QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Duy Linh Ho**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2019/3298
DELIVERED ON:	25 November 2022
DELIVERED AT:	Brisbane
HEARING DATE(s):	15 February 2022, 7-9 June 2022
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, police shooting, death in custody, avoiding being placed into custody, use of force, mental health response, incident command, entry into residence, police training.

REPRESENTATION:

Counsel Assisting:	Ms Rhiannon Helsen
Ms Luu:	Ms Paula Morreau, instructed by Caxton Legal Service

Queensland Ambulance Service:	Ms Jennifer Hewson, instructed by QAS
Commissioner of Police:	Mr Mark O'Brien, QPS Legal Unit
SC Low Constable Granzien SC Marsic Snr Sgt Manning-Jones:	Ms Eleanor Lynch, Gilshenan and Luton
Det Sgt Downey:	Ms Sarah Ford, Gilshenan and Luton

Contents

Introduction

1. Mr Duy Linh Ho was a Vietnamese man who died on 22 July 2019 after being shot by a Queensland Police officer acting in the course of duty. Mr Ho was aged 41.

2. Mr Ho lived with his partner, Ms Luu, and four children aged between five and eight at Doolandella in Southwest Brisbane. Ms Ross was Ms Luu's brother's fiancé. She was also staying with the family when Mr Ho died. The home was a two storey brick residence. On the morning of 22 July 2019, the Queensland Ambulance Service (QAS) received a call from Ms Luu. She was concerned that Mr Ho had self-harmed with broken glass after locking himself in the bathroom and cutting his arm the previous evening. He was expressing suicidal ideation and paranoid thoughts. Ms Ho could not have anticipated that her call for help would set in place a chain of events of resulted in the death of her partner.

3. Officers from the QAS and Queensland Police Service (QPS) went to the residence where Mr Ho refused any treatment for his laceration. He continued to behave in an aggressive, and at times, threatening manner. He barricaded himself at the top of the stairs inside the dwelling holding a mirror and samurai sword. The children, Ms Luu and Ms Ross were assisted from the home at the request of the QPS.

4. Attempts to negotiate with Mr Ho to disarm and leave the residence peacefully continued as the children left the home. A police and ambulance officer located themselves just inside the doorway near the base of the stairs. After the last child left the incident escalated quickly. Mr Ho advanced toward a police officer stationed in the doorway of the residence. He was brandishing his sword and was subsequently shot twice. He was declared deceased at the scene.

Inquest issues

5. The primary purpose of an inquest is to inform the family and the public about the matters required by s 45 of the *Coroners Act 2003*, including when, where and how the person died and what caused the death. A coroner may also comment on ways to prevent deaths from happening in similar circumstances in the future.

6. A coroner is not able to include in the findings or any comments or recommendations any statement that a person is, or may be, guilty of an offence or civilly liable. Where a coroner suspects that a criminal offence has been committed, they can make a referral to the Director of Public Prosecutions or relevant prosecuting authority.

7. Information about a person's conduct in a profession can be given to the disciplinary body for that profession if the coroner believes the information might cause the body to inquire into or take steps in relation to the conduct.

8. Mr Ho'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 was mandatory.

9. Following a pre-inquest hearing on 15 February 2022 the issues for inquest were settled as:

- The findings required by s.45(2) of the *Coroners Act 2003.*
- The circumstances leading up to the shooting of Mr Ho on 22 July 2019, including the timeliness of the response by police and engagement with police and the Queensland Ambulance Service at the residence immediately preceding the death.
- Whether the police officers involved acted in accordance with the Queensland Police Service policies and procedures then in force and whether said actions were appropriate, including but not limited to, the positioning of officers and decision to remain in the residence.
- Whether the training provided to officers in responding to a similar incident is sufficient.
- Consideration of the adequacy of the investigation into the death conducted by officers from QPS Ethical Standards Command.
- The appropriateness of the communication and liaison with the family members at the scene and during the investigation into the death in custody.

The evidence

Personal Circumstances and History

10. Mr Ho was born in Vietnam in June 1978. He came to Australia with his family and acquired citizenship in 1985. Mr Ho and Ms Luu had been in a relationship for approximately 17 years, including some periods of separation. He was known to family and friends as Linh or Louie.

11. In her Impact Statement, Ms Luu said that Linh was a kind and loving person. He was liked by everyone who met him and always happy to help out. He had a large group of friends. He was very protective towards his children, and he loved them more than anything in the world. Understandably, his children miss him and have struggled to comprehend the circumstances of his death.

12. Ms Luu clarified that she and the children were not being held hostage by Linh. This was accepted by the investigating officer, Det Sgt Downey, who agreed that Mr Ho was not stopping anyone from leaving the home. The media reporting of his death which suggested that he was holding them hostage brought great shame to the family and to Linh's memory. Ms Luu had to explain the actual circumstances repeatedly to many different people. Ms Luu has experienced guilt about trying get help for Linh by calling 000. I extend my sincere condolences to Ms Luu and to Mr Ho's family and friends.

13. Mr Ho was unemployed at the time of his death. He worked in early 2019 as a forklift driver but it appears he was terminated from this role in June 2019 because of absences from work.

14. Mr Ho had a limited Queensland Criminal History commencing in 1999, which largely relates to minor drug offences. He also had a significant traffic history.

15. Officers who attended the incident were told by Ms Luu that Mr Ho suffered from depression and had a mental health condition for which he was medicated. Ms Luu told investigating police that he suffered from bouts of depression and would have episodes where he was agitated. He also had a lengthy history of drug use, including methamphetamine (ice).

