taken property from a private residence. He was located on a nearby street. Ashley stabbed a police dog and a police officer. He became unresponsive after droperidol was administered to him by paramedic. His clinical decline was not recognised until after he was placed in an ambulance, around eight minutes after paramedics arrived on the scene. The cause of passing was undetermined.

The State Coroner accepted Ashley had a combination of vulnerabilities that contributed to stress being placed on his heart when police restrained him. The State Coroner accepted the actions of the restraining police officers were appropriate in the circumstances. The State Coroner accepted the level of assessment of Ashley by paramedics was less than optimal but did not represent wilful omissions of care.

The State Coroner was satisfied QPS and Queensland Ambulance Service (QAS) are continuing collaborative development of training products for sudden post arrest medical decline. No recommendations were made.

## **Case summaries**

Deaths in custody  
and deaths in  
police operations

## Reportable deaths include deaths in custody and deaths that happen in the course of or as a result of police operations.

The term **'death in custody'** is defined in section 10 of the Act to include those who at the time of their death are in custody, trying to escape from custody or trying to avoid being placed into custody. 'Custody' is defined to mean detention under arrest or the authority of a court order or an act by a police officer or corrective services officer, court officers or other law enforcement personnel. An inquest is mandatory in these circumstances.

As per section 77(2)(b) of the Act, the following contains a summary of the investigation, including the inquest into each death in custody finalised during the reporting period.

### **Inquest into the deaths of Anthony Michael Charlwood and Krystal Renee Evans**

[READ FINDINGS](#)

#### *State Coroner Ryan – 18 June 2025*

##### **Anthony Charlwood and Krystal Evans died in a motorcycle crash on 26 November 2022.**

Mr Charlwood was riding the motorcycle and Ms Evans was the pillion passenger. Mr Charlwood rode the motorcycle at high speed attempting to evade a police officer trying to intercept him for traffic offences, and collided with a light pole.

With consideration given to QPS policies and procedures and the evidence, the State Coroner was satisfied the Acting Sergeant's actions in attempting to intercept the motorcycle were appropriate. The investigations by Coomera Forensic Crash Unit and the Ethical Standards Command were also accepted as appropriate.

No recommendations were made.

## Inquest into the deaths of Raghe Mohamed Abdi, Zoe Dorethea Antill & Maurice Fredrick Antill

[READ FINDINGS](#)

*Deputy State Coroner Gallagher – 17 April 2025*

**Zoe and Maurice Antill were killed at their home in an apparently random attack by Raghe Abdi.**

Raghe was being monitored by the Queensland Joint Counter-Terrorism Team. He had been fitted with an electronic monitoring device (EMD) as part of bail conditions. On 16 December 2020, police were notified his ankle bracelet had been tampered with. He could not be located. On 17 December 2020 police attended after receiving reports of a man walking along the verge of Logan motorway. When officers approached, Raghe pulled a knife from his pocket and advanced. Officers retreated and ordered Raghe to drop the knife, but he charged and was shot. After his death, it was discovered Raghe was responsible for the deaths of the Antills.

The Deputy State Coroner found the State and Commonwealth monitoring of Raghe sufficient. Current QPS policy and procedures were considered sufficient, with the subsequent improvements made.

The Deputy State Coroner found that, in the circumstances, the officers' use of force was appropriate and the QPS investigation into the three deaths was adequate.

Given the unforeseeable nature of the deaths, the extensive investigations carried out, and the recommendations already made and implemented, no further recommendations needed to be made.

## Inquest into the death of Jamie Brian Campbell

[READ FINDINGS](#)

*State Coroner Ryan – 31 March 2025*

**Jamie Campbell died in the Intensive Care Unit at The Prince Charles Hospital on 17 March 2021.**

The cause of death was hypoxic ischaemic encephalopathy due to, or as a consequence of, cardiac arrest of unknown cause. On 14 March 2021 Jamie was restrained by QPS officers at the Eatons Hill Hotel after he was found agitated and thrashing on the bathroom floor. Jamie was administered two doses of Droperidol by QAS officers who did not recognise he was critically unwell. The second dose of Droperidol was not clinically indicated. At the time, Jamie was experiencing a medical emergency. Unknown to the ambulance officers, he had a lethal concentration of methamphetamine in his system.

The State Coroner found it was not possible to separate the various contributors that led to Jamie suffering a cardiac arrest. The State Coroner accepted the actions of ambulance officers did not comply with policies and procedures. Appropriate training had been provided.

The State Coroner accepted police officers displayed an awareness of Jamie's vulnerable position and the need to ensure his restraint did not inhibit his ability to breathe. It was noted disciplinary processes and investigations into the ambulance officers had occurred and QAS training had been updated.

The State Coroner made no further recommendations.

## Inquest into the death of Mohamad Ikraam Bahram

[READ FINDINGS](#)

### *State Coroner Ryan – 11 February 2025*

**Mohamad Ikraam Bahram (Ikraam) died of multiple gunshot wounds on 23 February 2020.**

Ikraam drove to Brisbane CBD where he stabbed a tourist he had chased across city streets with a knife. When Ikraam was confronted by police officers on Mary Street he rushed at the officers with a knife. Officers tried to retreat but Ikraam did not comply with verbal directions to stop and drop the knife. He was shot by police officers.

The State Coroner accepted Ikraam may have experienced a mental health incident related to schizophrenia and found his pharmacological treatment was appropriate and reasonable. The State Coroner concluded the police officers' use of lethal force was reasonable, proportionate, consistent with their training and appropriate. The State Coroner accepted that QPS training was sufficient and officers had communicated respectfully with Ikraam's family following the death.

Metro South Hospital and Health Service submitted it had fully implemented all recommendations made in the Clinical Review after Ikraam's death. On that basis, the State Coroner considered no further recommendations were required.

## Inquest into the death of Shane Anthony May

[READ FINDINGS](#)

### *State Coroner Ryan – 16 December 2024*

**Shane May died in palliative care at Rockhampton Base Hospital (RBH) on 11 May 2022 from multiorgan failure, due to, or as a consequence of metastatic lung cancer.**

Mr May was a prisoner in custody at the time of his passing. On admission into custody Mr May tested positive for COVID-19. Despite treatment, he did not improve and was transferred to RBH by QAS on 3 April 2022.

