QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Shaun Basil Kumeroa**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2014/3598
DELIVERED ON:	18 January 2016
DELIVERED AT:	Brisbane
HEARING DATE(s):	22 September 2015; 14 – 17 December 2015
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, avoiding being placed in custody, police shooting, siege, involvement of negotiators and SERT police

REPRESENTATION:

Counsel Assisting:	Mr Stephen Keim SC and Miss Emily Cooper
Queensland Police Commissioner:	Mr David Kent QC and Mr Michael Nicolson (Public Safety Business Agency)
SERT officers 35, 72, 113, 131, 139:	Mr Troy Schmidt (Gilshenan & Luton)
Queensland Police Union of Employees:	Mr Calvin Gnech

Detective Senior Sergeant Lacey, Sergeant Buckley, Detective Sergeant West (police negotiators):	Mr Adrian Braithwaite (QPUE)
Channel 7 Network:	Mr Nicholas Andreatidis (Schweikert Harris)

Contents

Introduction

1. Between August 2013 and November 2014, officers from the Queensland Police Service (QPS), acting in the course of their duties, shot and killed five men in separate incidents.

2. The incidents occurred at the Sunshine Coast (2), Brisbane (2), and the Gold Coast. Three of the deaths occurred over the course of one week, from 18 November 2014 – 24 November 2014.

3. The functions of the Queensland Police Service, as set out in the *Police Service Administration Act 1990,* include:

   - the preservation of peace and good order;
   - the protection of all communities in the State;
   - the prevention of crime;
   - the detection of offenders and bringing of offenders to justice; and
   - upholding of the law generally.

4. The community has high expectations of police, particularly in times of crisis. All operational police are trained in a range of "use of force" options, including equipment such as firearms, to assist in the performance of their functions. However, the community expects that police will act lawfully and professionally in the exercise of their duties, and in accordance with operational policies and training.

5. The use of firearms by police, particularly when that use results in a death has the capacity to affect the trust and confidence that the community has in the police. A death in these circumstances raises many issues, including:

   - public scrutiny and suspicion of the circumstances of the death;
   - emotional trauma for the police officers involved;
   - emotional trauma for the family of the deceased person;
   - the degree to which the use of firearms by police is controlled by appropriate safeguards;
   - decision-making by police officers in critical incidents; including whether other use of force options could have been deployed.

6. The *Coroners Act 2003* recognises the need for public scrutiny and accountability by requiring all deaths in custody to be investigated by the State Coroner. The Act requires that an inquest be held into all such deaths.

7. These findings examine the circumstances of the death of Shaun Basil Kumeroa at Inala on 29 September 2014. His death followed a lengthy standoff with the QPS after police officers responded to an anonymous call relating to a possible drug deal taking place.

8. Findings under s 45 of the *Coroners Act 2003* in relation to this case will be made in the first phase of this inquest. In the second phase during 2016 I will hear evidence concerning what recommendations, if any, should be made to help prevent deaths occurring in similar circumstances in future.

9. The full list of issues to be considered as part of the inquest into Mr Kumeroa's death is attached to these findings. These findings do not consider all issues as some will be the subject of consideration during the second phase of this inquest. The findings:

    - confirm the identity of the deceased person, how he died, the place and medical cause of his death;
    - clarify the circumstances leading up to the deaths;
    - consider the appropriateness of the actions of attending police; and
    - consider the adequacy of the investigation into the death conducted by officers from the Queensland Police Service (QPS) Ethical Standards Command.

The Inquest

10. Shaun Kumeroa's death was reported as a death in custody under the *Coroners Act 2003*. He died while he was trying to avoid being put into custody. In those circumstances an inquest must be held.

11. An inquest was held in Brisbane over 14 – 17 December 2015. All of the statements, records of interview, photographs and materials gathered during the investigation were tendered at the inquest.

