From: douglas sheridan
To: justiceinquiry
Subject: Re: (4) Re: Coroner J.Olle.
Date: Wednesday, 8 September 2021 4:59:17 PM

From: douglas sheridan [redacted]
Sent: Saturday, 17 July 2021 12:14 PM
To [redacted]
Subject: (4) Re: Coroner J.Olle.

From: douglas sheridan [redacted]
Sent: Wednesday, 2 June 2021 1:49 PM
To [redacted]
Subject: Re: Coroner J.Olle.

RE;CORONER. J.OLLE.
Our list of concerns .

(0).How could coroner J.OLLE morally and LEGALLY close his findings on an (((UNASCERTAINED & APPEARS)))) to had died from????.Without a proper police and HMIT investigation as told to us in writing it was happening which never did, how is it LEGAL to shut up shop.

(1).The coroner J.OLLIE told the Attorney General he never received our emails of information over a 2yr period, & then after reading them, he saw no reason for further action. When we have proof receipts to the contrary

(2).Well which coroner said OK, for ambulance statements should be taken 20mths later just prior to inquest. After reading OUR EMAILS of such request.

(3).Did the coroner take time to read the ambulance statement ,if so he would have noticed the copious amounts of FLUIDS blocking her airways making it impossible to do their other procedure's.

(4).Why was there only one ambulance officers statement taken & not 2 who were present. plus extra 2 mica officers.

(5).Why were there no ambulance statement ever mentioned & no appearance of such at the inquest.

(6).Why did the coroner accept so many answers, with I can't remember from husband [redacted].

(7).Why when blood tests obtained & failed & new tests disappeared just before death, did

coroner J.OLLIE make a feeble attempt by phone 22mths later at the inquest & not prior to inquest which suggests there was no HMIT or police investigation, Due to time lapse unable to find to no avail & too late, after being made aware of such within 8days of such death by email.

(8).Why initially at inquest did the coroner indicate pulmonary odemia then change to heart arithmea. Most trauma & accident victims suffer this demise, to easy.

(9).Why when lungs were twice their weight were no fluid samples kept. Coroner wrote back, **because it was a home death.**??

(10).Why didn't the coroner raise concerns with the flattening of the GYRI, and excess fluids in the lungs & AIRWAYS. **because it was a home death and there were no antemortem lab tests taken**. ??

(11).Why is the coroner report lacking in detail manipulating & favouritism.

(12).a list of 30 queries of concern's were handed to the inquest assistant Sgt [redacted] plus others before the beginning of inquest to be given to the coroner before he made his findings, plus also concerns sent via email to the coroner the following day. To which the coroner claims he never read any emails from us.

(13).Why in J.OLLIE' findings did he try to make light of a supposed conversation between [redacted] & [redacted] causing **fraction's** between them, when the truth is HE stuck an **insurance policy** in [redacted] hand & was worried about [redacted] **super funds** not being in his name. While [redacted] daughter was dead in the front room,(there was no conversation).
(13A) WHY didn't coroner J.OLLE ASK POLICE TO INVESTIGATE moneys as a MOTIVE.

(14).The transcript of the inquest are incoherent dribble, unbelievable, and seems to be missing some important information in sections.

(15).Why was there such a turnover of coroner staff on this case .It seems there was no less than 6 handlers overall we had communicated with, **keeping it unfamiliar to any one person**. (not a good look)

(16).There were [redacted] case findings for 16th nov [redacted] with 6 findings published to the public. But this case was not opened up for publishment for 11mths,and then only after inquiry from attorney general.?Ect from us.

(17).Why the body release of an unascertained death without just cause so soon.?

(18).Why the failings of autopsy staff missing personal items.?

(19).Were blood hair & other samples kept for further investigation.???

(20).What investigations were done by HMIT & POLICE when they could not even produce blood tests or phone call information,or consult any of the Ambulance officers .
Someone please ask them for a copy of investigations if they have one.

(21). Why were we officially notified of investigations taking place.?. Somebody initially showed a lot of concern. We were indicated to by local police to be expecting a knock on our door. **well that never happened**

(22). Why was there a need for an investigation by (HMIT) & police((yet no follow up)).Somebody initially showed a lot of concern. Did coroner J.OLLE TAKE OVER

(23). YOU & WE need to know who must have called off the (HMIT) & police inquiry's as you may have internal problems that need looking into.

(24). You may ask Dr Burke if [redacted] with her lungs & airways full of water if she DROWNED FIRST before her heart arrhythmia.?.

(25). Why was there no explanation of toxicoligy readings or interpretations outlined in Dr Burke' submissions & no mention of hyponatremia.

(26). With a normal SODIUM count being between 135-145 ,and with a reading inballance of 125 can be lethal.DR Burke makes no mention of [redacted] count of (((112))) leading to hyponatremia then leading to heart arrhythmia. Plus LUNGS FULL OF WATER.

(27). The other toxicoligy counts don't add up either.All due to excess water.

(28). Still of interest is [redacted] father [redacted], having a common interest in the same area of horse racing as a stable manager, and J.OLLE owning race horses at his relatives in same area, just hoping there is no acquaintance issues involved, perhaps working in same stable.