Investigations identified an enlarged mediastinal node, an opacity in the left upper prevascular region and an opacity in the upper lobe posteriorly. Mr May was to undergo a CT lung biopsy to determine the nodule type, as well as a CT scan of his brain, abdomen and pelvis due to previous history of cancer. Mr May returned to Capricornia Correctional Centre and was readmitted to RBH in early May 2022 for further management due to his symptoms. Investigations revealed extensive hepatic metastatic disease. His presentation was in keeping with acute liver failure, secondary to liver metastases with a severely poor prognosis. A decision was made in consultation with his family to commence palliation.

The State Coroner was satisfied Mr May died of natural causes, and he received regular, timely and appropriate medical care while incarcerated.

The State Coroner made no recommendations.

## Inquest into the death of Damon Paul William Savage

[READ FINDINGS](#)

### *State Coroner Ryan – 04 November 2024*

#### **Damon Savage died on 27 August 2020 after being shot by police.**

Mr Savage called police after assaulting his partner. When police attended, he was armed with two knives and advanced towards officers. He died after he was shot by police who had called on him to drop the knives. He did not comply with that command. Issues explored at inquest were whether the use of lethal force was appropriate and whether the investigation by the Ethical Standards Command was appropriate and sufficient.

The State Coroner found the use of lethal force was in accordance with QPS policy. The State Coroner accepted the officers acted appropriately and after the taser was deployed, there were no other less than lethal force options open.

The State Coroner considered the Ethical Standards Command investigation was thorough and professional, and no recommendations could be made which would prevent similar deaths.

## Inquest into the death of John Raymond Ainsworth

[READ FINDINGS](#)

### *State Coroner Ryan – 18 October 2024*

#### **John Ainsworth passed away on 12 January 2021 in the Townsville University Hospital (TUH) Palliative Care Unit from cerebrovascular disease.**

Mr Ainsworth was a prisoner in custody at the time. During October and November 2020, he experienced a decline in health. Nursing staff and inmates noticed him to be increasingly forgetful, unsteady and lethargic. On 25 November 2020, he suffered a severe stroke due to an occlusion of the middle cerebral artery with irreversible brain injury. Mr Ainsworth was treated with intravenous thrombolysis and transferred to the acute stroke unit at TUH. He continued to decline and suffered a further anterior cerebral artery stroke on 4 January 2021. In consultation with his family, the decision was made to commence palliation.

The State Coroner was satisfied Mr Ainsworth died of natural causes and the medical treatment provided was regular, timely and appropriate. There were no comments or recommendations made by the State Coroner.

## Inquest into the death of Luke Brian Gilbert

[READ FINDINGS](#)

### *Deputy State Coroner Gallagher – 11 October 2024*

#### **Luke Gilbert died of gunshot wounds to the chest on 1 October 2022.**

Luke consumed alcohol throughout the evening. He encountered two police officers. Luke bumped into one of the officers. A brief verbal exchange occurred. The officers asked Luke what he had. He produced a knife and dared the officers to shoot him. Despite verbal directions from the officers to stop and drop the knife, Luke continued to walk faster towards them. QPS officers attempted to tactically withdraw. Luke did not comply with verbal directions to stop and drop the knife. He advanced on the officers and was shot by them.

The Deputy State Coroner accepted police acted in accordance with policies and procedures and their actions were appropriate. The Deputy State Coroner accepted the training provided by Queensland Police Service was appropriate. Subsequent legislative amendments authorising scanning to detect knives in safe night precincts (Jack's Law) might have provided an opportunity to detect the knife earlier. The Deputy State Coroner accepted it was speculative as to whether Luke might have reacted differently.

The Deputy State Coroner recommended QPS consider mandating the uniform placement of Tacmed kits in all QPS vehicles, and a submission be made to the Australian New Zealand Policing Advisory Agency Board to conduct research into victim precipitated homicide.

# Deaths in care

The focus of a coronial investigation into a death in care is whether the circumstances of the death raise issues about the deceased's care that may have caused or contributed significantly to the death. Section 27(1)(a)(ii) of the Act mandates an inquest if such issues are identified.

A 'death in care' is defined in section 9 of the Act which makes the deaths of specific types of vulnerable people in the community reportable to a coroner. Namely, children who are in certain types of care or care facilities, involuntary mental health patients, and people with disabilities with high support needs who lived in funded support accommodation arrangements. These deaths are reportable, regardless of the cause of death. Coronial scrutiny is warranted because the ability of these groups of people to make independent, informed decisions about their lives is subject to intervention by the State.

During the 2024-25 period, 205 deaths in care were reported to the court. When compared with 2023-24 where 145 deaths in care matters were reported, this represents a 29.3% increase. The court works closely with care providers and the National Disability Insurance Agency to obtain necessary materials for an independent review of the care given before the death.

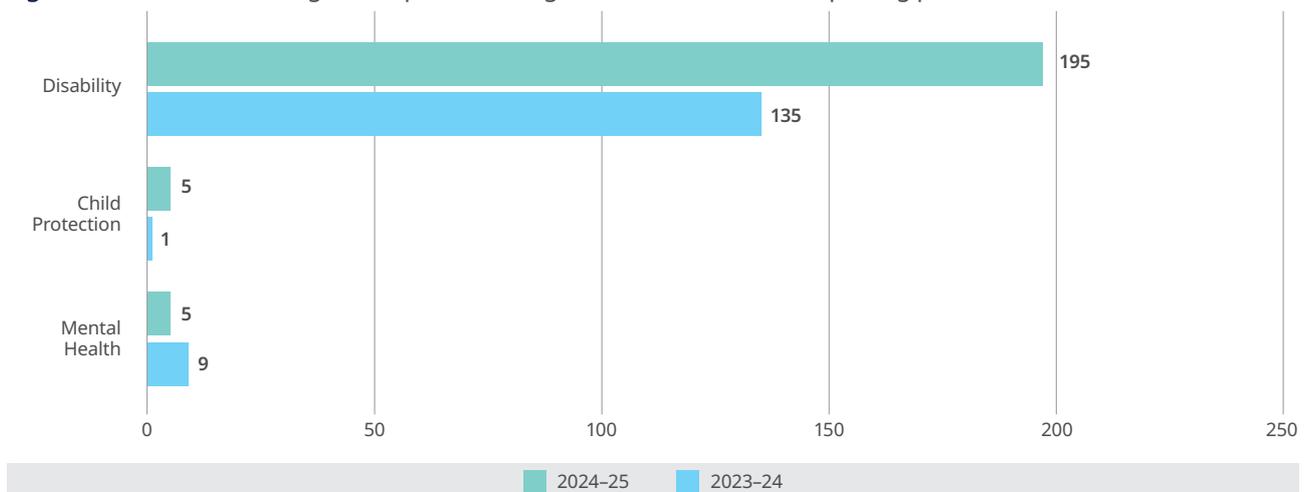
## Death in Care (Disability)

While the court received 195 reports of deaths of persons with disabilities, it finalised 199 cases for deaths in care in 2024-25. These finalisations include cases lodged in previous reporting periods. By the end of this reporting period, 162 were determined to have resulted from natural causes, 4 were attributed to health care procedures and/or natural causes, 11 were attributed to domestic accidents, 6 to unknown/natural causes, 5 to interpersonal violence or suspected drug or alcohol poisoning, and 1 was attributed to a road transport accident.