12. Senior Counsel Assisting, Mr Keim SC proposed that all evidence be tendered and that oral evidence be heard from the following witnesses:

    - Detective Sergeant Sandra Pfeffer
    - Sergeant Michael Kelly
    - Inspector Richard Kroon
    - Detective Senior Sergeant Richard Lacey
    - Sergeant Julie Buckley
    - Detective Sergeant Stephen West
    - Inspector Bradley Wright
    - SERT Operative 35
    - SERT Operative 72
    - SERT Operative 113
    - SERT Operative 131
    - SERT Operative 139
    - Janice Aldham
    - Eric Vitasz

13. I consider that the evidence tendered in addition to the oral evidence was sufficient for me to make the necessary findings under section 45 of the *Coroners Act 2003*.

The evidence

Personal circumstances

14. Mr Kumeroa was 42 years of age at the time of his death. He was born on 27 June 1972 to Geoffrey 'Bill' Kumeroa and Yvonne Trott at Patea, New Zealand. Shaun was the second of four children.

15. In 1990, Mr Kumeroa married and had two sons who would now be aged 21 and 19 years respectively. His marriage ended around 1999 and Mr Kumeroa subsequently had little contact with his sons.

16. Mr Kumeroa first came to the attention of New Zealand police aged 17 years, when he was admonished for burglary. This was followed by 18 charges in the next 8 years for various property and drug offences, including possession of cannabis. He had a long history of traffic offences in New Zealand between 1990 and 1996 which resulted in periods of detention.

17. After the breakdown of his marriage, Mr Kumeroa came to Australia. He stayed in contact with his mother, Yvonne Trott, and his siblings. Ms Trott described her son as a 'lovable rogue' who started using illicit drugs in his teen years, and struggled to overcome the addiction throughout his life.

18. He was imprisoned for four months in 2004 for breach of a suspended sentence relating to offences of unlawful and indecent assault, wilful damage and entering a dwelling and stealing. He was charged three times in 2007 in relation to the possession of methamphetamine.

19. In the lead up to his death, Mr Kumeroa had been in a relationship with Emma Lamaro since about 2009. They had a child together in June 2011. In July 2013, Mr Kumeroa was registered on the opiate treatment program. He had been a user of heroin, morphine and valium.

20. Mr Kumeroa was engaged in full time employment with Mr Eric Vitasz, a subcontractor for a construction company. Mr Kumeroa struggled with literacy and he was supported by his employer to complete courses to gain higher qualifications.

21. His relationship with Ms Lamaro ended in or around May 2014. Custody of their daughter became an issue when Ms Lamaro moved to Boonah (over 100km from Chevron Island, where Mr Kumeroa resided). The situation soured and a Domestic Violence Protection Order was made on 3 June 2014.

Medical history

22. Throughout July-August 2014, Mr Kumeroa undertook a positive parenting program with psychologist Wendy Pailthorpe. Ms Pailthorpe's records were tendered at the inquest. They confirm that Mr Kumeroa went to five sessions but did not attend the final session. Mr Kumeroa said that he was

undergoing a drug rehabilitation program, and was concerned for his daughter's welfare. He denied feeling depressed and responded well to the parenting program generally.

23. Toxicology testing revealed the presence of non-toxic levels of the anti-anxiety medications Diazepam and Nitrazepam. No alcohol or other drugs were detected. Dr Storey, the pathologist, confirmed evidence of previous drug use. Serological testing returned a positive result for Hepatitis C.

24. I have had the benefit of reviewing a report from the Director of the Clinical Forensic Medicine Unit, Dr Adam Griffin. That report provides a summary of Mr Kumeroa's complete medical history dating back to 2008. Dr Griffin also provides an explanation for the drugs detected in Mr Kumeroa's blood post-mortem. By way of summary, Dr Griffin made the following key conclusions:

- There were no records confirming any contact with psychiatrists or psychiatric institutions;
- There was never a clear diagnosis of depression;
- The principal contact with mental health professionals was through psychologists in the community by way of General Practitioner referrals;
- No mental health disorder was ever formally described, having regard to the entirety of the medical records;
- Antidepressants and sedative drugs were prescribed intermittently for management of what appeared to be a sleep disturbance. Dr Griffin noted that this may have been a feature of depression, but was not on its own sufficient to substantiate a diagnosis of depression;
- Dr Griffin could not identify any concerns in relation to the provision of health care to Mr Kumeroa;
- Overall, the records demonstrated drug seeking behaviour on multiple occasions. On the occasions that this was recognised it was managed well. The continued prescription of Nitrazepam was not the best choice for him, but Dr Griffin saw no connection between this prescribing practice, and the death;
- It would have been normal practice for Mr Kumeroa to experience withdrawal symptoms from the Suboxone anytime from 22 September 2014 to 27 September 2014;
- Access to and availability of community and health support services were known to Mr Kumeroa as he had previously used such services in the community on multiple occasions.