(28)A. Also upon introduction of [redacted] to coroner J.OLLE at the inquest Mr [redacted] stood up & stepped out into the aisle doing a 360 turning his back on the judge J.OLLE showing off his purple track suit emblazoned with the storm emblem on his back. Indicating they knew each other.
(28)B. Also [redacted] lawyer brother now barrister arriving from NZ within 10hrs at [redacted] and computers missing within a week, was of concern to us.

(29)Why didn't coroner J. Olle pick up on a DR statement of bruising on her legs or mention or show concern of at inquest.

(30)2yrs without an investigation, as if there was why weren't we queried or questioned.(WHY).

(31)Did the coroner J.Olle ever check Insurance claims. superannuation & bank accounts plus home & assets.?????? **MOTIVE. over est $1m**

(32)Did the coroner know phone call information is hard to track down after 2yrs.

(33)Why did DR Burke make no mention or consult any of the Ambulance officers concerns of flooded airways & excess fluid to collaborate his findings of **flooded lungs** & flattening of the GYRI.Or the TOXICOLOGY information in his summary.

(34)If the coroner J.Olle. & the DR took into account they found NO PROBLEM with stomach or

But they had no BODY or samples for

bowel, then what was causing the pain & suffering.
further testing. Unascertained death and released for cremation within 4days (not lawfull).

(35).Since autopsy showed no signs of stomach or bowel problems, you have to wonder what was causing [redacted] problems, and twice she told us of being terribly sick, once after [redacted] had prepared a meal, and another after going to his parents for dinner. Was [redacted] aware that they may find nothing in the colonoscopy and they may start asking what's going on here with her problems . Now do feel that these are query's that the coroner judge J.Olle should have shown diligence with.

(36).Did see pics on facebook of [redacted] and a young girl pose at a work function 2 weeks prior to [redacted] passing to whom he has gone on to marry and taken on a world tour with. If this case was still open, these are scenario's that the coroner could still be checking on.

(37).When we were notified of CORONER judge J.Olle' final decision and we were in touch with Judge I.Gray that we were not happy about HE'S outcome, we were informed that if you want to pursue this further we had to take it up with the Supreme Court, and at NO stage we were informed of our right of APPEAL within the coroners court, till we came across this information in depths of their website, and only then did we approach for such and was dually KNOCKED BACK with no reason and you will find they had received most of the information within.

(38).(extract copied from ambulance statement)
On closer examination I noticed she presented with anginal respirations and her airway was completely obstructed with copious amounts of white fluid.
I positioned myself at the head of the patient and attempted to clear the patients airway with suction and insert a oropharyngeal airway into the patients upper airway. Each time I attempted to manually ventilate the patient with oxygen 100% via a closed circuit oxy saver the patients upper airway would block again with white fluid. Each time I would attempt to clear it again.
Coroner J.OLLE. SUGGESTED AN OVER consumption OF WATER may have had side effects (TO FILL YOUR LUNG WITH WATER)?????

(((Drowning - kills by asphyxia, as the lungs fill with liquid. Post-mortem signs: •Fine white foam at nostrils and mouth)))

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Water inhalation[edit source | editbeta]

If water enters the airways of a conscious victim, the victim will try to cough up the water or swallow it, thus inhaling more water involuntarily. Upon water entering the airways, both conscious and unconscious victims experience laryngospasm, that is the larynx or the vocal cords in the throat constrict and seal the air tube. This prevents water from entering the lungs. Because of this laryngospasm, water enters the stomach in the initial phase of drowning and very little water enters the lungs. Unfortunately, this can interfere with air entering the lungs, too. In most victims, the laryngospasm relaxes some time after unconsciousness and water can enter the lungs causing a "wet drowning". However, about 7–10% of victims maintain this seal until cardiac arrest.[14]This was called "dry drowning", as no water enters the lungs. In forensic pathology, water in the lungs indicates that the victim was still alive at the point of submersion. Absence of water in the lungs may be either a dry drowning or indicates a death before submersion.[15] (HER LUNGS WERE FULL)

(39). We saw [redacted] 2 page statement at [redacted] police station, but the copy we received ended up as 5 pages and a lot of info seems to be married up with ours. **Who's office may have done this.**

(40). It seems Dr Gray. J.OLLE.POLICE.OR HMIT did not confer with ambulance staff or witness's at all.

(41). Coroner J.Olle asked [redacted] where he bought the pack of water, he said officeworks. BUT NEVER ASKED HIM WHY.

(42). There was no investigation done by HMIT or POLICE as ambos were never contacted till weeks prior to inquest upon our request.

(43). [redacted] was stranded at home all the time because [redacted] made sure the baby capsule was installed in his car, hence [redacted] could not do any checking on him with the girl he went on to marry later.

(44).police taking statements stated [redacted] **left the scene** to the backyard, you will be getting a knock on the door by police soon.

(45).why are not police and other authorities included and involved with the coroners dept.Here's betting they have no knowledge or document of this case.IT WAS A CLOSED SHOP.

(46).Why did ambos find it ***necessary*** to call on the police at the scene.