## Death in Care (Child Protection)

Of the five deaths reported because the children were subject to orders made under the *Child Protection Act 1999* at the time of the deaths, all five were determined to be the result of natural causes.

Figure 7: Death in care categories reported during 2024-25 and 2023-24 reporting period



## Death in care (involuntary mental health treatment)

Of the five deaths reported because the person died while subject to a treatment authority, all five were determined to be from natural causes. During the reporting period, Coroner Lee finalised an inquest into the death of Chloe Jane Campbell, who died in 2019. A summary of the case follows.

### Inquest into the death of Chloe Jane Campbell

[READ FINDINGS](#)

#### Coroner Lee – 17 September 2024

**Chloe Campbell died on 30 April 2019 in the Intensive Care Unit at Logan Hospital from hypoxic-ischaemic encephalopathy, due to, or as a consequence of, hanging.**

Ms Campbell's passing followed a suicide attempt and subsequent cardiac arrest requiring resuscitation the previous evening. Ms Campbell was an inpatient at the Mental Health Unit at Logan Hospital and was subject to a Treatment Authority under the *Mental Health Act 2016*. Ms Campbell received prompt attention from nursing staff, the Code Blue Team, admission into the Intensive Care Unit and supportive treatment and care following the hanging injury. However, Ms Campbell became haemodynamically unstable and unsupported in the Intensive Care Unit and Fentanyl was administered to prevent any distress as she died.

The coroner found the treatment received at Logan Hospital between 18 and 30 April 2019 was appropriate. The coroner found the Metro South Hospital and Health Service's approach to addressing ligature risks prior to and after Ms Campbell's passing was reasonable in the circumstances and consistent with the statewide approach.

The coroner found there were no matters to be addressed through recommendations to prevent similar deaths in the future.

# Higher court decisions relating to the coronial jurisdiction

If a coroner decides not to hold an inquest, a person may apply to the State Coroner or, if the coroner is the State Coroner, the District Court, for an order that an inquest be held.

If the State Coroner declines the application, the person may apply to the District Court for an order that an inquest be held. Additionally, a person who is dissatisfied with an inquest finding may apply to the State Coroner or the District Court to set aside the finding. If a finding is set aside, the State Coroner or District Court may order that a new inquest is held.

Applications are occasionally made to the Supreme Court to decide a dispute between family members over release of a deceased person.

The following section contains a summary of the decisions of higher courts handed down in relation to the coronial jurisdiction during the reporting period.

## **Cole v Wilson [2024] QDC 208**

[READ DECISION](#)

On 9 November 2021, the then Northern Coroner delivered findings in respect to an inquest into the death of Ms Gwen Grover who died on 14 October 1983. Her Honour ruled the death was due to suicide. The applicant, sister of the deceased, then applied to the District Court to set aside the findings and order the State Coroner to hold a new inquest into the matter.

Professor Duflou, forensic pathologist, provided evidence about the location of the gunshot and positioning of the body. The District Court set aside the findings that the death was self-inflicted. However, the court declined to order the State Coroner reopen the inquest to re-examine the findings or hold a new inquest, due to the age of the case, lack of further evidence and relevant witnesses having passed.

## **Taylor v Friday [2024] QSC 329**

[READ DECISION](#)

This decision concerned a dispute over burial of the deceased person. The Northern Coroner had exercised a power to release the deceased person to his spouse.

The deceased's mother applied to the Supreme Court as she wished to bury him in New South Wales, where he was raised, for reasons of spiritual and cultural connection to that region. The deceased's spouse wished to bury him in Townsville where he had lived, for the sake of their children.

The deceased person left no Will, and his wishes regarding his burial grounds were not contained in any testamentary document.

The close and abiding connection to country of his family, where he had strong cultural and spiritual connections, were balanced against the wishes of the spouse and children.

The Supreme Court decision favoured the spouse deciding where the deceased was to be buried.

# Systemic death review initiatives

## Domestic and Family Violence Death Review Unit (DFVDRU)

The DFVDRU is based within CCQ and provides specialist advice and assistance to coroners in their investigations of domestic and family violence related homicides and suicides and the deaths of children who were known to the child protection system. Through analysing demographic characteristics, static and dynamic risk indicators, and lethality risk indicators, the DFVDRU identifies trends and patterns regarding domestic and family violence related homicides and suicides to assist in identifying opportunities for prevention.

Systemic death review processes have been established across jurisdictions to facilitate these types of deeper learnings.

In 2024–25, the DFVDRU completed **66 case reviews** to assist coroners in their investigations of domestic and family violence related deaths and deaths of children known to the child protection system. The increase in completed reviews from last financial year has been achieved due to the implementation of a preliminary review model. The preliminary review model has enabled the unit to effectively triage cases and provide coroners with timely advice on more matters. As part of the preliminary review model, the unit assesses a matter and provides initial advice, recommendations for additional material to be requested and recommends whether an in-depth review may assist the coroner's investigation.

The DFVDRU maintains two comprehensive statistical databases:

- Queensland Domestic and Family Violence Homicide Database
- Queensland Domestic and Family Violence Suicide Database.

Data held by the DFVDRU is shared with government and non-government sectors to inform policy and practice reforms. In addition, the DFVDRU supports other death prevention activities within CCQ and provides advice on national and state policy and practice initiatives as they relate to the coronial jurisdiction.

The DFVDRU is a founding member of the Australian Domestic and Family Violence Death Review Network and continues to work closely with other death review mechanisms in Australia and undertake research in partnership with Australia's Network Research Organisation for Women's Safety (ANROWS).

The DFVDRU is committed to engaging with the service system and community to share insights from their work that can enhance understanding of domestic and family violence, support best practice service delivery and collaboration, and inform efforts to eradicate domestic and family violence deaths.