Events leading to the death

25. On 11 September 2014, a Family Dispute Resolution Conference was held with respect to future arrangements for the care of Mr Kumeroa's daughter. According to the evidence of both Mr Vitasz and Ms Aldham, Mr Kumeroa was not satisfied with the conference outcome. The QPS interview with Ms

Lamaro[1] confirmed that an agreement was reached at the mediation for random urine testing to screen for drugs and alcohol. Ms Lamaro had proposed that their daughter live with her and that Mr Kumeroa care for her four days a fortnight, and every third weekend.

26. Mr Kumeroa refused to agree. He wanted shared custody. The mediator informed the parties that the matter would have to be determined by the court in the absence of an agreement. In the meantime their daughter would remain in Ms Lamaro's care.

27. Ms Aldham and Mr Vitasz gave evidence confirming that Mr Kumeroa had interpreted the mediation outcome to mean he had lost the care of his daughter. This appears to have been both an unfortunate misunderstanding and an overreaction. It is clear that Mr Kumeroa was a devoted father, and there were many positive and likeable aspects of his personality. However, he appears to have been unable to cope with the prospect of a protracted legal process associated with a dispute over arrangements for the care for his daughter.

28. I accept Detective Sergeant Pfeffer's opinion that the mediation outcome and Mr Kumeroa's frustration with the outcome were precursors to the serious events that followed and, ultimately, his death.

29. On 16 September 2014, Mr Kumeroa attended Ms Lamaro's residence where he assaulted and threatened Ms Lamaro and her mother, Gail Howard, with a knife and hammer.

30. On 17 September 2014, police started an investigation into the assault. A pretext phone call was recorded between Ms Lamaro and Mr Kumeroa. He said the police were coming for him and he was not going back to jail. Mr Kumeroa said the police would eventually get him and he had a '45' on him. He 'would go down with a bang'. An arrest warrant then issued for serious assault, breach of a domestic violence order and wilful damage.

31. A further consequence of Mr Kumeroa's reaction to the perceived loss of contact with his daughter was the loss of contact with the Suboxone[2] program he was participating in. The statements of Dr Sue Ballantyne, Director, Medicines Regulation and Quality[3] and Dr Pem Ariyawansa, Gold Coast Hospital Service[4] were tendered at the inquest. The current Opioid Treatment Program Guidelines was also tendered.

32. Dr Ariyawansa stated that Mr Kumeroa received his last dose of Suboxone on 19 September 2014, three days after the assaults on Ms Lamaro and Ms Howard. Dr Ariyawansa also stated that:

[1] Exhibit E18
[2] Suboxone is a restricted drug used in the treatment of opioid dependence.
[3] The entity responsible for administering the opioid treatment program in Queensland.
[4] The doctor responsible for Mr Kumeroa's care and treatment under the program.

- A week before his death, on 22 September 2014, and having already missed 2 doses, Mr Kumeroa asked to be dosed at a Brisbane pharmacy (as opposed to his regular Gold Coast Pharmacy);
- Dr Ariyawansa could not authorise the dose at a different clinic as it was hard to determine Mr Kumeroa's suitability to safely recommence Suboxone. It was possible that he may have used other illicit/unsanctioned substances that could interact adversely with Suboxone and Dr Ariyawansa wanted to see Mr Kumeroa before authorising further doses.

33. The records of the Alcohol and Other Drugs Treatment Service confirm that the clinic tried to contact Mr Kumeroa on 24 September 2014, and left a message on his phone. He returned the call and was told he needed to attend at the clinic to receive his medication. It was noted that he became irritable and then ended the call. An appointment date and time was then sent to him via text message but he did not attend.

34. I accept that part of the difficulty in engaging with the program, as he had been doing, derived from the fact that Mr Kumeroa was aware that police officers were wanting to talk to him about the assaults on Ms Lamaro and Ms Howard. Police had attended at his home address and workplace on 17 September 2014. He appears to have been actively avoiding places he was known to frequent. Evidence to support this conclusion was given by Ms Aldham and Mr Vitasz.