16. Ms Luu said that Linh had experienced trauma as a child, and he did not get any help for that. He lost his mother and brother suddenly in the months leading up to his death and used drugs as a means of coping. He was very stoic and was reluctant to see a doctor for help with his mental health.

17. Records obtained from his general practitioner, Dr Hunt, showed that Mr Ho had a history of opiate dependency. On 17 April 2019, Mr Ho had presented to his general practitioner with depression and anxiety. He was reportedly struggling to sleep, not eating well, using ice, and experiencing psychotic symptoms. Ms Luu attended with Mr Ho and reported that she was very concerned by his behaviour, particularly after he had used ice. Dr Hunt was of the view that Mr Ho likely was suffering from a semi-transient drug induced psychosis.

18. A letter provided by Dr Hunt to investigators indicated that he had been treating Mr Ho primarily for his opiate dependence, which was entrenched since at least 2004. He had been prescribed Suboxone Film. Dr Hunt had not referred Mr Ho to a mental health practitioner, although on 17 April 2019 he prescribed Zyprexa to assist him to settle at night.

Events leading up to the death

19. On the evening on 21 July 2019, Mr Ho became agitated at home and used broken glass to self-harm. He locked himself in an ensuite bathroom and stayed there overnight, making loud noises and yelling that he wanted to die or kill himself. Ms Luu repeatedly asked him to open the door, but he refused. She described him as paranoid, and he was suggesting someone was on the roof.

20. At around 4:00am the following morning a neighbour, Ms Stark, heard someone screaming for help. Ms Luu said that Mr Ho opened the bathroom window and yelled '*help me, someone help me.'* Ms Stark went to the home and spoke to Ms Luu, who was very distressed. Ms Stark heard the sound of glass breaking and suggested the QAS be called to help. She did not enter the house or see Mr Ho.

21. After Ms Stark left, Mr Ho came out of the bathroom. Ms Luu saw that he was bleeding from a laceration on his arm. At 5:22am, Ms Luu called 000 and was transferred to the QAS. She asked that they attend to help Mr Ho, who had sustained a cut to his arm and was experiencing mental health issues. She said he had been violent and that it was a suicide attempt.

22. At 5:24am, an electronic request was put through the Interagency Computer Aid Dispatch Electronic Messaging System from the QAS to the QPS for assistance. At 5:26am, a CAD incident job was created with code 503 assigned – *Attempting/Threatening Suicide* and code *504 – Mentally Ill Person.*

23. At 5:34am, Ms Luu made a second call to QAS. She tried to cancel her request for assistance. However, the call taker declined to cancel the job and confirmed that the QAS were proceeding to the address.

24. At 6:18am, a QAS Advanced Care Paramedic (ACP) crew consisting of Adam Rutledge (ACP Rutledge) and Daniel Stafford (ACP Stafford) arrived and spoke with Ms Luu outside the home. Mr Ho stayed inside and refused to be assessed or receive any treatment.

25. The QAS officers explained to Ms Luu that they had a 'duty of care' to assess Mr Ho before they left, and this was required in self-harm incidents. Ms Luu encouraged Mr Ho to allow the officers to see him, but he locked the front door and refused to open it. The QAS officers were able to conduct a visual assessment of Mr Ho through a window. They noted that he while he had no obvious signs of a major haemorrhage, he appeared agitated and was verbally aggressive.

26. At 6:25am, a QPS crew from the Inala Station arrived, consisting of Senior Constable Sarah Marsic and Constable Briohny Granzien. Senior Constable Marsic activated her Body Worn Camera (BWC). They were advised by the QAS officers that Mr Ho would not allow them to enter the home, and he was refusing treatment. SC Marsic and Constable Granzien started talking to Mr Ho and Ms Luu through the glass front door.

27. During the discussion, Mr Ho made a number of threats to suicide, stating that he wanted to die. ACP Rutledge formed the view that the most appropriate course, given Mr Ho's behaviour at the scene, was to place him under an Emergency Examination Authority (EEA) and have him assessed at a hospital. ACP Rutledge said that he tried to use de-escalation techniques such as empathy, an open posture and remaining calm. His obligation was to ensure the safety of Mr Ho.

28. Police officers were also concerned that Mr Ho was holding Ms Luu against her will, having regard to his aggressive behaviour. It was also unknown how many people were in the home. This concern was communicated to Mr Ho. A second crew was then asked to attend and provide assistance as Mr Ho was refusing to come outside and was making threats towards a female. SC Marsic told the inquest she confirmed with Ms Luu that she was not being held against her will.

29. At 6:53am, Ms Luu opened the front door with Ms Ross, and spoke to officers. Constable Granzien remained at the entrance door and spoke to Mr Ho, who was positioned at the top of the internal stairs armed with a sword and a mirror. It was then established that four children were asleep inside the home.

30. Constable Granzien said that Mr Ho was agitated throughout the incident. He told her that he hated police and was angry at the women inside the house.

31. At 6:57am, a QPS crew from Sherwood Police Station, consisting of Senior Constable David Low and Constable Robert Williams, arrived at the scene. SC Low entered the residence through the front door and saw Mr Ho at the top of the stairs. After a brief conversation, he exited the residence and asked Constable Granzien to continue engaging with Mr Ho.

32. SC Low transmitted a request over the radio for the District Duty Officer (DDO) to attend. He said that Mr Ho was armed and there were four children inside the dwelling. SC Low directed Constable Williams to go to the backyard of the home. He also told Ms Luu and Ms Ross to leave the residence.