## Domestic and Family Violence Death Review and Advisory Board (the Board)

The DFVDRU provides secretariat support to the Board. The Board is an independent body established by the Act to undertake systemic reviews of domestic and family violence deaths in Queensland and make recommendations to the Queensland Government to improve legislation, policy and practice to prevent or reduce the likelihood of domestic and family violence deaths.

The establishment of the Board was a key recommendation of the Special Taskforce on Domestic and Family Violence in Queensland in their Not Now, Not Ever report.<sup>5</sup>

The Board's functions include:

- reviewing domestic and family violence deaths in Queensland
- analysing data and applying research to identify patterns, trends and risk factors relating to domestic and family violence deaths in Queensland
- conducting or commissioning research to prevent or reduce the likelihood of domestic and family violence deaths
- writing systemic reports into domestic and family violence deaths, identifying key learnings and elements of good practice in the prevention and reduction in the likelihood of domestic and family violence deaths in Queensland
- making recommendations to the Minister about improving legislation, policies, practices, services, training, resources and communication to prevent or reduce the likelihood of domestic and family violence deaths in Queensland
- monitoring the implementation of the Board's recommendations.

In its 2023–24 Annual Report, the Board identified three potential areas of focus for case reviews. When making its decision, the Board scanned existing research, work undertaken by various taskforces and recent data. The Board also considered other factors including whether the Board had reviewed a case previously. The Board, with the assistance of expert advisors, identified and reviewed cases of DFV-related homicides involving arson, alongside recent literature and cross-jurisdictional practice, to inform the development of recommendations.

This process identified 16 domestic and family violence homicide cases (involving 22 deaths) between 2010 and 2023 where there was evidence of arson. Key findings and recommendations of this review can be found in the Board's 2024–25 Annual Report on the Coroners Court of Queensland website.<sup>6</sup>

<sup>5</sup> <https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/533db62b-b2c9-43cc-a5ff-f9e1bc95c7c7/dfv-report-vol-one.pdf?ETag=c69c3ef47071a137ddbbaedb49f7fe468>

<sup>6</sup> <https://www.coronerscourt.qld.gov.au/dfvdrab/annual-reports-and-government-responses>

# Coronial Registrars

The Coronial Registrar and Deputy Registrar (the Registrars) investigate apparent natural cause deaths that are reported to police (where a cause of death certificate has not been issued) and review deaths reported directly by medical practitioners, funeral directors and families. They also provide guidance to clinicians on whether to issue a cause of death certificate.

During the reporting period, a total of 3,689 deaths were initially reported through and/or managed by the Registrars, representing 61.6% of total deaths reported statewide.

As in previous years, the Registrars continued to drive engagement with stakeholders, including Residential Aged Care Facilities, Queensland Health and Private Hospitals, in a variety of forums to improve community understanding of the coronial process to lessen non-reportable deaths entering the system. The Registrars also continued to work with QPS and FMQ to divert non-reportable deaths, resulting in a decrease from the 3,942 deaths reported in 2023–24 to Coronial Registrars.

Coronial Registrars use a multidisciplinary approach to triage deaths reported to CCQ. The registrars operate under a delegation from the State Coroner to manage these matters in a number of ways:

**Investigating apparent natural cause deaths** – those deaths that have been reported by police (via Form 1) because a death certificate has not been issued by a practitioner in the community and is unlikely to be issued. Once reported, the Registrars are supported by the work of FPACS to determine a cause of death where appropriate after postmortem investigations.

**Reviewing deaths reported directly by medical practitioners** (via Form 1A) – who are seeking authority to issue a cause of death certificate for certain apparent reportable deaths, violent or otherwise unnatural (mechanical fall related), health care related or deaths in care. The Form 1A was updated this year, providing clearer guidance to practitioners about the Form 1A process, more efficiently capturing the details of the health care provided to the deceased and allowing for improved communication of family views.

**Reviewing deaths notified by families, funeral directors, disability service providers, and other entities including the Office of the Health Ombudsman, the National Disability Insurance Scheme Quality and Safeguards Commission and the QAS** to determine whether they are reportable deaths requiring coronial investigation. The Registrars also consider the individual concerns of families and other entities raised on matters reported via the F1A or F1 pathway. Registrar communication with families about their concerns as they relate to the coronial process is a significant part of the role as well as identifying for families the other regulatory bodies that would be better placed to consider those concerns. The Registrars' prompt investigation of funeral director reports allows for funeral plans to continue without disruption for families.

**Providing telephone advice to clinicians** – those seeking advice about the reportability of the death before they issue a cause of death certificate. This service is available during business hours and provides an opportunity to filter out non-reportable deaths and to triage the reportable deaths where a cause of death certificate may be authorised under section 12(2)(b) of the Act. This function was enhanced by updates to Births Deaths and Marriages online death certificate registration portal, allowing practitioners to lodge death certificates which have been authorised over the phone by the Registrars more quickly and with less administrative burden. The phone service and registrar triage pathway also allows for early notification of reportable matters and the opportunity to give directions to ensure investigations proceed efficiently. Registrar advice additionally gives reassurance to practitioners across the state that they are meeting their reporting requirements and an opportunity for education from Registrars about reportability of matters.

# Forensic pathology

Autopsy examinations can be a vital component in coronial investigations, yet their invasiveness, cost, and potential emotional impact on grieving families are major considerations. In line with the *State Coroner’s Guidelines 2013*, coroners are encouraged to prioritise the least invasive postmortem examination necessary to inform their investigation.

Autopsies are performed by forensic pathologists employed by Forensic Pathology and Coronial Services (FPaCS). A key priority for CCQ in collaboration with FPaCS is ensuring sustainable forensic pathology services. A triaging process and the introduction of preliminary medical examinations and investigations are intended to avoid the need for unnecessary autopsies.

A preliminary investigation can inform the pathologist or other doctor’s opinion as to probable cause of death. It may also include a preliminary examination process, which usually includes visual examination and

postmortem imaging of the body, taking and testing blood and other samples and collating information about the person’s medical history.

The number of full and partial internal autopsies continues to decline from previous years, while the number of examinations ordered overall significantly increased. Of the 3,066 examination orders made, just over 70% were for non-invasive orders, consistent with the purpose of the amendments to the Act in 2020 to provide coroners with discretion to order less invasive postmortem examinations.