35. On Friday 26 September 2014, Mr Kumeroa visited his long-term friend, Janice Aldham, at her home at Carole Park. She had not seen him for several years and said she was shocked to see him when he arrived at around 6:00pm. He stayed there until 11:00am on 28 September 2014. During the time he was there, he told Ms Aldham he was upset that he was not able to have contact with his daughter. He disclosed that he was "in a bad place" and said there was "no way out". Mr Kumeroa told Ms Aldham he wanted "sleepers" to help relax. Ms Aldham made a call to a home visiting doctor's service but Mr Kumeroa later cancelled the call out.

36. Ms Aldham knew he had a gun as he had confirmed this to her. She did not know what he intended to do with it and did not know if it was real or a replica. However, her evidence was that it was not like Mr Kumeroa to have access to a weapon.

37. On Sunday 28 September 2014, after leaving Ms Aldham's residence, Mr Kumeroa contacted his work supervisor, Eric Vitasz. Mr Vitasz's evidence was that he considered his relationship with Mr Kumeroa was a father-son relationship. Mr Vitasz had not seen Mr Kumeroa since the day after the mediation, when Mr Kumeroa received a phone call and suddenly left the workplace.

38. In a lengthy phone call on 28 September 2014, Mr Kumeroa told Mr Vitasz that he was on the run and had no petrol. He also had no money to buy

petrol. Mr Vitasz tried to convince Mr Kumeroa to return to the Gold Coast, and also offered to drive to Brisbane to collect him.

39. Mr Kumeroa told Mr Vitasz he was parked in a carport but would not provide further details. Mr Vitasz then arranged with Mr Kumeroa to transfer money into Mr Kumeroa's bank account to allow him to return to the Gold Coast, where Mr Kumeroa could get cleaned up and surrender to police, with Mr Vitasz's support. Mr Vitasz deposited the money and waited for Mr Kumeroa to execute the plan. This was to no avail and subsequent attempts by Mr Vitasz to contact Mr Kumeroa were unsuccessful.

40. Ms Aldham gave evidence that she spoke to Mr Kumeroa later in the afternoon of 28 September 2014. It was her understanding that he was going to come back to her place that night but when he did not show up she was not concerned.

41. Karleen Pirini, who lives at Camira near Goodna, confirmed that Mr Kumeroa stayed at her home at Camira on 28 September 2014. Mr Kumeroa told her he was going back to the Gold Coast. He had talked to his lawyer and his employer, who had offered him somewhere to stay.

Movements on 29 September 2014

42. Ms Pirini went out sometime between 11:00am and 12 noon on 29 September 2014. Mr Kumeroa was in his room folding clothes. Ms Pirini gave him $50 for petrol and told him he was welcome to stay another night, but he replied he was alright.

43. Detective Sergeant Pfeffer contacted two other persons in relation to Mr Kumeroa's movements on the day of his death. One person sent text messages to Mr Kumeroa's phone during the siege. They do not appear to have been responded to. This person said that Mr Kumeroa owed him money for drugs he had previously acquired.

44. Another person told police that he was approached by Mr Kumeroa asking for directions to Biota Street, Inala. This person said that Mr Kumeroa was in a black Mitsubishi Lancer. The witness ended up getting into the car with Mr Kumeroa, at which time he saw a gun on the front passenger seat. Mr Kumeroa said he wanted to get Suboxone, and that he had not been able to collect any from his usual chemist because he was wanted by police.

45. Detective Sergeant Pfeffer's evidence was that the second person is known to police. His interaction with Mr Kumeroa may have prompted the anonymous call to the Inala Police Station about a drug deal taking place between two persons in a parked car at 16 Gannet Street.

46. However, I accept that there was no evidence found to indicate that drugs were obtained by Mr Kumeroa and his toxicology results did not reveal he had taken any illicit substances.

47. The evidence from Ms Pirini and Ms Aldham suggests that Mr Kumeroa had intended to return to the Gold Coast to carry out the plan that he and Mr Vitasz had formulated. For some reason he was diverted to visiting Gannet Street.