33. Constable Granzien and ACP Rutledge entered the home and stayed at the base of the internal stairs, maintaining visual contact with Mr Ho while trying to negotiate with him to let the children leave the residence. Mr Ho was squatting with a sword and mirrors. He told them they were trespassing. Both officers repeatedly asked Mr Ho to disarm and come out of the residence peacefully.

34. SC Low positioned himself at the front entrance of the residence, where he was able to see Constable Granzien and ACP Rutledge. SC Low said that he assessed the situation as very high risk but there was sufficient space to negotiate from within the home.

35. ACP Rutledge said that he voluntarily went inside the home because he wanted to get "eyes on" and to facilitate more effective de-escalation. He said that he felt safe inside the home and was close to the door if the situation required him to leave.

36. At 7:08am, Centenary Patrol Group DDO, Senior Sergeant Manning-Jones, arrived at the residence and took position at the top of the driveway. He activated his BWC at 7:18am. Having apprised himself of the situation, he positioned crews in a cordon around the dwelling and arranged for police negotiators and the Public Safety Response Team (PSRT) to attend.

37. At 7:27am, trained negotiator, Detective Senior Constable Vincent, arrived at the scene and asked for a second negotiator attend. This request was made by Snr Sgt Manning-Jones to the Police Communications Centre at 7:32am. Detective Senior Constable Vincent declined to start negotiations until a secondary negotiator and a team leader arrived.

38. At 7:33am, Snr Sgt Manning-Jones broadcast over the police radio that he was in charge of the incident as follows:

> `*I'm in charge of this incident at Cassowary Street….standby for situation and mission. The situation: male POI 41-year-old held up at the top of the stairs with a samurai sword. Currently there are four young children asleep upstairs in the bedrooms not awake as of yet. Our mission at this stage is to bring those hostages out safely. Any further updates I'll let you know as we go along. The actual residence – there has been an inner cordon. For the information of those teams be ready to use any use of force necessary as they deem in the situation if that male does exit the residence. I'll update you with anything further as it comes through.'*

39. At 7:35am, PSRT officers arrived at the scene with the team leader, SC Butler, briefed by Snr Sgt Manning-Jones. SC Butler told the inquest that before his team could deploy, he heard gunshots. He understood that the plan was to negotiate with Mr Ho after the other occupants of the home had exited. There was effective containment in place and PSRT had the capability to deploy less lethal means of force, such as a bean bag fired from a shotgun.

40. At the inquest, Snr Sgt Manning-Jones agreed that his use of the term "hostages" was a poor use of jargon. He said that he wanted the occupants out of the house. He articulated that he was applying the ICENRIRE framework and wanted to isolate Mr Ho after the children were outside.

41. Constable Granzien and ACP Rutledge had continued to negotiate with Mr Ho inside the residence. Two children woke up and exited the dwelling. While Mr Ho became agitated at times, there was never any suggestion he intended to harm the children. However, he told police he wanted them to draw their weapons and use them on him. Constable Granzien said that she had both cover and distance and Mr Ho engaged in conversation with her while she was inside the home. She was not fearful as she was being covered by SC Low.

42. Before the last two children left the home, SC Low's BWC captured Mr Ho saying to Constable Granzien:

> *'Don't fucken make me, fucken jeopardise my kids hey. I'll fucking kill you before I fucken touch my kids'.*

43. Mr Ho called out for the remaining children to wake up. While a third child exited the dwelling at 7:44am, the fourth and youngest child could be heard crying. Mr Ho encouraged her to go outside. He was agitated and upset, stating, '*she doesn't want to go, I know she doesn't want to go'*.

44. SC Low and Constable Granzien encouraged the fourth child to come downstairs. She exited the residence at 7:47am through the front door and was carried to the QAS vehicle.

45. Snr Sgt Manning-Jones immediately broadcast:

> '*all four hostages have been released. I'll change the mission now is to apprehend the POI. Repeat apprehend the POI*.'

46. This broadcast was acknowledged by the radio operator and repeated. During this time, the second negotiator, Detective Senior Constable Quakawoot, arrived on scene and was in the process of receiving a briefing from Detective SC Vincent.

47. As the fourth child exited the residence, the following conversation was recorded on SC Low's BWC:

Mr Ho:	*Let's get this over and done with. Can you please go. Come on. Can you please move.*
SC Low:	*We're not moving anywhere buddy.*
Const Granzien:	*We don't want you to do anything silly ok, I've just seen your four beautiful kids.*
Mr Ho:	*Then let's go*
Const Granzien:	*Please, please, please just talk to me.*

48. SC Low subsequently motioned for Constable Granzien and ACP Rutledge to leave the dwelling. Constable Granzien said that she thought it was apparent at that time that Mr Ho 'wanted to end it' and she saw his demeanour switch. He chopped at the corner of the mirror and kept hacking at it, becoming increasingly irate.

49. Constable Granzien said that she was confident in Snr Sgt Manning-Jones' skills as a DDO, and his aim was to get everyone safely out of the home. However, she had not heard his mission statement as her radio was turned down to minimise distractions for Mr Ho during the negotiation.

50. Snr Sgt Manning-Jones also agreed that he was unaware whether his mission statement was received by those inside the inner cordon. Ideally, they would have acknowledged receipt. His plan was to adjust the inner cordon with negotiators in place. The PSRT would step forward to effect an apprehension if required.

51. SC Low said that the cue to get Constable Granzien and ACP Rutledge out of the house was Mr Ho walking across the balustrade to the top of the stairs. His intention was to try to tactically withdraw.

52. SC Low had stayed at the front entrance. Sounds of banging and breaking glass could be heard as Mr Ho, armed with a sword and a mirror, rushed down the stairs towards SC Low.