**Table 7:** Orders for examinations issued for reportable deaths

Financial year	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Deaths reported	5,812	5,797	5,631	5,714	6,044	6,530	6,071	5,990
Examinations ordered	2,629	2,476	2,353	2,095	1,524	1,380	1,969	3,066
Percentage	45.23%	42.71%	41.78%	36.66%	25.22%	21.13%	32.43%	51.19%

**Table 8:** Number and type of examinations ordered for reportable deaths

Type of order	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	2023-24	2024-25
Full internal	1,032	765	800	520	551	571	537	424
Partial internal	630	614	498	762	677	638	584	392
External	967	1,049	1,008	319	296	171	128	95
Prelim examination	N/A	N/A	N/A	N/A	N/A	N/A	445	1,441
Prelim investigation	N/A	N/A	N/A	N/A	N/A	N/A	275	714

# Access to coronial information

The Act limits access to coronial investigation documents due to the highly sensitive and personal nature of the content. A coroner may only consent to release of records if they are satisfied the conditions of the Act are met. Consideration must be given to whether the applicant has sufficient interest in a document as well as the extent to which the document contains information that cannot be released, the conditions under which access may be given and whether release of the information is in the public interest.

## Finalised information requests

Applications for access to records for non-research purposes require coronial consideration of factors including the privacy of the deceased and their family members, the openness and transparency of coronial processes, and the potential benefits to public health and safety. Applicants deemed to have sufficient interest may include the deceased's immediate family, a legal representative, health practitioner or insurer, as well as public agencies or regulatory entities. Priority is given to applications submitted by family members as timely access to coronial records can support the bereaved and assist in progression of other legal or financial processes. Information requests and related queries are processed by CCQ's Information Release Team.

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**890** Individual requests for documents and queries were received by CCQ during 2024–25.

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## Genuine researchers

The coronial system is an important source of information for researchers and, in turn, academic analyses can be invaluable in assisting the jurisdiction's work in preventing future deaths. Scholarly investigation of reportable deaths is important to improving public health and safety as research outcomes inform a broad array of issues. Completed research projects may inform publication of scientific articles in Australian and international journals,

as well as provide outcomes of interest to multiple agencies and jurisdictions including emergency health care professionals, police, public health groups, drugs/therapeutic goods administration, legislators, clinicians, mental health support services and the domestic and family violence prevention sectors.

Generally, researchers may only access coronial documents once the investigation is finalised. The State Coroner may give access to documents on open files if the State Coroner considers it appropriate having regard to the importance of the research and the public interest in allowing access before the investigation has finished.

Access to coronial records for research purposes requires the State Coroner to be satisfied the applicant is a genuine researcher and the information sought is reasonably necessary for the research. Assessment includes consideration of the applicant's qualifications, standing and reputation in the research community, whether the applicant has obtained relevant ethical approvals, the purpose of the research and how its outcomes are intended to be published and used. A wide range of individuals and organisations have been recognised as genuine researchers for the purpose of undertaking diverse research activities into areas including suicide prevention, road safety, fire fatalities, drowning deaths, scuba diving deaths, SIDS, building standards and the efficacy of the coronial system.

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**4** research projects approved.

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The Act requires the names of persons given access to documents as genuine researchers to be noted in the annual report. The following genuine researchers were approved during the reporting period:

## University of Melbourne Faculty of Law

Lauren Bellamy

### Examination of the utilisation/investigation of family law system engagement as a reviewed intervention point within Australian state-level domestic violence fatality review mechanisms

A doctoral thesis research project seeking to understand the extent to which Australian state-level domestic violence fatality reviews (DVFRs) identify, analyse, and provide recommendations to the federal family law system (FLS). The research aims include to:

- Contribute to a greater understanding of the connection between FLS engagement and domestic and family violence (DFV) fatalities, and its importance as a potential intervention point to be considered in domestic violence fatality review (DVFR) processes
- Illuminate potential options for reform and add to knowledge about working across the federal-state divide
- Build on the overarching aims of Australian DVFRs informed by past tragedies to contribute to the enhancement of intervention and prevention measures for fatal and non-fatal DFV
- Result in benefits for DFV victim-survivors engaged with the FLS by aiming to identify potential law and policy reforms that enhance system accountability, contribute to risk assessment development, and foster a safer environment.

## Queensland Public Health and Scientific Services

Dr Rexson Tse

### Comparing ventricular wall thicknesses measured at postmortem examination to histology slide: A method validation study for quality improvement in peer reviewing postmortem reports

Cardiac hypertrophy is a disease associated with sudden death due to physiological or pathophysiological events which cause thickening of heart muscle to a degree that impedes effective ventricular contractions. The resulting chronic and increased cardiac stress represents a greater risk of fatal cardiac arrhythmia, infarction, congestive heart failure and stroke. Macroscopic diagnosis postmortem is based on morphological features of increased size, weight and heart wall thickness. Microscopic diagnosis requires histological examination of heart wall thickness. In cases where diagnostic features have implications to the cause of death, a common terminology and methodology are required for reviewable parameters for age, gender, and body weight and height.

The proposed research project aims to provide a method development study to validate the use of histology slide analysis to measure ventricular wall thickness postmortem. Comparison of ventricular wall measurements made during autopsy with measurements obtained from analysis of histology slides is expected to validate the methodology and improve the reviewability of postmortem findings during peer review and consequently the overall quality of postmortem reports.

## Queensland Public Health and Scientific Services

Dr Marna du Plessis, Dr Bianca Phillips,  
Dr Jessica Vidler and Dr Sanmarie Schlebusch

### Postmortem diagnosis of sepsis: a review of cases at a medico-legal facility in Australia

Sepsis/sepsis-3 (septic shock) is a leading cause of mortality and morbidity globally. Clinical diagnosis of sepsis ante-mortem may be assessed using a broad range of overt parameters and criteria to effectively recognise and respond to infection and significantly improve patient outcomes. As these parameters are unable to be used postmortem and there are currently no practical protocols to guide forensic pathologists in diagnosing sepsis, postmortem diagnosis remains challenging and the true incidence of sepsis-related mortality is likely to remain underreported in the absence of guidelines to assist in the postmortem diagnosis.

The research project intends to examine Queensland coronial cases where the cause of death was determined as sepsis or infection to evaluate criteria which may aid forensic pathologists in making a sepsis diagnosis in a postmortem setting. Compilation of the criteria and development of guidelines is intended to provide a diagnostic tool that may assist in postmortem sepsis diagnosis, increase the clinical understanding of sepsis pathobiology, and improve the accuracy of reported sepsis-related mortality rates.

The outcomes of this study are intended to inform development of a diagnostic tool that will prospectively be examined to determine its usefulness, validity, and reliability in postmortem sepsis diagnosis.