Initial police notification and response

48. At 11:45am, the Inala Station Client Service Officer (CSO), Michelle Kalinowski, received an anonymous call regarding a drug deal taking place between two persons in a parked car at 16 Gannet Street, which was only 300 metres from the Inala Police Station. First response officers, Sergeant Michael Kelly and Sergeant Stephen Gracey, arrived on the scene at 11:48am.

49. Sergeant Kelly observed Mr Kumeroa sitting in the car in a carport. Sergeant Kelly started speaking to Mr Kumeroa while approaching the vehicle from the rear. Mr Kumeroa said that he was waiting for a friend and then produced what appeared to be a gun. Sergeant Kelly moved backwards, drew his firearm, and called out 'gun, gun, gun' to Sergeant Gracey, who was positioned towards the front of the vehicle. Sergeant Gracey also drew his firearm.

50. Second response officers, A/Senior Constable Cameron Burness and Constable Erin Whyte, arrived on scene at the point where Sergeant Kelly called out 'gun, gun, gun'. Within minutes of the second response officers' arrival, more crews arrived, including Senior Constable Ashley Auld, Sergeant Steven Bowser and Senior Constable Rachel Zuanetti.

51. Constable Burness activated his body worn GoPro camera. Unfortunately, it only recorded 25 minutes before the battery failed. The footage clearly depicts Sergeant Kelly yelling forcefully and repeatedly at Mr Kumeroa that he would be shot if he presented the firearm towards police. It is clear that there was only limited success engaging in any conversation at this time.

52. Mr Kumeroa made several calls on his mobile phone and eventually told Sergeant Kelly that '*his little girl had just been taken away from him and this is what this is all about*.' Sergeant Kelly said that although Mr Kumeroa remained calm throughout, he was in fear of him. My observation of the video footage indicated that Sergeant Kelly acted professionally throughout this interaction.

Further police response

53. At 11:53am, Inspector Bradley Wright, from the Special Emergency Response Team (SERT), was informed of the situation.

54. At about midday (15 minutes after the initial response), a Police Forward Command Post was created in Brolga St, Inala. Inspector Richard Kroon was involved in creating the command post. He declared an emergency situation under Part 2 of the *Public Safety Preservation Act 1986* at

12:05pm. Inspector Kroon's evidence was that his objective was to contain the scene and exclude people from the area for their safety.

55. As they were not wearing ballistic vests, Sergeants Gracey and Kelly were replaced by Detective Senior Constable Christopher Randell and Plain Clothes Senior Constable Matthew Young. Officers Randell and Young also attempted to engage in conversation with Mr Kumeroa but were unsuccessful.

56. By about 12:30-12:40pm, SERT officers started to arrive and position themselves. The SERT Commander (Operative 35) was briefed by Inspector Kroon and viewed the stronghold from about 50-60m away. Operative 35 was instructed to take control of the inner cordon. Operative 35 communicated a containment plan to his crew via radio, and general duties police were replaced with SERT Operatives 72 (Team Leader), 113, 131 and 139.

57. Inspector Kroon said that SERT engagement had been requested, and their deployment was approved because of their capacity to assist in a siege situation. They were intended to provide a platform for the negotiation with Mr Kumeroa to occur safely. SERT officers also receive more training in, and have access to, a wide range of use of force options. The SERT Bear Cat was positioned behind Mr Kumeroa's vehicle to provide a safe negotiating platform and to prevent him from leaving in the vehicle. I accept that close containment was warranted, as there was a range of possible escape paths into the surrounding unit blocks, where residents had taken shelter.

58. The SERT officers were able to engage with Mr Kumeroa to obtain contact details for him and Ms Lamaro. They were also able to get his child's name. The evidence at the inquest confirmed that the SERT officers, particularly 113, were more successful than the negotiators in engaging with Mr Kumeroa and getting information from him.

59. I accept the submission of Senior Counsel Assisting that I should not see this as a criticism of the negotiators or their strategies. Rather, it is a reflection of the advantage operative 113 had in being able to speak directly to Mr Kumeroa from a relatively short distance where he was able to make eye contact from time to time. The evidence also suggests that the SERT officers had picked up effective communication skills from their regularly joint work with trained and professional negotiators. I accept that the negotiators and SERT officers worked together to reinforce messages about how a safe exit from the siege could be achieved by Mr Kumeroa.