53. SC Low drew his firearm and gave a number of verbal commands for Mr Ho to drop the knife. Mr Ho smashed the mirror at the bottom of the stairs in close proximity to SC Low. He continued to approach SC Low, armed with the sword. SC Low discharged his firearm three times. Two of the bullets hit Mr Ho who immediately fell to the ground close to SC Low. ACP Rutledge immediately rendered first aid assistance. Unfortunately, Mr Ho succumbed to his injuries and was declared deceased at 8:17am. SC Low said that he was:

> *Scared for my life. Scared for others, if outside. There is no doubt he would've tried to kill me or someone else*

54. Snr Sgt Manning-Jones had declared a crime scene at 7:53am. Officers from the Ethical Standards Command were advised and attended the scene. The officers involved in the incident were substance and alcohol tested. All results returned were negative. Interviews and walkthroughs were conducted with each of the officers involved. A door knock of the residential addresses in the immediate vicinity was undertaken.

55. Ms Luu said that the incident escalated when police officers arrived as Mr Ho did not want them at the residence.

56. Ms Ross was concerned that once the QPS and QAS officers arrived, Mr Ho may hurt them as she had heard him make threats to do so. She was not concerned for her wellbeing, or that of any other members of the household, including the children. She did not believe Mr Ho would harm family members. He had reiterated to her and Ms Luu that he did not want anyone from QAS or QPS inside the residence and did not require any help.

57. Snr Sgt Manning-Jones confirmed that he did not make a request for the Special Emergency Response Team (SERT) to attend the incident location during the course of the morning. He indicated that he had formed the view, having also spoken with Inspector Partrige, who had a background in SERT, that the incident did not meet the threshold to deploy SERT.

58. Snr Sgt Manning-Jones had successfully completed the Incident Command Workshop for supervisors and Fundamentals of Incident Management Training.

Investigation findings

59. As Mr Ho's death was a death in custody, an investigation was conducted by Det Sgt Downey from the QPS Ethical Standards Command. Det Sgt Downey prepared a detailed coronial report with various annexures, including witness statements, footage, forensic analysis, and various photographic exhibits.

60. The BWC footage captured by the officers involved was scrutinized and summarised by Ethical Standards Command investigators. A forensic examination of the scene was undertaken at the direction of A/Inspector Koplick. Extensive photographs were taken of the residence and the discarded projectiles.

61. A ballistics examination of SC Low's weapon and load bearing vest was also undertaken.

62. A FARO 3D forensic scan was also undertaken of the scene and was included in the brief. This demonstrated the estimated positions of Mr Ho, ACP Rutledge, Constable Granzien and SC Low prior to and at the time of the shooting.

63. A/Snr Sergeant Werth is the Officer in Charge of the Firearms Training Section. He was asked by Det Sgt Downey to conduct a review of the circumstances surrounding his death and whether the actions taken in response were in line with QPS Policy, procedures, and training.

64. Having considered the requirements of the Situational Use of Force Model in OPM 14.3.2, which are to be satisfied for an application of force to be regarded as appropriate in line with the QPS' organisational position as it relates to the lawful application of force, A/Snr Sergeant Werth formed the view that the lethal use of force by SC Low was justified. While tactical withdrawal and repositioning was implemented as a less lethal use of force response to remove from harm officers, the time and space required to achieve this meant that SC Low was not able to move out of harm's way in time to select any other option other than lethal force.

65. In relation to the decision to contain Mr Ho by way of cordons, police actions were considered to be in accordance with established Incident Command.

66. Det Sgt Downey noted that efforts had been made to verbally deescalate the situation by negotiating with Mr Ho for one hour and 22 minutes before the final confrontation. Extensive and exemplary attempts were made by Constable Granzien to build a rapport with Mr Ho, by way of active listening, empathy, asking open ended questions, stating 'I' messages to personalise the communication process and to establish trust. Despite those attempts, Mr Ho continued to get upset while QPS were in attendance.

67. It was noted that while Taser or OC spray may have been effective in obtaining compliance from Mr Ho, there was no safe or tactically sound method for SC Low or Constable Granzien to ensure effective deployment in the close range required.

68. A/Snr Sergeant Werth considered the actions of SC Low in discharging his firearm was in accordance with QPS training and was necessary to mitigate the risk posed by Mr Ho.

69. In terms of the actions of police during the course of the incident, it was acknowledged by Investigators that there may have been an opportunity for police to tactically reposition to an external location after release of the fourth child from the residence. However, it was noted that police may have lost visual contact with Mr Ho and the rapport already established with Constable Granzien. There was only a period of around ten seconds from the time Constable Granzien and ACP Rutledge exited the dwelling until SC Low discharged his firearm.

70. Investigators found that SC Low's action in discharging his firearm was authorised, justified and excused by law. It was noted that given Mr Ho's actions in rushing at police while armed, there was a reasonable apprehension that he could cause serious harm or death to SC Low or other officers' safety and the need to discharge his firearm to stop the threat was warranted.

71. No further preventative recommendations than those identified in the Incident Review were suggested by investigators.

Operational Review of the Incident

72. A formal review was co-ordinated by the QPS 'Operational Review Unit' led by Inspector Timothy Mowle. This involved an operational debrief with all those involved in the incident, as well as an organisational debrief with relevant subject matter experts. The Review Report prepared was intended to identify the immediate lessons learnt and expedite any necessary change to procedures and practice where necessary.