## Queensland Public Health and Scientific Services

Dr Marna du Plessis, Craig Hacking,  
Trevor Watkins and Michelle Craigie

### Prevalence and associated findings of pneumomediastinum and cervicofacial subcutaneous emphysema on postmortem computed tomography in cases of external pressure to the neck

Pneumomediastinum (air in the chest cavity containing the heart, major blood vessels, trachea, and oesophagus) and cervicofacial subcutaneous emphysema (accumulation of air in the subcutaneous tissues of the neck and face) can occur due to increased pressure within the lungs causing air to leak into surrounding tissues. In deaths caused by suspected hanging or strangulation, these features can indicate a person was alive at the time of the injury and assist forensic examiners in determining the cause, manner, and mechanism of death.

The research project intends to examine postmortem CT scans relating to Queensland coronial cases admitted to the medicolegal laboratory based in Coopers Plains, Brisbane, to investigate the prevalence of pneumomediastinum and cervicofacial subcutaneous emphysema. Findings are anticipated to guide autopsy practice to assist forensic determination of the cause of death in cases of suspected strangulation or hanging where full/invasive autopsy examinations are not performed.

The research is also expected to contribute to knowledge advancement by building on previous studies to assist forensic specialists distinguish artefact from pathology and provide the basis for future research and development of platforms to guide teaching and training and inform policies and procedures.

Research outcomes are anticipated to contribute to the advancement of knowledge by filling gaps and building on previous studies; findings can be the basis of future research and development platforms; inform policies and procedures; guide teaching and training; assist the forensic community and coroners on cause, manner, and mechanism of death; help to distinguish artefact from pathology; guide autopsy practice and preparation for cases; provide information in cases where full/invasive autopsy examinations are not performed; and provide long-term benefits to the Queensland and wider health care community.

# Funeral assistance

The Department of Justice (DOJ) can arrange for a simple burial or cremation service, to afford dignity to a person who has passed away in Queensland in circumstances where relatives or friends are unable or unwilling to meet the costs of a funeral, or where the deceased person's assets cannot cover the costs.

## Funeral Assistance Scheme applications 2024–25

**390**

Applications  
approved

**\$1,570,918**

Statewide  
expenditure

**\$331,139**

Expenditure  
recovered

**21.08%**

Expenditure  
recovered

In 2024–25, CCQ continued to administer the Funeral Assistance Scheme (the Scheme) on behalf of DoJ. The Scheme is governed by the *Burials Assistance Act 1965* (the Act) and is known as 'Funeral Assistance'.

Funeral Assistance is not a monetary grant and eligibility is based on a set list of criteria which must be met by applicants. Applications can be made by either individuals (family members or friends) or agencies (such as police officers or social workers where there are no known or willing next of kin) and are submitted in person at courthouses across Queensland (including Regional Services Outlets). When an application is approved, a simple funeral (burial or cremation) is conducted by the Government Contracted Undertaker in the Local Government Area boundary where the person died, and according to the deceased person's wishes (if known).

CCQ is also responsible for the administration of the budget, cost recovery activities, policy, procedure, strategic oversight, management, reporting and dealing with appeals. Funeral costs may be recovered subject to conditions of section 4A of the Act. This can include recovery of monies from the deceased's bank account, money held by the Queensland Public Trustee (QPT), QPS, Queensland Health, and other agencies as appropriate.

Under the Scheme, a return to Country transfer for any Aboriginal and Torres Strait Islander persons who have passed away outside of Community can be authorised, to enable them to be returned to their

homelands within Queensland. The cost of this transfer is usually required to be covered by the individual applicant. In some circumstances, individual applicants may apply for special consideration for a return to Country transfer under the Scheme if they cannot cover the cost of the transfer themselves. This special consideration is subject to delegate approval and may involve a substantially longer application processing time. If approved, the return to Country transfer will be undertaken by an appropriate Supplier as determined and contracted by DoJ and will not be paid as a monetary grant to the applicant, or as a reimbursement of any transfer costs incurred by the applicant outside of the approved arrangement.

In 2024–25, 390 applications were approved at a cost of \$1,570,918. This was a 2.90% increase on approved applications in 2023–24 which were 379 applications costing \$1,249,375. Cost recovery activities increased in 2024–25 with \$331,139 recovered, an 86% increase compared to the amount of \$178,027 recovered in 2023–24.

Revenue reported as cost recovery under the Scheme each year may include funds recovered against applications approved in previous financial years, as applicants may discover funds at a later date, or the QPT may administer a deceased's estate that the Scheme has registered an interest in.

The net cost of \$1,239,779 for 2024–25 comprises total expenditure outlaid less the total costs recovered under the Scheme.

# Government contracted undertakers

DoJ engages government contracted undertakers (GCUs) to undertake the provision of coronial services in Queensland. The current service combines the conveyance of deceased persons under the Act and the burial or cremation of deceased persons under the *Burials Assistance Act 1965*. CCQ administers the contracts on behalf of DoJ.

## GCU conveyancing 2024–25

**5,664**

Conveyances  
by GCUs

**\$5,276,615**

statewide expenditure  
on conveyances

The State Coroner is responsible for ensuring that all reportable deaths are investigated. When a death is reported to the coroner, the deceased person must be conveyed by the GCU, at the direction of a QPS officer or a coroner, from the place of death to a facility such as the local hospital mortuary for a coronial investigation. Depending upon the nature of the death and the local health resources available, the deceased person may be transported to another hospital or health facility for an examination, pathology test, or autopsy to be conducted.

GCUs are funeral directors officially engaged by DoJ under a contractual agreement called the Standing Offer Arrangement (SOA). In accordance with the SOA, the GCU must provide delivery of the following legislated services to our communities:

- Conveyancing Services of the deceased persons for all reportable deaths that occur in Queensland under the *Coroners Act 2003*, the deceased person must be transferred by the GCU from the place of death to an authorised facility
- Burial and Cremation Services approved under the Funeral Assistance Scheme in accordance with the *Burials Assistance Act 1965*.

GCUs are also responsible for conducting simple funeral services where an application has been approved under the Funeral Assistance Scheme.

25 GCU contracts are active across 77 Local Government Area boundary. CCQ has an Assurance Program as part of its performance management. This program includes site visits, which is essential for building strong relationships with suppliers.

The total number of claims accepted for conveyance of deceased persons in Queensland in 2024–25 was 5,664 at a total expenditure of \$5,276,615.