60. The police negotiators at the scene were Detective Senior Sergeant Richard Lacey (Negotiator Team Leader), Sergeant Julie Buckley, Detective Sergeant Stephen West and Detective Sergeant Graham Kershaw. They were all on site by around 12:40pm. Negotiations commenced at 1:30pm, and a surrender plan was created and communicated to Mr Kumeroa via loudspeaker. He was told to leave any weapons inside the vehicle, exit the

vehicle with his palms facing out and to proceed to the rear of the vehicle. The consequence of pointing his weapon at police was restated on a number of occasions.

61. Officers Kershaw and West attempted contact with Mr Kumeroa using a phone they provided to Mr Kumeroa. It was about 2:10pm by this time. These methods continued to attract a limited response from Mr Kumeroa, who said that he wanted to speak with his daughter. A recorded message from Ms Lamaro was then relayed to Mr Kumeroa via operative 72.

62. The Negotiation Team Leader, Detective Senior Sergeant Lacey, told investigators after the event that there were some technical difficulties in relaying the message to Mr Kumeroa. Eventually other methods were used to ensure Mr Kumeroa received the message.

63. The SERT officers' evidence was that Mr Kumeroa's demeanour fluctuated throughout the incident. Although he initially appeared calm, he was constantly fidgeting with the mechanism on his weapon. However, his overall level of engagement caused QPS officers at the scene to be generally optimistic that he would follow the surrender plan.

64. Mr Kumeroa's initial response after the message was relayed was positive. He was seen to put the gun down, grab some clothing from the back of the car, and put the keys in the ignition and sunglasses on his head. These actions were seen as a sign Mr Kumeroa was preparing to exit the vehicle safely. SERT operatives told each other to be prepared for the application of non-lethal force if Mr Kumeroa decided to attempt to run after leaving his vehicle.

65. SERT operative 113 endeavoured to encourage the positive behaviour, and instructed Mr Kumeroa to place both hands on the steering wheel, step out of the vehicle safely and await further instructions. He told him that he was doing the right thing.

66. Subsequently, Mr Kumeroa put the clothes back down and took hold of the gun. At one stage, he looked back and said 'Ain't life a bitch.' He sat for some time, looking around over his shoulder and through the rear vision mirror.

67. At 3:49 pm, Mr Kumeroa exited the vehicle with the gun in his right hand at waist height. As he turned to face police officers, he continued to raise the gun. The evidence of the SERT operatives at inquest was that they were of the view that Mr Kumeroa was going to shoot at them or their colleagues. They perceived that their lives were in danger.

68. SERT operatives 113, 131 and 139 all fired simultaneously and Mr Kumeroa immediately fell to the ground. The Channel 9 footage of the incident[5] shows Mr Kumeroa (wearing a red shirt) exiting the vehicle quickly with a gun in

[5] Exhibit F5

his right hand. He raises the gun directly at police, bringing his left hand to his right hand. He fell to the ground as soon as police shot him.

69. SERT operative 35 was the Tactical Commander for the incident. I accept his evidence that, in accordance with training, SERT operatives made a threat assessment when Mr Kumeroa broke the line of the vehicle he occupied. He said SERT officers receive a considerable amount of scenario training that enables them to react calmly in high-pressure situations. After assessing the position of Mr Kumeroa's hands as he exited the vehicle operative 35 formed the view that it was necessary for the officers to fire upon him in order to save their own lives. I heard evidence from each of the officers to the same effect.

70. SERT officers 113 and 131 were medics with advanced first aid training. They immediately commenced CPR. The Queensland Ambulance Service was on standby and QAS officers were attending to Mr Kumeroa within 1 minute 40 seconds of the shooting. Mr Kumeroa was pronounced deceased at the scene by the QAS officers at 4:26pm.

71. It became apparent, sometime after the shots were fired, that the gun possessed by Mr Kumeroa was a replica. Detective Sergeant Pfeffer's evidence that the gun was a replica of exact size and weight, and had moving metal parts that appeared operative. The evidence of the SERT officers was that they could hear Mr Kumeroa from time to time 'cocking the pistol'. The effect of all of the evidence is that the weapon looked like a genuine Beretta. There was no indication that it was not a functioning weapon.