73. The Review made the following six findings and recommendations arising from this incident. In May 2022, Inspector Mowle provided an update on the implementation of the Operational Review Unit's recommendations, each of which has been actioned.

I. Review Finding and recommendation 1: Delay in Police Response

74. There was a delay in police attending the incident location as the job was received from the QAS during a QPS shift changeover at 6:00am. After the job came through at 5:26am, it took crews almost an hour to attend. There was no information in the first call that suggested that it needed to be assigned a higher priority.

75. It was recommended that all Districts consider their own areas of responsibility and implement appropriate district instructions in consultation with divisional officers in charge to cater for 'cover shifts' as required.

76. The May 2022 update indicated that on 30 December 2019, a memo was forwarded to all Regions, under the hand of the Deputy Commissioner Regional Operations, requesting that all areas review their rostering practices and district instructions regarding this review finding.

II. Review Finding and recommendation 2: Information transfer between QAS and QPS

77. There was a lack of information transferred between QAS and QPS via CAD systems, particularly related to personal information such as names and addresses. This may have been useful to the QPS prior to arrival. In this instance, the QPS gained information from Mr Ho's partner after she left the house. Earlier access to information about Mr Ho may have assisted negotiations, threat assessments and resourcing.

78. It was recommended that the Community Contact Command develop a memorandum of understanding with the QAS regarding the sharing of information between communication centres to assist tasked units during multi-agency responses.

79. The May 2022 update indicated advice received from Community Contact Command that a comprehensive MOU between QAS, QPS, QFES and PSBA had been signed on 14 July 2017 and remains in effect. This confirms there is no inter-agency or legislative impediment to the QAS providing QPS responders with relevant patient or incident address information.

III. Review Finding and recommendation 3: Police negotiators

80. It was established that a trained QPS negotiator was present for approximately 20 minutes before the critical incident. However, the negotiator took no active role in negotiations. Police OPM Policy 2.19.9 stipulated that a '*minimum of two negotiators*' are required to be present to perform the function of negotiator. This meant that untrained QPS and QAS officers did most of the negotiation with Mr Ho while waiting for a second negotiator to arrive.

81. The Organisational Capability Command and the Negotiator Coordination Unit acknowledged review finding 3 and collaboratively reviewed the adequacy of current negotiator policy contained in OPM 2.19.9, particularly the limitations imposed on a single negotiator being unable to support frontline operators.

82. The policy now sits within OPM 17.10.2 'Negotiators' and provides guidance for a single negotiator response. A nationally consistent approach to Police Negotiation has been developed. This outlines the agreed national arrangements for Police Negotiation when considering issues related to the management of 'High Risk Situations'.

IV. Review Finding and recommendation 4: Tactical repositioning

83. The Operational Review determined that the police reluctance to tactically reposition to an external location after the release of the fourth child may have accelerated Mr Ho's final actions.

84. Earlier removal of the QAS paramedic and QPS officer from inside the stronghold may have lessened the threat perceived by Mr Ho and provided him with space and time to rationalise his options. There may have been a missed opportunity to isolate and contain him in the stronghold and inject trained negotiators into the incident to peacefully resolve the situation.

85. It was recommended that the Incident Command Training Section, People Capability Command, draw on elements of this incident and reinforce that a negotiated resolution is the preferred option, with ICENRIRE objectives and associated tactics prioritised to achieve this outcome.

86. The May 2022 update indicated the Incident Command Training Section are developing a desktop training exercise using this incident as a 'lessons learned' case study. Key teaching points will include reinforcing a negotiated resolution as the preferred option, plus the prioritisation of ICENRIRE objectives.

V. Review Finding and recommendation 5: Risk to QAS

87. The Operational Review determined that QAS paramedics were put at risk being near an armed man. QAS paramedics are provided rudimentary training in self-defence and related tactics and in this case were not required to boost authoritative numbers due to the accessibility of back up and specialist units available and in attendance at the incident.

88. It was recommended that Inservice and Recruit scenario-based training be further developed to include tactical repositioning training and scenarios, and this incident be drawn on to support this development and used as a case study for training purposes.

89. The May 2022 update indicated Operational Skills Section have combined elements of tactical repositioning and approach plus the development of incident action plans into the dynamic interactive scenario training for the Operational Skills Training curriculum.

VI. Review Finding and recommendation 6: Snr Sgt Manning Jones

90. A review of the BWC footage revealed conversations which were interpreted as unprofessional and not in the interests of Mr Ho's safety or the peaceful resolution of the incident. The DDO was recorded as stating:

- *'The mission is to get hostages out safely; I don't care about him'*
- *Yeah, remove hostages. I don't give a fuck about him. Once they're out we can deal with what we can do with him.*
- *Apprehension of the POI, I don't care if he's safe or not, doesn't bother me. I don't give a fuck, apprehend the cunt; and*
- *I've got a rifle being deployed, so if he wants to go nuts upstairs , they'll end up shooting him.*

91. The District Officer and Assistance District Officer, South Brisbane District have discussed with Snr Sgt Manning-Jones his professional responsibilities as a representative of the QPS, and the negative impact such recordings may have on the reputation of the QPS and community confidence.

92. An Operational Advisory Note (OAN) was developed by the ORU and disseminated to all Regions and Districts on 23 December 2019 under the hand of the Deputy Commissioner, Regional Operations. OIC's of Regions and Districts were instructed to bring the content of the OAN to the attention of all staff within their area of responsibility.

Autopsy results

93. An external and full internal post-mortem examination was performed by Senior Forensic Pathologist, Dr Beng Ong, on 23 July 2019. A number of toxicology tests were undertaken as well as a CT scan.