# Appendices

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**APPENDIX ONE**

# Reportable death types

## Unknown identity

The death of a person with unknown identity (even if nothing is suspicious about the death) must be reported to a coroner.

## Suspicious circumstances

Are generally where homicide is suspected or it's unclear whether another person has been involved. A coroner also has jurisdiction to investigate the suspected death of a 'missing person'. Suspected deaths are reported when there is reason to suspect the person is dead.

## Violent or unnatural

Those caused by accident, suicide or homicide rather than a disease's natural progression i.e. car accidents, falls, drowning, drug overdoses, and industrial and domestic accidents. These deaths are reportable even if a delay occurs between the incident causing injury and the death, as long as the injury caused or contributed to the death and the person would not have died without the injury.

## Death in custody

If the person died while in custody, escaping from custody or trying to avoid being put into custody. 'Custody' is defined broadly to capture detention under any state or federal legislation (with some limited exceptions) whether or not by police.

## Death as a result of a police operation

Include those such as the death of an innocent bystander while police are attempting to detain a suspect or someone who dies by suicide while police are present.

## Death in care

Deaths of certain vulnerable people in the community (namely children under guardianship or in care, involuntary mental health patients, and people with disabilities with high support needs who lived in funded supported accommodation arrangements or receiving a relevant class of NDIS supports) are reportable deaths, whatever the cause of death may be or where it occurred.

## Cause of death certificate is unlikely to be issued

Medical practitioners must issue a cause of death certificate if they can form an opinion as to the probable cause of death. If they cannot, they must report the death so the medical cause of death can be established.

## Health care related

Broadly, this refers to a health procedure (i.e. dental, medical, surgical, diagnostic, or health-related such as anaesthetic or drug), or any care, treatment, advice, provided for the benefit of human health. These deaths include those due to a failure to treat or diagnose, and clinical or medication incidents and errors. A death is health care related if both: health care, or failure to provide health care, caused or contributed to the death; and/or before the health care was provided, an independent person (qualified in health care) would not have expected the health care to cause or contribute to the death, or for the death to occur at that time.

## APPENDIX TWO

Inquests finalised during  
2024-25 reporting period

Deceased name	Coroner	Inquest category	Recommendations made	Keywords
<u><a href="#">Ivona Jovanovic</a></u>	<i>Coroner Mackenzie</i>	Public interest	Nil	Gunshot wound to chest, suspicious circumstances, conflicting witness accounts, inadmissible evidence at criminal trial, discontinued prosecution
<u><a href="#">Christopher Glen Essery</a></u>	<i>Deputy State Coroner Gallagher</i>	Public interest	1 recommendation	Health care related death, inflammatory bowel disease, optimisation for surgery, surgery
<u><a href="#">Anthony Michael Charlwood and Krystal Renee Evans</a></u>	<i>State Coroner Ryan</i>	Mandatory	Nil	Deaths in custody and in the course of police operations, motorcycle crash, attempted interception, pursuit policy
<u><a href="#">Trevor Charles Stone</a></u>	<i>State Coroner Ryan</i>	Mandatory	Nil	Natural causes, death in custody
<u><a href="#">Raghe Mohamed Abdi, Zoe Dorethea Antill &amp; Maurice Fredrick Antill</a></u>	<i>Deputy State Coroner Gallagher</i>	Mandatory	Nil	Stabbing, killing and death in police operations
<u><a href="#">Jamie Brian Campbell</a></u>	<i>State Coroner Ryan</i>	Mandatory	Nil	Police restraint, ambulance, amphetamine use, administration of sedative during restraint, droperidol, monitoring post sedation, hypoxic ischaemic encephalopathy, cardiac arrest, sympathomimetic toxicity, veteran

Deceased name	Coroner	Inquest category	Recommendations made	Keywords
<u>Mohamad Ikraam Bahram (Ikraam)</u>	State Coroner Ryan	Mandatory	Nil	Mental health, schizophrenia, treatment authority, community category, capacity to consent, no less restrictive way, advance health directive, family engagement, risk assessment, police shooting, active armed offender
<u>Shane Anthony May</u>	State Coroner Ryan	Mandatory	Nil	Natural causes, death in custody, multiorgan failure, metastatic lung cancer, palliative care
<u>Robert George Kenneth Malayta</u>	State Coroner Ryan	Mandatory	Nil	First Nations man, death in custody and in police operations, stolen vehicle, tyre deflation device, drowning, police search
<u>Audrey Yvette Carrick</u>	Coroner Lee	Public interest	Nil	Health Care, Management of Chronic Cardiac Condition in context of Advanced Age and Comorbidities, Interventional Cardiology: Transcatheter Aortic Valve Replacement, Pacemaker, Expert Opinion
<u>Ashley Charles Washington</u>	State Coroner Ryan	Mandatory	Nil	Death in custody, First Nations man, Taser, police dog, police restraint, administration of sedative, ambulance response, failure to recognise rapid deterioration
<u>Damon Paul William Savage</u>	State Coroner Ryan	Mandatory	Nil	Death in custody, police shooting, mental health, substance use, domestic violence

Deceased name	Coroner	Inquest category	Recommendations made	Keywords
<u>Maxilian Patrick McDowall (Max)</u>	<i>Coroner MacKenzie</i>	Mandatory – State Coroner directive	4 recommendations	Cyclist deceased in road traffic crash with Brisbane City Council bus, simultaneous traffic light access to both cyclist and bus, Brisbane City Council Bus driver blind spots, failure of bus driver to observe cyclist, failure of cyclist to appreciate danger, improvements to traffic light signalling and bus driver awareness systems
<u>John Raymond Ainsworth</u>	<i>State Coroner Ryan</i>	Mandatory	Nil	Natural causes, death in custody
<u>Jeremiah (Jayo) Rivers</u>	<i>Coroner MacKenzie</i>	Public interest	5 recommendations	Missing Person, Deceased disappeared in unclear circumstances from a group of fellow pig hunters in far south-eastern corner of Queensland, lies to police, evidence of drug trafficking and COVID-19 breaches, potentially suspicious death and criticism of QPS search and rescue operations and investigations
<u>Luke Brian Gilbert</u>	<i>Deputy State Coroner Gallagher</i>	Mandatory	2 recommendations	Death in police operations, police shooting, safe night precinct, category M weapon, knife, antisocial personality disorder, alcohol use disorder, major depressive disorder, mental health, victim precipitated homicide, subject precipitated homicide, Jack's Law