Autopsy results

72. Experienced forensic pathologist, Dr Philip Storey, conducted a full internal autopsy examination on 30 September 2014.

73. External examination showed gunshot wounds to the trunk, two to the front of the chest wall, three to the back as well as a gunshot wound to the left forearm. Discrete areas of bruising were also noted to the right flank, and to the outer aspect of the right upper arm. Dissection revealed the presence of lodged projectiles in the subcutaneous tissues immediately beneath these areas of bruised unbroken skin.

74. Dr Storey explained that there were definitely four, but possibly five gunshot wounds:
    i. Skin entry wound to the left chest and passing into the left lung, the pericardial cavity, the heart, the diaphragm, the liver and coming to rest beneath the skin at the right flank. The bullet did not exit the body.
    ii. A skin entry wound to the left chest and passing into the left chest, the diaphragm, the abdomen, and then passing to the rear of the right hip region. The bullet did not exit the body.

iii. A skin entry wound to the upper left back, near the midline, passing through to strike the rear of the first right rib, the very upper portion of the right lung, the right axilla (armpit), behind the right upper humerus (arm-bone) and coming to rest beneath the skin at the right lateral upper arm. The bullet did not exit the body.
iv. A skin entry wound at the rear left upper back passing predominantly downwards and exiting the body in the lower back.
v. An entry wound at the lateral left wrist with exit at the medial left wrist and with damage to the bones of the left forearm.

75. The projectile injuries resulted in severe internal organ damage, as well as significant blood loss. The internal trauma to the heart was particularly severe, and immediately non-survivable (entry wound 1). Other wounds were severe and life threatening, including severe trauma to the chest which resulted in the passage of air into the chest cavities with collapse of the right lung, together with acute trauma to the left lung, severe intra-abdominal damage (particularly to the liver and spleen) with loss of blood in the abdominal cavity. There was also acute damage to the spinal cord in the upper back.

76. Toxicology testing revealed the presence of non-toxic levels of the anti-anxiety medications Diazepam and Nitrazepam. No alcohol or other drugs were detected. Dr Storey confirmed evidence at the right forearm of previous drug use. Serological testing returned a positive result for Hepatitis C.

77. Dr Storey also explained that there was evidence of significant coronary atherosclerosis, but that this did not contribute to the death.

78. Dr Storey concluded that the cause of death was due to gunshot wounds to the chest and abdomen.

The investigation

79. Detective Sergeant Sandra Pfeffer, from the Queensland Police Service Ethical Standards Command, conducted an investigation into the circumstances leading to Mr Kumeroa's death. She produced a comprehensive report and I heard evidence from her at the inquest.

80. Upon being notified of the deaths, the ESC attended at the scene and an investigation ensued. The investigation was informed by statements and recorded interviews with:
    - all police officers involved;
    - persons who were inside the neighbouring units in the lead up to the death;
    - other people who knew and had contact with Mr Kumeroa; and
    - next of kin.

81. Forensic analysis was conducted and photographs were taken. All police investigation material was tendered at the inquest. I am satisfied this matter has been thoroughly investigated and all sources of relevant information have been accessed and analysed.

82. The ESC investigation concluded that there was no misconduct displayed by any of the officers involved and further concluded that no disciplinary proceedings were required.

83. During her evidence, Detective Sergeant Pfeffer said it appeared Mr Kumeroa deliberately chose to get out of the car and take the action he did, aware that as a consequence police would use potentially lethal force. He had previously been recorded stating that he knew police were looking for him, that he was in possession of a weapon, and would "go out with a bang".

84. The footage acquired from Mr Butkowski, and the earlier footage from Constable Burness, depicts the repeated instructions given to Mr Kumeroa by police to surrender for his own safety. Police continually warned him that if he exited the vehicle with the gun he would be shot. There is no evidence to suggest that he was unable to comprehend those warnings.