94. At autopsy, two gunshot wounds were located on the body. One was on the top of the head to the left-hand side. The second was to the left side of the abdomen. Both wounds were considered to be consistent with distant range gunshot wounds. An incised wound to the right forearm was noted. There were also several minor surface injuries to the head and limbs , which could have been sustained when Mr Ho fell or collapsed down the stairs after being shot.

95. The toxicology analysis indicated that Mr Ho had high levels of methamphetamine (0.62 mg/kg) and morphine that were capable of causing death. He had also been exposed to heroin and cocaine. Dr Ong considered that Mr Ho's behaviour during the course of the incident could have been influenced by these drugs.

96. The cause of death was found to be gunshot wounds to the head and torso.

Conclusions on Inquest Issues

Findings required by s. 45

97. I am required to find, as far as 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 evidence, including the material contained in the exhibits, I make the following findings:

Identity of the deceased –	Duy Linh Ho
How he died –	Mr Ho had a longstanding substance use problem. Prior to his death he had consumed a large amount of methamphetamine and had locked himself in his bathroom. After he self-harmed his partner called the Queensland Ambulance Service to help him. Police officers and paramedics came to his home. They tried to negotiate with him to leave to get assistance while they were inside his home. After his children had exited the home, he died from gunshot wounds to the head and torso sustained during a confrontation with police when he moved rapidly towards a police officer while armed with a sword. He had failed to comply with numerous verbal commands to drop the weapon.
Place of death –	46 Cassowary Street, Doolandella, Queensland
Date of death–	22 July 2019
Cause of death –	Gunshot wounds to the head and torso.

The circumstances leading up to the shooting of Mr Ho on 22 July 2019, including the timeliness of the response by police and engagement with police and the Queensland Ambulance Service at the residence immediately preceding the death.

98. The events leading up to Mr Ho's death are set out above. The engagement between first response officers and Mr Ho on the morning of 22 July 2019 was captured on the BWC footage of the officers involved. This is the best evidence of the events of that day. The chronology of events was largely not in contention at the inquest.

99. Ms Luu and Ms Ross said that on the evening of 21 July 2019, Mr Ho became agitated while at home. He used broken glass to self-harm. He locked himself in the ensuite bathroom of his residence where he stayed overnight. He made loud noises and yelled that he wanted to die or kill himself. Neighbours were also

concerned about his wellbeing. Despite repeated requests from Ms Luu, he refused to open the door. She described him as being paranoid and he suggested someone was on the roof.

100. At 5:22am, Ms Luu first called 000 and her call was transferred to the QAS. She asked them to come to her home to help Mr Ho, who had sustained a cut to his arm and was experiencing mental health issues. She indicated he had been violent and that it was a suicide attempt. Although Ms Luu gave Mr Ho's name and identifying details this information was not relayed in full to the police.

101. At 5:34am, Ms Luu made a second call to QAS attempting to cancel her request for assistance. The call taker refused to cancel the job and confirmed that QAS were still proceeding to the address.

102. At 6:18am, a QAS Advanced Care Paramedic (ACP) crew consisting of ACP Rutledge and ACP Stafford arrived at the residence and spoke with Ms Luu outside the address.

103. After the job came through at 5:26am, it took crews almost an hour to attend. The first police did not arrive until 6:25am. Police tried to engage with Mr Ho from then until around 7:47am, when he was shot by SC Low.

104. The delay in the QPS response was considered in the review completed by Inspector Mowle. It related to the fact that the QAS had asked for QPS assistance during a QPS shift changeover (6:00am) and the job was not allocated a high priority. I do not consider that the delay in attendance was outcome changing.

105. The evidence of those who engaged with Mr Ho throughout the incident was that he remained agitated about the presence of police inside his home. This was apparent from the BWC footage. While the level of his distress fluctuated, it was apparent he was in crisis. It was only around 20 seconds from when the fourth child exited the residence that SC Low discharged his firearm.

106. The evidence of Constable Granzien, ACP Rutledge and SC Low was that there was a rapid change in Mr Ho's demeanour after the fourth and youngest child left the home. Unfortunately, the dynamic changed within seconds and events escalated rapidly. The footage disclosed that SC Low motioned for Constable Granzien and ACP Rutledge to exit the dwelling while he remained at the front door.

107. Sounds of banging and breaking glass could be heard as Mr Ho, still armed with a sword and a mirror, rushed down the stairs towards SC Low. SC Low subsequently drew his firearm and gave a number of verbal commands for Mr Ho to drop the knife. The mirror smashed at the bottom of the stairs in close proximity to SC Low. Mr Ho continued to approach SC Low armed with the sword. As a result, SC Low discharged his firearm three times with two of the bullets hitting Mr Ho. The period between the other officers leaving the residence and SC Low discharging his weapon was 10 seconds.

108. Mr Ho immediately fell to the ground close to SC Low. ACP Rutledge immediately rendered first aid assistance. Unfortunately, Mr Ho succumbed to his injuries, and he was declared deceased at 8:17am.

Whether the police officers involved acted in accordance with Queensland Police Service policies and procedures then in force and whether their actions were appropriate, including but not limited to, the positioning of officers and decision to remain in the residence.

Whether the training provided to officers in responding to a similar incident is sufficient.

109. The Incident Review conducted by the QPS identified the central issues in relation to the actions of police prior to the death of Mr Ho. The critical factor in the circumstances was the apparent failure by police to tactically withdraw once all of the occupants, other than Mr Ho, had left the residence. There is no suggestion that the attending police were not authorised to enter the residence for the purpose of exercising powers under the *Public Health Act 2005*.