Deceased name	Coroner	Inquest category	Recommendations made	Keywords
<u>Chloe Jane Campbell</u>	<i>Coroner Lee</i>	Mandatory	Nil	Death in care, involuntary treatment, mental illness, management of environmental hazards, ligature risk, compliance with statewide and local guidelines and procedures
<u>ABC (a pseudonym)</u>	<i>Coroner O'Connell</i>	Public interest	2 recommendations	VAD substance supplied to a self-administration VAD patient but unused and not returned nor disposed of, use by a non-VAD patient, a better system of protecting self-administration VAD substances against misuse by non-VAD patients
<u>Charmaine, Aaleyn, Matilda, Wyatt and Zaidok McLeod</u>	<i>Coroner O'Callaghan</i>	Public interest	2 recommendations	Mental Health Services, Department Child Safety, Seniors, Disability Support, domestic and family violence, QPS, Family Court, suicide, filicide
<u>Markiah Eric Allenby Major</u>	<i>Coroner Williams</i>	Public interest	Nil	Missing person, suspected passing, suspected death, First Nations young person, police investigation, vulnerable witness Roger Ward (A Pseudonym) v The Queen [2017] VSCA 37

## APPENDIX THREE

# Presentations by Coroners, Coronial Registrars and Counsel Assisting

Education sessions over the year were provided for key stakeholders for better communication between CCQ, our stakeholders and, in turn, families and friends interacting with the coronial system. The Coronial Registrars continued their regular clinical education forums to a variety of stakeholders.

Presenter	Presentation topic	Date	Stakeholder
Coroner MacKenzie	Road Deaths	June 2025	QPS Forensic Crash Unit
Deputy State Coroner Gallagher and Julie Pietzner-Hagan	The role of the Coroner and Counsel Assisting and importance of Coronial Recommendations to systems of Mental Health and Law Enforcement	June 2025	Mental Health Integrated Care
State Coroner Ryan	The role of the State Coroner in response to deaths of service members and strategic responses	June 2025	QPS / AIPM Strategic Command Program
Deputy State Coroner Gallagher	Keynote presentation – documentation nursing and midwifery staff are required to complete when a patient death occurs	May 2025	Queensland Nurses and Midwives' Union – QNMU Professional Development Day
Deputy State Coroner Gallagher	Coronial Matters	May 2025	Australian Funeral Directors Association
Coroner Bain	Case Review of South Australian Coronial Matter	May 2025	Olser (Accredited Australian Medical Council and Medical Board of Australia provider of CPD Home services to Australian Registered Doctors)
Coroner Williams	Medicolegal Quandaries	May 2025	Australia and New Zealand College of Anaesthetists Annual Scientific Meeting Conference

Presenter	Presentation topic	Date	Stakeholder
Coroner Zerner and Registrar Lambert	Education and Information session	May 2025	Office of the Health Ombudsman
Registrar Lambert	Clinical Safety CNC Study Day	April 2025	Children's Advice and Transport Coordination Hub (CATCH), Queensland Children's Health
CA Julie Pietzner-Hagan	Pre-Service Watchhouse Officer Training	April 2025	QPS
Coroner Zerner	Coroner's Insights for Best Practices and Documentation Aged Care	April 2025	Queensland Nurses and Midwives Union
Registrars Lambert and Hendy	Role of the coroner and the importance of documentation in the Aged Care Industry.	March 2025	Palm Lake Care Residential Aged Care Facility
CA Julie Pietzner-Hagan	Watchhouse Officer Training	March 2025	QPS
Deputy State Coroner Gallagher	Coronial Matters	February 2025	Metro South Hospital and Health Service, Queensland Health
Deputy State Coroner Gallagher and Coroner Bain	Coronial Matters	February 2025	Gold Coast Hospital and Health Service
Coroner Williams	Overview of the coronial system	February 2025	Australian True Crime Podcast
Coroner Fairweather and External Stakeholders	Human Rights and Coroners	February 2025	Human Rights Law Association
Coroner Fairweather	Coronial management	December 2024	Queensland Health, Patient Safety and Quality Podcast

Presenter	Presentation topic	Date	Stakeholder
State Coroner Ryan, Coroner Zerner, Julie Pietzner-Hagan, Emily Cooper (External) and Jess Rosengren (External)	WLAQ Seminar Series: Coroners Court Proceedings in Qld – Part 1	December 2024	Women Lawyers Association Queensland
Coroner Zerner	Overview of the coronial system	November 2024	Queensland Health – Annual Health Lawyers Conference
Coroner Fairweather	A day in the life of an oncall Coroner	November 2024	Northern Rivers Physicians
State Coroner and Acting Inspector Gary Worrell, Water Police (External)	Coronial System and Water Police overview	November 2024	Shorncliffe Volunteer Marine Rescue Brisbane
Coroner Williams	Overview of the coronial system	October 2024	Far North Queensland Lady Doctors Association
Registrar Lambert	CCQ & Coronial Processes	October 2024	Central Queensland Hospital and Health Service Quality & Safety Unit
Registrar Lambert and Dr Rebecca Williams (External)	Intern Training	October 2024	Townsville University Hospital
Deputy State Coroner Gallagher	Coronial Procedures and Reports	October 2024	Index Medicolegal
Coroner Lee	Role of the coroner in health care related deaths	August 2024	Medico-Legal Society of Queensland
Deputy State Coroner Gallagher	The State Coroner and Deputy State Coroners' responsibilities in relation to deaths in custody	August 2024	QPS Custodial Conference

## APPENDIX FOUR

# Presentations by the Domestic and Family Violence Death Review Unit

In addition to monitoring the implementation of the recommendations and producing an Annual Report, the Board, via the Domestic and Family Violence Death Review Unit, responds to requests from across the sector to deliver presentations to discuss the role and work of the Board in more detail.

The DFVDRU delivered six presentations, or participated in information sharing sessions, in 2024–25 including with:

- Brisbane Domestic and Family Violence High-Risk Team
- Sexual Violence Review Board, Office of the Victims' Commissioner
- QPS, Domestic and Family Violence & Vulnerable Persons Command Conference
- Coroners Quarterly Conference, Coroners Court Queensland
- Australian Domestic and Family Violence Death Review Network workshop with ANROWS
- Sexual Violence Systems Response Committee (SRC) led by the DFSV Prevention and Integration Team at the Department of Families, Seniors, Disability Services and Child Safety.

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**CORONERS COURT**  
OF QUEENSLAND

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**QUEENSLAND  
COURTS**