85. Detective Sergeant Pfeffer considered that there was no other reasonable option available to the SERT officers to resolve the situation and to preserve their own lives. Detective Sergeant Pfeffer's evidence was that in this situation, where the officers had genuine fear for their lives, the only appropriate response was lethal force. I accept the evidence of SERT operatives 113,131 and 139 in this regard. They were impressive witnesses and I accept that they acted professionally and in accordance with the high level of training they receive throughout this unfortunate incident.

86. There was limited information received during the course of the incident that indicated Mr Kumeroa had purchased replicas. When the weapon was inspected after the event it was ascertained that that it was a replica. The weapon was a very accurate facsimile of a Beretta pistol. Officers could not have reasonably predicted or assumed that the weapon did not have firing capacity. In Detective Sergeant Pfeffer's view, the officers had no other option other than to treat the weapon as a fully functioning firearm. I also accept the conclusions of Detective Sergeant Pfeffer in this regard.

87. I heard considerable evidence surrounding the separation of each of the SERT officers after the shooting, and the 'buddy' system SERT has in place for these types of critical incidents. A copy of this was tendered to me at the beginning of submissions. The SERT officers were all breath tested, and subsequently interviewed by ESC officers.

88. For present purposes, I am satisfied that the integrity of the evidence of the officers was suitably preserved and that the steps taken assisted the welfare of the officers.

Findings required by s. 45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all the material contained in the exhibits and the evidence heard at the inquest, I am able to make the following findings:

Identity of the deceased – The deceased person was Shaun Basil Kumeroa.

How he died - Mr Kumeroa's death occurred some months after his relationship with Ms Lamaro had broken down, and at a time when he was concerned that contact with his daughter might cease.

Mr Kumeroa confronted Ms Lamaro and her mother and assaulted them. This prompted police involvement and a warrant was issued for his arrest.

On the day of his death, police were called to 16 Gannet Street, Inala in response to an anonymous call indicating suspected illegal activity.

A siege situation ensued, lasting almost four hours. It ended when Mr Kumeroa spontaneously and rapidly exited his vehicle, raised a gun and directed it at police. SERT officers acting in the course of their duty consequently shot Mr Kumeroa.

After his death, the gun was inspected and it was ascertained that it was a replica Beretta pistol.

Place of death – He died at Inala in the State of Queensland.

Date of death – He died on 29 September 2014.

Cause of death – The cause of death was gunshot wounds to the chest and abdomen.

Comments and recommendations

I close the inquest into this death with respect to the findings required by s. 45 of the *Coroners Act 2003*. I extend my condolences to Mr Kumeroa's family.

Any comments and recommendations under s. 46 of the Act will be considered in the second phase of the inquest.

Terry Ryan
State Coroner
Brisbane
18 January 2016

Attachment 1

List of Issues

1. The findings required by s. 45 (2) of the Coroners Act 2003; namely the identity of the deceased, when, where and how he died and what caused his death;

2. The appropriateness of the current QPS use of force model and the options of force available to police officers;

3. The adequacy of Queensland Police Service:
   (i) policies in relation to the use of firearms; and
   (ii) training provided to operational police officers in the use of firearms.

4. The adequacy of the investigation into the death conducted by the Ethical Standards Command Internal Investigations Group, particularly, the separation of the first response police officers, post-incident, and the timing of their interviews with ESC officers;

5. The regulation of replica firearms in QLD;

6. The use of negotiators and the options available for use when trying to negotiate a surrender plan with an offender;

7. The effectiveness of the negotiation processes in the present case, including the reason for any technical difficulties encountered;

8. The positioning of the inner cordon police officers in the present case leading to the necessity to use lethal force soon after Shaun departed his car;

9. The appropriateness of actions by the attending police officers, generally, on the facts of the particular case;

10. The current position regarding ownership of body worn cameras used by QPS officers and the storage of data; and

11. Lessons learned from these incidents as to the benefits of body worn cameras being used by the police officers in terms of:
    - preserving evidence;
    - providing a reliable record of what occurred;
    - avoiding unnecessary controversy about what happened; and
    - vindicating police officers who have acted in accord with their training and policy.

12. The adequacy of powers under the *Public Safety Preservation Act 1986* to manage emergent situations under that Act, and the effectiveness of current guidelines within the QPS operational procedures manual for helicopters operating near scenes of police operations