110. It was submitted on behalf of Ms Luu that after the fourth child had left the residence, the safer course would have been for police to retreat from the bottom of the stair area and shut the door behind them. It was submitted that de-escalation on the part of SC Low should have been instinctive. Alternatively, he should have been given an earlier mission objective or command that indicated that the next step was de-escalation and tactical withdrawal, to bring on the next level of negotiation. That course would have been more protective of Mr Ho's right to life.

111. As the Incident Review noted, the decision to leave QPS officers inside the residence with ACP Rutledge may have escalated the situation and hastened Mr Ho's final actions.

112. However, I note that the timeframe between the last child leaving the dwelling and Mr Ho's actions in advancing towards SC Low was less than 10 seconds.

113. The actions of Snr Sgt Manning-Jones as officer in charge, including his language and decision to 'apprehend the POI', coupled with the negotiator's unwillingness (in accordance with QPS policy) to actively engage with Mr Ho until a team was present, were also concerning features of this incident.

114. In effect, primary responsibility for engagement with Mr Ho and attempts to deescalate the situation were left to Constable Granzien. However, it was evident that she developed rapport with Mr Ho which served to deescalate the incident for a prolonged period of time. Her actions also ensured the children were able to leave the home. She did an exemplary job but should not have been placed in such a pivotal and dangerous position.

115. After hearing from the witnesses at the inquest, I accept the evidence of A/Snr Sgt Werth and Det Sgt Downey that the use of lethal force by SC Low was justified, proportionate and tactically sound given the actions of Mr Ho and the rapid escalation of the event. There was clearly a reasonable fear of death or grievous bodily harm given Mr Ho was armed with a sword and was rapidly approaching SC Low.

116. Mr Ho was experiencing a deterioration in his mental health and was significantly affected by drugs. Unfortunately, his actions escalated the incident after he produced the sword and advanced on police while he was armed with it. He also smashed the mirror in a threatening manner. He continued to move forward after being called upon to drop the weapon.

117. I also accept that the training provided to officers in relation to the situational use of force model and incident command, as well as dealing with those suffering from a mental health episode is extensive.

118. In addition to initial training while at the Academy, the training is encompassed within mandatory annual Operational Skills and Tactics training which includes scenarios involving critical incidents based on actual scenarios. Improvements to training were made after this incident as outlined by Inspector Mowle, Inspector Edwards and Superintendent Kurtz. In my view, the training provided to officers in responding to a similar incident is sufficient.

119. It was submitted for Ms Luu that no directions were given from Snr Sgt Manning-Jones to the inner cordon negotiators, apart from not having Ms Luu near the front door. It was also submitted that it was a significant failure, during the interactions with Mr Ho, for the police radios of the relevant officers to be turned down, so that Constable Granzien and SC Low were unaware of Snr Sgt Manning-Jones' directions. This resulted in ineffective communication to those in the inner cordon.

120. The family submitted there was no evidence of planning by Snr Sgt Manning-Jones to put into place the mission of apprehension, which included, strategic repositioning. The only planning was to ensure that the suitable resources were there including the PSRT and negotiators. It was submitted that an anticipatory mission statement creating awareness of what the next step might be was necessary because there had not been any plan as to what would occur with Mr Ho to that point.

121. The family did not disagree that the focus on taking the children out of the residence was appropriate. However, the question of what to do with Mr Ho was postponed by Snr Sgt Sergeant Manning-Jones and was not discussed until just after the last child left the residence, when he announced the mission was to apprehend the person of interest. It was submitted that this demonstrated a lack of planning as well as a mis-formulated announcement of the mission objective.

122. It was also submitted that Snr Sgt Manning-Jones' evidence that he considered de-escalation should be rejected because his choice of language was not consistent with a plan of attempting negotiations. It was submitted that he did not consider Mr Ho's safety at all times, given his statements, at least four times, to the contrary.

123. Snr Sgt Manning-Jones recognised during the course of his evidence that his actions could have been improved. This included the words used to articulate the secondary mission, describing the children as 'hostages', the development of a further step in the Incident Action Plan while the children were leaving the residence, as well as communication with those directly in contact with Mr Ho. Those matters were explored comprehensively by Inspector Mowle from the perspective of best practice and have been addressed by way of targeted training to all officers.

124. This was a dynamic situation with many variables. The events initially progressed slowly as the children left the home. Ultimately, it was rapidly brought to a head by the actions of Mr Ho.

125. It is clear that all officers involved assumed that the incident would proceed in the way it had as a protracted negotiation or 'siege'. The engagement of specialised services by Snr Sgt Manning-Jones to assist while enroute to the residence demonstrated a planned approach consistent with the ICENRIRE principles.

126. With the benefit of hindsight, I agree that there may have been a brief opportunity to tactically reposition the officers who were inside the residence to an outside position after the fourth child left. Mr Ho would then have been effectively contained within the home.

127. However, as I noted in the findings in relation to the Death of Daniel Lewis, whether the actions of the officers were appropriate should not be determined retrospectively. It is necessary to consider this question objectively from the perspective of the officers at the time of the incident.

128. I also accept the evidence of Det Sgt Downey that given the rapport Constable Granzien had gained with Mr Ho and how engagement had progressed in the hour before, such a step may have served to break the rapport and the visual contact police had with Mr Ho. It is also unclear whether the door, which had three locks fitted, could have been closed effectively before Mr Ho advanced on SC Low.

129. Ultimately, I accept the submission on behalf of the Commissioner that the QPS officers conducted their interactions with Mr Ho in accordance with QPS policies and procedures, and consistent with the training delivered to deal with incidents of this nature.

130. With respect to the actions of QAS paramedics in attendance, I accept Professor Rashford's evidence that the actions accorded with QAS policies and procedures. ACP Rutledge made a concerted effort to calmly engage with Mr Ho and continued to try and deescalate the situation while complying with his duty to provide Mr Ho with the mental health care and treatment he clearly required. ACP Rutledge's presence within the house during negotiations was unorthodox, but the evidence suggested the presence of a person who was not a police officer had a calming effect on Mr Ho.

131. It is clear that extensive reviews have been undertaken by QAS to consider processes and procedures, having learnt from this incident and improved any perceived shortcomings. This includes the training that has been implemented, changes made to the associated Standard Operating Procedures and the integration of the mental health liaison service within the Brisbane Communication Centre as articulated by Professor Rashford within his reports.

The adequacy of the investigation into the death conducted by officers from QPS Ethical Standards Command.

132. I agree with the submission from Counsel Assisting that the investigation conducted by Det Sgt Downey, as detailed in her coronial report, was professional, extensive and thoroughly considered the circumstances of this matter. All of the relevant exhibits were obtained, which extended beyond sourcing material relevant to considering the s 45 findings and assisted in relation to whether further preventative recommendations might be made.

The appropriateness of the communication and liaison with the family members at the scene and during the investigation into the death in custody.

133. Submissions for Ms Luu highlighted a concern that the QPS released media statements including the word “hostage” in relation to the incident. The family submitted that I should refer this issue to the QPS Ethical Standards Command to investigate whether media statements describing the children as hostages were released.

134. I do not consider that it is necessary for this issue to be further investigated. The narrative adopted by Snr Sgt Manning-Jones at the time of the incident clearly articulated that he considered the children to be hostages and that the situation was a siege. I consider that the situation did fall within the meaning of the term siege as Mr Ho was located within a stronghold and was refusing to leave. While Snr Sgt Manning-Jones subsequently acknowledged that the term hostage was not accurate, it is not surprising that media outlets adopted that narrative immediately after the incident. There was no evidence that the officers engaging directly with Mr Ho used the term hostage.

135. Ms Luu also sought a recommendation under s 46 of the *Coroners Act* for an amendment to the OPM to require a person to be appointed as a liaison officer at the scene of a critical incident to ensure the welfare of the family and that their needs at the scene are met, analogous to the support received by QPS members at the scene.

136. Counsel Assisting submitted that the engagement and liaison with the family at the scene was adequate, given the nature of the critical incident.

137. I agree that it was unfortunate that Ms Luu and her children, as well as Ms Ross were in such close proximity when the critical incident transpired. While they were distressed, they remained positioned in an ambulance securely out of view of what was transpiring as officers responded to Mr Ho. I agree that was the best option available at the time. The children were then taken from the scene by Ms Luu’s mother. Ms Luu and Ms Ross were transported from the scene by plain clothes police as soon as practical.

138. With respect to QPS communications with Mr Ho’s family during the investigation, a comprehensive review was provided by Detective Sergeant Downey, which outlines the records of interactions between QPS and Mr Ho’s family and QPS offers of support. The appointed Family Liaison Officers (FLO) met with Ms Luu on the morning of Mr Ho’s death and later engaged with Vietnamese speaking Police Liaison Officers from Inala.

139. The Ethical Standards Command is currently reviewing the role of FLOs and will develop Command Instructions and resource materials and training for members.

140. The Queensland Audit Office's *Delivering Coronial Services* Report of 2018 included in recommendation 4 that processes and practices across the coronial system be improved by "ensuring sufficient counselling services are available and coordinated across agencies to support families and inquest witnesses". The Coronial System Board has commenced work on a Family Engagement Strategy, which will draw together work by partner agencies to improve support to families.

141. The details of the review being undertaken by the Ethical Standards Command to improve the FLO role and the Family Engagement Strategy are not clear at this time. In the circumstances, I consider it is appropriate to await the outcome of that work before making a specific recommendation about support for families at incident scenes.

Comments and recommendations

142. The *Coroners Act 2003* provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

143. It was submitted for Ms Luu that OPM 14.3 should be amended to require that lethal force should only be used "as a last resort". The OPM currently provides that police officers are to only use the minimum amount of force necessary to safely resolve an incident, and "*the preservation of human life should remain a primary focus of officers attending any incident*".

144. The OPMs require that any use of force must be justified and appropriate, reasonably proportionate and legally defensible. The OPM notes that "it is unlawful to use more force than is justified by law to effect a lawful purpose".

145. Lethal force can only be deployed in self-defence or in the defence of others against the imminent threat of death or serious injury; to prevent the commission of a particularly serious crime involving grave threat to life; to arrest a person presenting such a danger and resisting their authority; or to prevent the person's escape, and only when less extreme means are insufficient to achieve these objectives.[1]

146. The Commissioner of Police submitted that this forms a part of the foundation for training about use of force options. I accept the evidence of Inspector Mowle that adding another layer into the thought process of a police officer considering use of force options may lead to a detrimental outcome.

147. A comprehensive Critical Incident review was conducted by the Operational Review Unit, about which I heard evidence from Inspector Mowle. I accept that the areas for improvement identified in his report are sufficient to address the shortcomings and learnings recognised from this incident. The steps that have been taken since this incident outlined above are sufficient to address concerns about the adequacy of the police response.

[1] *Police Powers and Responsibilities Act 2000,* s 616; *Criminal Code*, s 271

148. I close the inquest.

Terry Ryan
State Coroner
BRISBANE